The ETHICS of PROFESSIONAL PRACTICE

Richard D. Parsons

The Ethics of Professional Practice

Richard D. Parsons
West Chester University

Allyn and Bacon
Boston • London • Toronto • Sydney • Tokyo

Editor-in-Chief, Social Sciences: *Karen Hanson*
Senior Editorial-Production Administrator: *Joe Sweeney*
Editorial-Production Service: *Walsh & Associates, Inc.*
Composition Buyer: *Linda Cox*
Manufacturing Buyer: *Julie McNeill*
Cover Administrator: *Brian Gogolin*

A Pearson Education Company
160 Gould Street
Needham Heights, MA 02494

www.abacon.com

Library of Congress Cataloging-in-Publication Data

Parsons, Richard D.
The ethics of professional practice / Richard D. Parsons
p. cm
Includes bibliographical references and index.
ISBN 0-205-30878-3
1. Professional ethics. I. Title
BJ1725.P37 2000
174—dc21 00-041629

Printed in the United States of America

15 14 13 12 12

Conrad Parsons
A man of conviction . . .
An ethical man . . .
and most importantly
a Loving Fath

CONTENTS

PREFACE

For those working in the helping profession, the power of the helping pro counselor, therapist, or consultant—is more than evident. Equally eviden this process carries a similarly powerful and awesome set of responsibi omission or commission, not all those serving as professional helpers resp the helping process and as a result fail to protect the welfare of their clients to turn on a television talk show or read a local paper to find examples of pists who have sexually abused their clients, counselors who have ignored cidal pleas for help, or even medical and social workers who have persona the misfortune of others.

As helpers we are given the responsibility to care for individuals wh of needing help, are often those who are most vulnerable to manipulation. premeditated and blatant abuses of client welfare are the exception and n demonstrate the power of the helping relationship, even when the "helpe harm. Equally deleterious to client welfare—even if unintended by the he instances when ignorance of ethical standards of practice mitigates clien harm. These helpers may appear (to themselves or others) to be acting client, but their ignorance of the nature of the helping relationship and the poseful change debases even the most fundamental caveat of helping: to do in instances where a counselor acts without a clear theoretical framework, ers from a reference of unexamined values and employing untested or ina ment strategies, or when a helper violates client rights in order to sati policies and practices, the client suffers and the profession fails to advance

Standards of Practice

Professional help givers need standards of practice and guidelines for m complex ethical decisions encountered in the practice and performance of t text will expose you to the standards of ethical practice established and ma fessional boards and organizations as well as the array of ethical con emanate from the unique nature of the helper and relationship.

To BE Ethical

This is not the first text to discuss the unique challenges and needs for eth practice. As with many of the other texts, this book cites ethical standards professional organizations such as the American Counseling Association (ican Association of Marriage and Family Therapists (AAMFT), the Amer ical Association (APA), and the National Association of Social Worke

Appendix A). Throughout the book, the principles advanced by these defined and illustrated with fictional case illustrations. Knowing one's of ethics is essential. However, knowledge alone is insufficient.

We must move beyond simply knowing the ethical principles of pr ing ethical practitioners. If professional helpers expect to **BE** ethical in a professional life, then they must know and experience ethics at their m The helper must travel a personal journey of discovery, assessment, those factors that will influence his or her professional work. Only then able to truly appreciate and master the essential standards of ethical pract the helping professions. It is only then that this person will **BE** ethical i sional thought and action.

Focus

This text has been designed to move the reader from being a passive rec mation presented to becoming an active participant in the process of val ification. The text will provide the following emphasis.

1. A THEME that posits that ethical practice is more than someth essential way to BE. The emphasis throughout the text will be reader to assimilate the material into his or her own value structure ethical practitioner.
2. While points of similarity across professional disciplines will be will bring the human experience to the review of ethical standar make "professional ethics" more than a simple compilation of the provided by the major professional organizations (e.g., AP AAMFT).
3. The cases presented, as well as the guided exercises, are all desigr reader's application of the principles discussed. Given this empha each chapter employs multiple case illustrations, simulated ca guided practice.
4. In addition to such a cognitive focus, the text targets the reader's a well. Throughout the text exercises will be provided that engage valuing processes. The purpose of these exercises is twofold. First, exercises will help to clarify the points under discussion. Second tantly, it is hoped that the exercises will help the reader personaliz sented and assimilate values, which are in line with professional et practice.

Chapter Overview

In the first major part of the text, *Helping: The Role and Influence of the* of the helping relationship and the role of helper characteristics are disc

ial presented within Chapters 1 and 2 demonstrates that helping is more application of techniques or procedures. It is a process in which each parti his or her values, beliefs, needs, and even dreams in order to make the increasingly intimate relationship. Thus, it is argued, that it is imperative t aware of his or her own values.

Part Two, *Ethics and Standards of Practice*, reviews specific stan and their underlying operating values. Further, the material in Part Two tionship between professional ethics and the law. The chapters presented the text (*The Nature of the Helping Relationship*) address specific ethic emerge as a result of the unique nature of a helping relationship. Issues suc flicts: The System and the Interests of Others (Chapter 5), Informed Con Confidentiality (Chapter 7), and Boundaries and the Ethical Use of Powe presented in detail, highlighting the subtle challenges to the ethical practi section of the text, Part Four, *The Process of Helping*, discusses the spec lenges confronting the ethical practitioner as he or she attempts to provid effective treatment (Chapter 9) and remain accountable for the efficacy (Chapter 10).

A Final Thought

This book, like most other texts can be an impersonal factual disseminato Hopefully, the case illustrations and the exercises will help to make it less real key, however, is you, the reader. As you read this book, make the m Invest yourself in the exercises: The more of you placed into your readi material will be able to stimulate your growth as an ethical helper.

This preface ends with a reminder that ethics is not simply a thing t The principles of ethical practice go beyond a demand for comprehensi stration of that comprehension by performance on pencil and paper test. itself is valueless. It is in **being ethical** that life is given to these principl *d'être* for our helping is enacted.

ACKNOWLEDGMENTS

Throughout the upcoming pages of this text, a single theme will be appare
what we know or what we do, it is how we are. I have been very fortunate to
ethical people in my life, all of whom have helped give shape to this textbo

My parents modeled for me the fundamental values of autonomy, be
tice, and altruism that serve as the core to our professional ethics. I have had
fessors—especially Joel Meyers and Roy Martin—who helped me to u
embrace the professional code of ethics, and professional colleagues—
Wicks and Wally Kahn—who have served as reminders and resources at t
conflict. I also would like to acknowledge my graduate students. Their cl
concern in being the best they could be "for their clients" serves as a const
the reason I (we) am (are) in the helping profession. I am indebted to the inpu
vided by my reviewers: Cheryl Sibilsky, Lansing Community College; Ste
Paso Community College; Robert Scheurell, University of Wisconsin, M
Kimberly Battle-Walters, Azusa Pacific University. Finally, I would like t
thank you to Kelly A. Malaney for her assistance with typing and Joseph
not only for the many hours he provided in cross referencing the various c
sional conduct but also for putting up with my ribbing and developing sens

PART ONE

Helping: The Role and Influence of the Helper

CHAPTER

1 An Introduction to the Formal Process of Hel

Maria: Hi. Are you Ms. Wicks? I'm Maria. Mr. Brady told me that I had to come

Thus, with what appears to be a simple social introduction, begins a proce process which, while appearing so natural, so easy, is in truth, complex and lenges for both the helper and the client. Helping another person cope wit facilitating that person's movement toward a specific outcome is a ve process. It is a process involving at least two people. While various names be applied to the person providing the help (e.g., psychologist, counselor, a worker, etc.), we will refer to this person simply as the helper and the perso help as the client.

Ms. Wicks, a social worker consulting at a local school district, is abo a helper with Maria (the client) in a process that will require her to employ edge and skills along with a unique sensitivity. She will be called upon to r decisions as she guides Maria through this process. Helping for Ms. Wicks is a process for which there are no clear-cut formulas or recipes to follow.

The process of helping another, the direction it takes, and the outco influenced by the person of the helper. It is not just the helper's technical kn that influence and give shape to the helping process, it is also his or her valu operating ethics. The unique role and influence of the helper within the dev helping relationship is the focus of the current chapter.

Chapter Objectives

The chapter will present the role that the helper's beliefs, values, and ethic ing the decision making that occurs within the helping dynamic.

After reading this chapter you should be able to do the following:

1. Define helping as a dynamic process, reflecting both an artistry and a
2. Describe the unique ethical responsibilities and roles of the profession a helping relationship.
3. Identify the salient characteristics of the effective helper and the degr currently possess these characteristics.
4. Identify the reciprocal roles and responsibilities of both the client and ethical helping relationship.

The Helping Process: A Blending of Art and Science

The effective helper understands and appreciates the fact that helping sterile application of techniques or procedures. While a helper's unders do may be grounded in theory and research, the "when" and "how" to d tivity that extends well beyond theoretical knowledge and technical ef the many options and decision points afforded the helper working with ing case illustration (Case 1.1).

In reviewing Kim's complaint did you feel that the roommate was something else on Kim's mind? Was there a problem? While Kim was v what did you notice about her behavior, her style of communicating? S stopped Kim and asked a question at any point? Should the RA have c many questions—with no simple, clear answers.

As previously suggested, helping is a process for which there is n sequence of steps to be applied. Helping is not an automatic, cold, and problem solving. It is truly an awesome human encounter, one eng helpers' feelings as well as their minds. The complexity and dynamic na process is infused with subjectivity, intuition, and often confusion, rende as much of an art as a science. It is important to realize that as with any reflects not only the subject, or in this case the client, but also the artis mobilizes his or her values, beliefs, needs, and even dreams to make t increasingly intimate relationship.

As a contributor to this product and process, what might the RA Illustration 1.1 have contributed to the dynamic with Kim? What did t

CASE ILLUSTRATION 1.1
Kim's

Kim is a college freshman. During her first week of school she came to sp assistant (who is an upperclassman). On entering the RA's room she s "minor complaint" and before the RA could respond, Kim continued to s

> I know school has just started, and I am just a naive, little, helpless fresh down on to the floor), well, I . . . (voice becomes quiet) have a kind of . guess you could call it a small, but not real small problem, with my roo want to seem like a complainer. I'm not, am I? But (fidgeting a little), g embarrassing to talk about, I mean you're a guy (giggles), of course you oh HELL I'm just gonna say it. I think my roommate . . . is . . . well, she ing like me. No, what I mean to say is . . . I really like guys (smiles flirta I haven't had a chance to meet anyone here, except the freshman boys, b don't think she does, if you know what I mean. Well anyway, you get th just need another room!

EXERCISE 1.1
You as Helper—You as Artist

Directions: Return to Kim's case. As you read the descriptions and review
tion, try to develop a complete image of the interaction. Imagine you are th
Kim look like? Where are you standing? What might you have been doing
ing to see you? How might that affect your interest and availability to speak

After developing a real sense of the scenario with you as the RA, re
lowing questions:

What meaning did you make of all of the varied verbal, nonverba
flirting, etc.) communication?
How do you interpret the para-verbals (i.e., intonation in her voi
messages?
What elements of her style or her message did you pay attention
How did you "feel" about Kim?
What did you want to do?

Compare your observations and conclusions with a colleague or clas
she focus on other data? Have other feelings? If so, what effect might the
helper play in defining the problem or selecting a path for problem resolutio
unique characteristics of the helper influence the nature of the interaction?

needs and concerns did the RA bring to this interaction? What feelings
behaviors were stimulated or elicited by Kim? The uniqueness of the
process and outcome of the helping relationship. Two different RAs workin
have attended to different pieces of her story or her style and may have mo
ferent outcomes or the same outcome through different paths. Exercise
opportunity to identify the way the personal uniqueness of each helper ca
very nature and outcome of the helping encounter.

The Helping Process: The Meeting of Client and Helper

Albeit a very unique and special relationship, the helping relationship is *fir*
exactly that, a relationship. It is important to note that too often in our ea
assistance, we rush in with our answers, our directions, our solutions, tryin
do something to "solve the problem." We must remember that helping is
context of a helping relationship (Parsons, 1995). The quality of the relati
fore the keystone to the helping process and thus needs to be of primary con
ing to develop their helping skills.

Helping: A Special Kind of Interpersonal Process and Response

Social encounters and social relationships are not unfamiliar. The norm of these encounters is more or less familiar and comfortable for all of u helping process or the meeting of a client and helper so different?

Client's Needs as Primary

Helping is a process by which one person, the helper, interacts with a facilitate this other's (the client's) movement toward some specific out social exchanges, *primacy is given to one member*, the client. It is the c cerns, and goals that are the focus of the encounter. It is the client's welf of the relationship and the driving force behind the ethical helper's dec

As a result of this "focus on one," the purpose and outcome of the the needs and goals of that "one" and these are specified and terminal. encounters that may be open-ended with both parties remaining engag individual needs are being met, the helping relationship is designed to cific goal and terminate with the achievement of that goal. Once the g need for the helping relationship no longer exists. This outcome-spe nature of helping cannot be forgotten. Nor can the helper forget that it cerns, and goals of the client which are primary to the shaping and devel ing relationship. Consider the helping exchange presented in Case Il interaction takes place between a crisis hotline worker and a woman w ing. The exchange demonstrates the unique elements of a helping relat trasted to other social elements.

CASE ILLUSTRATION 1.2
Telephone Crisis Worker

CRISIS INTERVENTION WORKER: Yes, ma'am. I can hear tha I know it seems scary. Yes, ma'am, I am here, I am listening. what is happening?

CLIENT (voice on the phone screaming): My baby is turning blue . . baby . . . my baby

HELPER: (interrupting) . . . Ma'am! Ma'am!

CLIENT: Yes? (trying to catch her breath)

HELPER: It is important for you to try to focus on what I am te hear me?

CLIENT: Yes . . . but my . . .

HELPER: (interrupting) I know its hard for you but keep listenin must try. Roll your baby over on her stomach, place your left h and lift her stomach off the floor. Now with your right hand g

firm slap in the middle of the back, between her shoulder blades. G
that and tell me what's happening—I can hear you.

(The helper continues talking as she listens to the mother.) Good
baby now, the baby is crying—that's good—open the baby's mo
ger in and clear out anything that may be inside her mouth.

Great . . . her cries are clear and strong.

CLIENT: (sobbing) She . . . she is looking better, she coughed up
Thank you, thank you . . . you saved her life.

Like other social encounters, this one is marked by verbal exchange
information. While it is certainly an interaction, it differs from the mor
exchange, not just in the content of the interaction, but in the fundamental na
tent. In this and all helping exchanges the nature and substance is the matter
with other social encounters there is a goal implied—but this again reflects t
rent state of the client, not the helper, and emphasizes the utilization of the c
and movement toward a specific outcome (Parsons, 1995). While the helper
may have been about to take a coffee break or may have felt anxious and w
have simply handed the phone to another, it was not her needs that wer
encounter.

When the needs, wants, and concerns of the helper take center stag
of the client, we have the potential for unethical behavior and a less than he
Exercise 1.2 should help to clarify this important distinction between a he
and other social interactions.

EXERCISE 1.2
Helping as a Unique Social Encounter

Directions: As with most of these exercises, it would be valuable to complet
then share your responses with a colleague or classmate to see how individu
impact the responses and the potential for the helping process.
Part I: Below you will find three different types of social encounters in w
currently engaged or may be seeking to develop. Select one of these encounte
response to the questions that follow.

Relationships:

1. A relationship with a member of the opposite sex
2. A relationship with a person of authority who evaluates your perfor
   fessor, supervisor, boss, etc.)
3. An encounter with a possible employer.

Questions:

1. What is your primary goal for this encounter? That is, what would y
   or gain through this relationship.

2. Assuming that your goal is achieved, what need(s) within you wo
3. How might your need and your desire to achieve this specific goal interacting? What would you share or not share? How would you s you behave? As you interacted with this other person what tho might you experience?

Using your written responses regarding your goal, needs and interactio these factors affect the nature of a helping relationship should you, the h this exchange?

The Role of the Client in the Process of Change

At a surface level, the roles and functions of the participants in this form are clear. The client brings concerns to a trained helper and expects the mulate appropriate goals and to employ cost/effective strategies that goals. What could be simpler? But helping is a relationship in which th responsibilities of the participants are not always simple or clear.

Some helpers, in their eagerness to be of assistance, deprive the c tunity to take an active role within the helping process. These helpers clients to the role of a "victimized party" in need of the helper's assista the brunt of the responsibility of the process of change on the helper's s

The perspective taken here is that helping is a collaborative pro helper and the client having responsibilities and roles to be played withi ethical standards for helpers articulated by the various professional o AAMFT, ACA, APA, NASW) (see Appendix A) define the reciprocal r client—specifying the rights of the client and the responsibilities of the c Hare-Mustin and colleagues (Hare-Mustin, Marecek, Kaplan, & Liss-L helper responsibilities and clients' rights converge on issues such as freec closure of information, and protection of human dignity.

While there is a unique role to be played by the helper, the client a and responsibility within the relationship. Clients are expected to choos use of the information provided, and to assume control of their participa process (Arbuckle,1977). However, it is the ethical responsibility of the l client to assume this role, with the client's welfare always being the p Table 1.1).

Freedom and Responsibility to Choose Wisely

If we revisit the client-helper exchange that opened this chapter, we migh "freedom" and the "choice" afforded Maria, the client. It is clear, at lea presentation, that her perspective was that she "had to come to talk with'

While absolute freedom may not be afforded clients under certain c those who are involuntarily committed), even these clients have the freec bility to choose wisely within the more narrowed range of choice provide Through open communication with the helper, the client will develop a re

TABLE 1.1 Ethical Principles Promoting the Welfare of the Client(s)

Professional Organization	Ethical Principle
American Counseling Association (1995)	A.1. Client Welfare a. Primary Responsibility. The primary responsibility of cc respect the dignity and to promote the welfare of clients.
American Psychological Association (1995)	Principle E: Concern for Others' Welfare Psychologists seek to contribute to the welfare of those wi interact professionally. In their professional actions, psych welfare and rights of their patients or clients, students, sup research participants, and other affected persons, and the v subjects of re-search. When conflicts occur among psycho obligations or concerns, they attempt to resolve these conf perform their roles in a responsible fashion that avoids or r Psychologists are sensitive to real and ascribed differences between themselves and others, and they do not exploit or people during or after professional relationships.
National Association of Social Workers (1996)	1.01 Commitment to Clients Social workers' primary responsibility is to promote the w clients. In general, clients' interests are primary. However, responsibility to the larger society or specific legal obligati limited occasions supercede the loyalty owed clients, and c so advised.
American Association of Marriage and Family Therapists (1998)	1 Responsibility to Clients Marriage and family therapists advance the welfare of fam individuals. They respect the rights of those persons seeki assistance and make reasonable efforts to ensure that their appropriately.

about treatment and treatment outcome. With this knowledge the client car what degree he or she wants to be engaged in this helping relationship. Ev freedom to choose to come, to stay, or to even talk. The helper, Ms. Wicks, to understand these options along with the possible consequence for each. I role, as client, to decide what she wants from the helping process and what do to get what she wants.

Assume Control of Their Participation in the Helping Process

Helping is not something one *does to* another, it is a process that one *dc* Helping works best when clients enter it voluntarily and assume some process. Even when a client is required, forced, or coerced to come for he

be facilitated by assisting the client to affirm the relevance of the helpi willingness to participate in the process. This is true even if the only co exert is to terminate the relationship, which is their right (Bennett, Bry Greenwood, 1990).

It is incumbent on the ethical helper to assist the client to see the this helping relationship while affirming his or her right to assume cor participation. Case Illustration 1.3 reveals how a helper who "believes the right and responsibility to assume control can facilitate the develo relationship in which control and direction is shared.

Imagine the impact on this helping relationship and the possibility "help" if Ms. Wicks, the helper, took a rigid, authoritative stance: "Sit Brady sent you here, you will stay here!"

The specific details over what falls within the realm of control of belongs to the helper is not predefined. Early in the development of ea ship roles and boundaries need to be established (see Chapter 8). The according to the nature of the problem at hand, the therapeutic approacl specific orientation and values of the participants.

Make Use of the Information Provided

It is hoped that the client will assume a role that shows both an interest i nature of the current situation and a desire to develop either a differe

CASE ILLUSTRATION 1.3
Maria Assumes Control

The following exchange occurred shortly after Ms. Wicks greeted Mar take a seat.

MARIA: I don't want to be here—I didn't do anything.

MS. WICKS: You sound like you don't want to be here, but you to return to class?

MARIA: No way! He's a jerk!

MS. WICKS: Well, we have 20 minutes before the next change c like, maybe you could tell me what happened? Maybe in talki come up with a plan to make it better.

MARIA: I don't like talking.

MS. WICKS: Well, you don't have to—if you would rather, you of the period in the career center or reviewing college brochu and sound upset and I would like to help if I could.

MARIA: Let me just take a minute. Can I get a drink of water? I I'll tell you what happened.

different life position. It is, however, a role that they have a right not to en may make recommendations and suggestions that if accepted by the client r achievement of his or her goal. The client, however, is under no obligati specific recommendations or suggestions of the helper. The client can and he or she will employ the information provided.

The fact that a client can decide to use or not use the advice, the inf insight gained by working with a helper may appear obvious. Yet, it is n helper who has extended himself or herself to a client, to feel disappointe angry, at a client who appears to be less than compliant. This point may be clear after completing Exercise 1.3.

When a helper has invested time, energy, and part of the self into sup it may be hard for him or her to accept the client freedom to use or not u vided. This is more dramatically brought home in situations in which the

EXERCISE 1.3
A Client Chooses to Reject Help

Directions: The following is a brief exchange between Alice (the client) worker). Tim has been working with Alice in a program geared to help sit employment. This is the sixth time they have met.

As you read the vignette, try to place yourself in the shoes of the helj the case illustration, respond to the following questions. As with previous prove beneficial for you to share your responses with a colleague.

ALICE (the client): Hi, sorry I'm late, but I got a phone call from an I was going out the door.

TIM (the helper): Well, Alice, we have approximately 20 minutes lef ment. How about we use the remainder of the session to discuss l with your telephone calls?

ALICE: I know I agreed to attempt to call at least three jobs for possil this was a busy week, plus I had a friend in town and we wanted tc So I just kinda figured we could do it another time.

TIM: Okay, but in addition to making the calls, you also agreed to c(est inventory I gave you. Maybe we could review your profile. L

ALICE: Gads, you know what, I remember you giving it to me but I misplaced it or something. Do you have another one? I could try next time.

TIM: Alice, I am a bit confused. We have been meeting for 6 weeks you stated that you really want to work on identifying a possible (get back to work you seem to have some difficulty following thro we discuss. Each time we have decided on a "homework," like to paper, or to go speak with a nurse's aide about her experiences in telephoning and interest inventory—you have had difficulty com

ALICE: Well, I'm sorry, but a lot of the things you suggest see things are just not convenient for me to do! So what should I d

1. If you were the helper in this scenario, how might you be feeling
2. How might your feelings about Alice be manifested in your inte they impact your desire to work with Alice?
3. How would you respond to Alice's comment that "a lot of the thin dumb."
4. At this point how easy is it for you to remember that the client has degree to which he or she will follow your recommendations?
5. If the client called and wanted your assistance with another prol willing to help?

ignore the helper's recommendations and advice results in the client's lc Illustration 1.4).

While it may be hard for any helper to accept a client's refusal to a recommendation designed to maintain life, the fact remains that the d life and death decision—rests with the client. It is the client who will u and how to use the information, and the assistance provided—even w such assistance, results in his or her death.

The Role of the Helper in the Process of Change

As noted throughout the previous section, the helping process is clearly a significant roles to be played by both the client and helper. But even wi

CASE ILLUSTRATION 1.4
A Client Chooses Death

Roberto is a 67-year-old widower with two adult children. At the age of 6(nosed with ALS. Over the course of the last year Roberto has experienc(his health and has become depressed. Dr. Sebring (a pastoral counselor with Roberto for his depression. Dr. Sebring has been employing a numb niques to help Roberto reframe his life condition in such a way as to reest with his disease. Roberto has been very engaged in his counseling and e techniques and strategies suggested by Dr. Sebring. As a result of his in seling, Roberto has found relief from his depression.

Roberto's disease has been progressing and within the last week h to swallow. Roberto's physician wants to insert a feeding tube but Robe procedure. Dr. Sebring has continued to work with Roberto encouraging and to follow his physician's recommendation. Roberto, however, is clear he does not want to be admitted into a hospital, nor does he want to ha inserted. Roberto refuses to accept the recommendations of either hi Sebring knowing full well that his refusal will result in his starvation and

about client responsibilities, one cannot forget that the client comes to t tionship often confused, anxious, and most certainly vulnerable. Helping of power: The helper is entrusted to use that power wisely and ethically, welfare being central. This concern for *client welfare* serves as the orga behind the various roles assumed by the helper within the helping relation dards (see Table 1.1) include statements such as that found in the ACA St cal Standards (1995).

> The member's primary obligation is to respect the integrity and promote client(s) (Section A.1.A).

Although the specific way this obligation and role of the helper is m: influenced by the theoretical approach, the nature of the problem, the uniqu of the client, and the context within which the help is provided, there responsibilities that universally fall to the helper in a helping relationsl generally responsible for the following: (1) defining and maintaining a help (2) facilitating a helping alliance; and (3) facilitating the client's moveme specific outcome. Each of the these responsibilities have as their prin "respect the integrity and promote the welfare of the client(s)" (ACA Cod tion A.1.a).

Defining and Maintaining a Helping Relationship

The helping relationship is oftentimes very intense and almost always inti invited to disclose the very personal details of their lives and their situa relationship is characterized by a power differential that leaves the client helper's actions (Keith-Spiegel & Koocher, 1985; Pope & Vasquez, 1991) the helper who is ethically responsible for the relationship (Adleman & Ba helper is responsible for creating and maintaining the boundaries that kee during these vulnerable times (see Chapter 8).

Unlike other relationships, in which the goal is to respond to and care needs, in helping it is the helper's responsibility to address the client's nee other way around. Relationships in which the helper is using the interactio to meet his or her own needs threaten this principle of professional conta following case illustration (Illustration 1.5) as it elucidates this point.

Returning, for example, to the American Counseling Association (ACA, 1995), we see the following mandate: "counselors are aware of the relationship . . . [and] maintain respect for the clients and avoid activities t their personal needs at the expense of the client" (Section A.5.a). The help for defining and maintaining some control over the types of information bei the nature of the relationship as appropriate to the client. To successfully fill this role, this responsibility, helpers need to be aware of their unmet nee that these may have on their objectivity and helping relationships.

Self-Awareness of Helper's Needs. Since the directive for the ethical h engaging in activities that seek to meet the helper's personal needs at th

CASE ILLUSTRATION 1.5
A Helper Who Needs to Be Needed

Aneesha is a guidance counselor in a public middle school. She has v month with Leonard, a seventh-grade student. Leonard was referred to t by his homeroom teacher. The teacher expressed her concerned that Le and somewhat vulnerable to being manipulated by his peers. The teacher t could use some assertive training.

Aneesha has recently divorced. She has found herself feeling lor compensate by spending more time at work. Aneesha comes early to s She has begun to contact students with whom she had previously worke status, and asking if they would like to come into talk with her.

Aneesha worked with Leonard for the past five weeks and his hon noted a change in Leonard. Leonard appears more verbally expressive, b peers. Further, Leonard has made it very clear to his teacher that he woul counseling. Leonard explained to his teacher that he had asked Aneesha i ing for a while and she said that it wasn't time yet. Leonard asked if the t the counselor.

The teacher shared her observations with the counselor along witl However, the counselor responded in no uncertain tone that she was t "knew when it was right to stop."

---

client, it is essential for helpers to be aware of their own unmet needs (e.g nurture, control, intimacy) so that they do not seek satisfaction via the he

The power of the helping relationship, the vulnerability of the cli sity of the helping encounter can exert subtle influences on the parties prove quite seductive to the unaware helper. Consider the following 1.4) as it raises your own awareness of the potential for such boundary

Ability to Maintain a Degree of Emotional Objectivity. Recognizing tive impact that one's unmet needs and concerns may have on the helpin essential, yet not sufficient, step. In addition to recognizing these unme helper needs to be able to maintain emotional objectivity throughout the Such emotional objectivity is often difficult to maintain, a point whicl Chapter 8.

The Use of Contracts. One strategy employed by many helpers in esta taining the helping relationship is to formally define the nature and bou tionship in terms of a helping contract (Sills, 1997). Ethical helpers infor purpose and nature of the helping process (see Chapter 6).

This process of providing information not only facilitates the clie ingly participate and choose wisely, but also sets the boundaries of the he The use of a contract can serve as a means for clarifying the nature, limit and rights of the helping relationship. In developing a contract the help

EXERCISE 1.4
Recognizing a Helper's Unmet Needs

Directions: Along with a classmate or colleague, review the following case d read the description of the five helpers listed below. Next:

1. Identify each helper's possible unmet needs.
2. Discuss the ways that the various helper characteristics and potential u negatively impact the helping relationship.

The case situation and client description: The client is a 45-year-old mother o to a marriage counselor, complaining that her husband was insensitive to woman and as a person. In her sessions she described her husband as traditi what chauvinistic. She stated that while he was a good provider, he was not her to go back to school and develop a career of her own. When discussing t tionship, the woman complained that her husband had a low sex drive while s ual and would like to experiment with creative sexual activities.

Five potential therapists:

1. A female therapist who divorced her husband, returned to school, and her degree.
2. A male therapist who comes from a traditional family and who himse home-wife and three children.
3. A male therapist who is married and is currently having financial diffi
4. A therapist who came from a broken home in which the divorce pr drawn out and painful.
5. A therapist who has been without an intimate partner for over two yea

client to specify goals and expectations, as well as to affirm the boundaries ship. While there are no hard and fast rules about the elements of a helping that seem to be essential to the informing nature of contract have been ider nett and colleagues (1990) and are presented in Table 1.2.

It should be noted that not all helpers endorse the value of a contrac and Glavin (1995) cite research that questions the value of a contract for th authors question the client's capacity to give informed consent or to agree Even with this as a possible caveat, clients have the right to have the h explained to them. The ethical helper will share information within the capac to understand that information and do so in language appropriate to the client prehension (see Chapter 6).

Facilitating the Development of a Helping Alliance

A second responsibility of a helper is to facilitate the development of a wo ship with the client. It is important for the helper to attempt to reduce the clie iety by providing the facilitative conditions for helping. Creating a warm

TABLE 1.2 Elements of a Written Contract

While we are not suggesting the use of a contract as a risk management tech
consult local laws that govern contracting, especially in terms of consumer r
employed, the following are some of the elements to be considered for inclu

- Name of helper and client
- A preliminary schedule of sessions
- A date when sessions will begin
- A statement of goals
- A description of the model, techniques, and strategies to be used
- A description of potential negative effects of treatment
- A description of alternatives techniques that might be employed, along assist the client to find these alternatives
- Fee structure and payment schedule
- Statement regarding fee policy for missed appointments, telephone cont
- A statement regarding the limits of confidentiality
- A statement of "no guarantee" of success and invitation regarding freed terms of the contract at any time.
- Signatures that identify client understanding and acceptance.

(Adapted from Bennett, Bryant, VandenBos, & Greenwood, 1990)

relationship in an atmosphere of understanding and acceptance is prin process.

Therefore, in addition to increasing our self-awareness of the limi negative impact our biases may have on the helping process, it is als helpers, need to develop a number of values and attitudes that assist th share his or her story.

The effective, ethical helper will demonstrate qualities of *accep genuineness* (Berenson & Carkhuff, 1967; Carkhuff & Berenson, 19 Truax & Carkhuff, 1965). While these conditions may not be sufficie comes in every case, it does appear that they are key to the helping alli in a facilitative way to the positive outcomes of helping (Ivey, Bradfo Morgan, 1993). So just as it may be assumed that ethical helpers are l skilled, they must also be people who can demonstrate these facilitative tance, warmth, and genuineness.

Facilitating the Client's Movement Toward Some Specific Outcome

In addition to providing the structure and conditions of a helping relatio expected to bring special knowledge and skill to the interaction, wh within the helping process, will assist the client to more effectively co

hand. A fundamental principle to which all professional groups subscribe ar be more fully discussed in Chapter 2 is that a helper must be aware of the his/her professional competencies and not exceed those limitations in the de her services (see Chapter 9).

Helpers need to bring specialized knowledge and skills to the process c ical helpers do not employ procedures or techniques for which they are not pr nor do they extend their helping to those individuals whose problems are we scope of training and expertise.

When operating alone in our offices, with no faculty member or su ing over our shoulder, our real desire to help the client before us may sedu ing new techniques or approaches or even attempting to help with problems t our training and our experience. Knowing the limits of our competenc ing to seek ongoing training, supervision, consultation; or making a refe helper are all characteristic of an ethical helper (Parsons, 1995). This issue will be discussed in greater detail in the next chapter (Chapter 2).

Case Illustration

We began the chapter with a brief introduction to Maria, a client seeking th the school social worker, Ms. Wicks. We will continue to follow the deve helping encounter between Marie and Ms. Wicks throughout the upcoming

As you read the case illustration, try to identify the presence of the va and important terms described within the chapter. Further, as you read the c self in the role of the helper and begin to identify the various concerns and consideration you might experience in that role.

Client: Hi. Are you Ms. Wicks? I'm Maria. Mr. Brady told me that I ha with you.

Helper: Hi. Yes, I am Ms. Wicks (getting up to shake Marie's hand). come in and have a seat? (Ms. Wicks makes a mental note about Maria Maria, while appearing annoyed, is a very attractive girl. She looks you in speaks and appears self-confident. Maria's manner of dress is somewhat skirt is very short and tight and her sweater has a very low neckline.)

MARIA: I don't want to be here—I didn't do anything.

MS. WICKS: You sound like you don't want to be here, but you are he like to return to class?

MARIA: No way! He's a jerk!

MS. WICKS: You certainly sound angry. Maria, I know you said you be here, but since you are I would love to hear what happened anc be of some help? We have 20 minutes before the next change o would like, maybe you could tell me what happened? Maybe in talk could come up with a plan to make it better.

MARIA: I don't like talking.

MS. WICKS: Well you don't have to, it really is your choice. If yo spend the rest of the period in the career center or reviewing c But you do look and sound upset and I would like to help if I c

MARIA: Let me just take a minute. Can I get a drink of water? I'l I'll tell you what happened.

MS. WICKS: (After Maria comes back). Well, how was that? B really do understand it is a bit strange to talk to someone you do been able to meet and talk with a lot of the people here at sch my experience that sometimes this has been very helpful. You but I am a social worker and I have been trained to help people you have any questions about what I do here or what a social v

MARIA: No, not really. You spoke with one of my friends who lems with his mom and dad. Did you see Jose Ramirez?

MS. WICKS: You know Maria one of the things I think is very work with people is that I respect their privacy. In fact, when y some things I will keep them in confidence. I mean, I won't tell we talk about without your permission. Now there are some e> like if you tell me you are going to hurt yourself or try to hurt I can't keep that secret. Your life is too important to me so I w many people as possible to help me keep you safe.

MARIA: Yeah, I know about confidentiality—I've gone to a shri

MS. WICKS: Since we have a few more minutes maybe we coulc together later today so that you could tell me what happened a we could decide if you and I could work on it? What do you th

MARIA: Yeah, that's cool. I have a report to give in my next cl study hall after that. Could I come back then?

MS. WICKS: (Looking at her calendar). Yes, I'm free. That's m about if we share a sandwich here in the office and get to knc better?

MARIA: Okay.

MS.WICKS: (Reaching in her desk). Here is a pass. So I'll see yo the bell. Get back to your class—and give a great report! See y

Reflections

1. Did you see any evidence of the creation of boundaries to this rel
2. Did Maria enact the role and responsibilities of a client, which wer the chapter?
3. If you were the helper in this situation, how might have Maria's ap story impact your objectivity or ability to be an effective, ethical h
4. What do you think Ms. Wicks needs to consider as she prepares t her role as an ethical helper, meeting with Maria at 12:15?

Cooperative Learning Exercise

The purpose of this chapter was not only to introduce you to the natu process, the roles to be played by both the client and the helper, and the un lenges to be confronted within this role of helper, but also to have the you own self in the role of helping. Being in touch with what you bring to the h is an essential first step to becoming an ethical and effective helper. There ceeding to the next chapter, reflect on the following and discuss your r supervisor, colleague, or classmate.

1. Review your responses to this chapter's exercises. Were you honest energy in responding? If not, why not? What might this suggest ab ment in becoming an effective, ethical helper?
2. What did you learn about yourself as a helper? What specific eleme as presented within this chapter—excite you or concern you?
3. Which particular characteristics of the effective, ethical helper do y sess most strongly, and which do you feel you need to focus on dev
4. How might you approach the reading, the exercises, and the reflec chapter to maximize your development as a more self-aware, ethica

Summary

The Helping Process: A Blending of Art and Science

The complexity and dynamic nature of the helping process is infused v intuition, and confusion, rendering its facilitation as much of an art as a foundation of theory and research serves as the base for effective helpi process is highly influenced by the personal application and artistry of th she adapts technology and research findings to the unique characterist clients.

The Helping Process: The Meeting of Client and Helper

Like other social encounters, helping is marked by verbal exchanges and mation. Unlike most social encounters, however, helping is one in which t to one member, the client.

Helping is a process by which one person, the helper, interacts witl a way so as to facilitate this other's (i.e., the client's) utilization of his or he or she moves toward some specific outcome.

The Role of the Client in the Process of Change

Ethics not only ensures clients' rights but places corresponding respons Clients are expected to choose wisely, to make use of the information provid control of their participation in the helping process. It is the client's role t

or she wants from the helping process and what he or she is willing tc
wanted

The Role of the Helper in the Process of Change

The helper's primary obligation is to respect the integrity and promote
client. This is accomplished in part by (1) defining and maintaining a h
(2) facilitating a helping alliance, and (3) facilitating the client's move
specific outcome.

IMPORTANT TERMS

acceptance
art
assume control
boundary violation
client
conditional valuing
congruent
contract
competence
defining and maintaining a helping relationship
dynamic process
emotional objectivity
facilitative attitudes
genuineness
helper
helping alliance
helping relationship
promote the welfare of
science
specific outcome
use of the information
warmth

SUGGESTED READINGS

Bersoff, D.N. (1995). *Ethical conflicts in psychology*. Washington, DC: American Ps
tion.
Parsons, R.D. (1995). *The skills of helping*. Boston: Allyn and Bacon
Rave, E.J., & Larsen, C.C. (1995) *Ethical decision making in therapy: Feminist per*
Guilford Press.
Sills, C. (Ed.). (1997). *Contracts in counseling*. Thousand Oaks, CA: Sage Publicatic

CHAPTER

2 Helper Variables: Wh Helper Brings to the Helping Relationship

Ms. Wicks: Maria, let me see if I understand what you are saying. You are sexuall you don't care that you are engaged in unprotected sex. The possibility of becomi contracting a sexually transmitted disease, even AIDS, doesn't concern you. Is th saying?

Ms. Wicks, the counselor in our sample case, appears to be actively liste rately reflecting Maria's explicit message. However, one must wonder about which she reflects that message. As a trained professional, Ms. Wicks attempting to remain objective as she continues her work with her client, Ma tivity does not mean emotionally detached or without one's own values and

Ms. Wicks has feelings, expectations, biases, and values regarding adol ing in unprotected sex, and while she is attempting to maintain a professional assume she can remain value free is naive at best and "from an ethical persp ous" (Newman, 1993, p.151). Does Ms. Wicks' tone of voice, inflection, or guage reveal her own biases and beliefs regarding unprotected adolescent se

The complexity of a helping process as a problem-solving venture, potential for intense emotional reactions to be experienced by all involved, n ing process highly vulnerable to the influence of the needs, interests, beliefs tions of both helper and client. We enter a helping relationship—as relationships—full of personal expectations, biases, and values. Further, as v encounters, these expectations, biases, and values cannot help but influen relationship, often in profound ways.

The ethical helper needs to be aware of her or his values, biases, and along with circumstances wherein these personal values, biases, and exp interfere with the effective helping of another. It is these affective and sub that the helper brings to the relationship along with clinical knowledge and as the focal point for the current chapter.

Chapter Objectives

Extending the discussion started in Chapter 1, which illustrated the role of th process of change, the current chapter will discuss the role that a helper's v

biases, and professional model plays in giving shape to the helping proce of change. After reading this chapter you should be able to do the follov

1. Explain the need for helpers to increase self-awareness of perso and expectations.
2. Describe the steps to be taken when helper–client values conflict.
3. Discuss the value of a helper having a theoretical model.
4. Define what is meant by "helper competence."
5. Discuss what is meant my the concept of cultural sensitivity.

Helper Values

While it is expected that the client's needs, values, and desires will give of the helping encounter and the nature of each helping interaction, expected is the role that the helper's values, needs, beliefs, and interests p helping process. Consider the following case illustration as it demonst influence that the helper's personal values, needs, beliefs, and interests m helping process (Case 2.1).

Clearly, Michele's personal interest in childbearing and current exp and grief around her inability to conceive is making it difficult for her t ally detached as she listens to Judy's story. While professional boundari ethical helping, the concept of helper detachment and total objectivity is that if gone unchallenged can prove detrimental to the helping relationsl

Helpers: Detached and Objective

The fact that helpers' biases, expectations or values are active in the he run contrary to your own belief that helpers must be totally objective, tc is neither possible nor desirable to be "scrupulously neutral with respe counseling relationship" (Corey, Corey, & Callanan, 1988, p. 67). The p of a helper's values, needs, beliefs and interest within the helping relatic concern and interest for all professional organizations (Table 2.1).

While professional organizations cannot police personal values— the importance of recognizing the existence of these values. Further fessional organizations have attempted to codify a set of values to guide tice and present these in the forms of codes of professional conduct anc one cannot simply compartmentalize the "ethics" of the professional virtue, value, and ethics of the person of the helper. As such, it is impera helpers to increase awareness of their own personal values, beliefs, and ex as their roles in giving shape to their professional identify and behavior dynamic.

CASE ILLUSTRATION 2.1
Michele: Maintaining Objectivity

Michele is a social worker for the Department of Human Services in a large
From all accounts, she is a consummate professional, respected by her pee
and truly embraced by all her clients. Because of her own competence, Mic
some of the hardest cases to handle.

Michele and her husband of five years have, for the past two years un
to have a child. Michele has just found out that she is unable to get pregna
tissues lining her fallopian tube. This news has been very upsetting to Miche
rently in counseling.

Michele has continued to go to work and to date has been able to m
professional calendar. Michele has just been assigned a new case. Judy, is a
gle women who is currently living in a halfway house for people progressi
treatment program. The following is part of the intake interview between M

MICHELE: Hi, Judy. Please come in and have a seat. Thanks for c

JUDY: No problem.

MICHELE: As you know I am a social worker for the Department o
and I will be your case worker while you are at Hansen House (the
will help you coordinate your work and therapy schedules and wo
ing to develop a career development plan.

JUDY: Yeah—I kind of know what you do—I've done this before.

MICHELE: You have?

JUDY: Well, not the halfway house, drug thing. But I had a social w
11 and another time, like at 13 or 14, living in Detroit.

MICHELE: So you worked with a social worker before. Could you
was like?

JUDY: It was okay—I had to go 'cause I was living on the street an
couple of times and tried to abort myself.

MICHELE: You were pregnant?

JUDY: Duh, yeah.

MICHELE: But you were just a kid! Just 11!

JUDY: Yeah—so? I was having sex when I was like 9 or 10. I must
nant like four times—with two abortions and two "whatevers."

MICHELE: Whatever? Judy, you are talking about human life here

JUDY: Whoa, cool it . . . that was then . . . I thought you were supp
me with this career thing? I don't need another person preaching

TABLE 2.1 Ethical Principles Regarding Objectivity

American Association of Marriage and Family Therapists (1998)	3.2 Marriage and family therapists seek appropri assistance for their personal problems or conflict work or performance or clinical judgment.
American Counseling Association (1995)	A.5.b Counselors are aware of their own values, and behaviors and how these apply in a diverse s imposing their values on clients.
American Psychological Association (1995)	1.13 Personal Problems and Conflicts (a) Psychologists recognize that their personal p conflicts may interfere with their effectiveness. refrain from undertaking an activity when they k that their personal problems are likely to lead to client, colleague, student, research participant, o whom they may owe a professional or scientific (b) In addition, psychologists have an obligatior of, and obtain assistance for, their personal probl stage, in order to prevent significantly impaired (c) When psychologists become aware of persor may interfere with their performing work-related they take appropriate measures, such as obtainin consultation or assistance, and determine whethe suspend, or terminate work-related duties.
National Association of Social Workers (1996)	1.06 Social workers should be alert to and avoid that interfere with the exercise of professional di impartial judgment. Social workers should inforr or potential conflict of interest arises and take re resolve the issue in a manner that makes the clier primary and protects clients' interests to the grea In some cases, protecting clients' interests may r of the professional relationship with the proper re

Helper Values and Expectations: Shaping the Helping Relationship

Many professional helpers (e.g., counselors, therapists and social work selves as totally objective, totally value-free. As noted above, total objecti It is possible that the feelings experienced in the helping encounter or the tations with which the helper enters the relationship can distort the helpe interfere with the effective utilization of an appropriate helping process. oftentimes be quite subtle in their development and thus can go unrecogni done their damage (see Case Illustration 2.1).

EXERCISE 2.1
Identifying Areas of Helper Value Conflict

Directions: Part 1: Review the characteristics and experiences of eacl ing helpers and assume that his or her unique experience may cause bi ular direction. Next identify a type of client problem for which the helpe strong feelings (for or against) and thus may have difficulty remaining no objective.

Discuss with your colleagues or classmates the impact such bias may ing process.

COUNSELOR A: A female professional who had to pay for her own baccalaureate education even as her family objected that a place fo home.

COUNSELOR B: A divorced professional who experienced and cor ence a bitter dispute over child custody.

COUNSELOR C: A person who was raised in a very strict, bible-c family and who identifies herself as a Christian fundamentalist.

COUNSELOR D: An overachieving, highly successful, somewhat d has been accused as being a workaholic by his coworkers.

Part 2: For each of the following clients, identify one of the counselors (li may have difficulty in remaining objective and nonjudgmental

CLIENT A: A person considering an abortion

CLIENT B: A person considering suicide

CLIENT C: A child abuser

CLIENT D: A person having an extramarital affair

CLIENT E: A person wishing to break away and becoming ind parents.

Helpers cannot always keep their own values out of the helping proce systems do influence the helper's view of goals, strategies, and even topics di gren, 1993). While helpers cannot be totally value-free, this does not mea license to make helping an indoctrination process (Grimm, 1994). Exerci illustrate the potential conflict that can exist between helper values and clier

As may be evident in the illustrations provided in Exercise 2.1, he biases can interfere with effective helping. Establishing professional boun taining professional detachment and objectivity in service of the clie absolute, remains a goal of ethical helping (see Chapter 8). In service of thi be necessary for the helper to not only clarify but also articulate his or h professional values and the role they may play in the helping process (Ne client has a right to know where the helper stands on various issues presen

helping process (Corey, Corey, & Callanan, 1998). To do less is to de self-determination (Brace, 1997). Therefore, the ethical helper will atten understand the role personal values may play in her or his enactment of prior to engaging in a helping relationship. Through such heightened helper may be more able to monitor the potential influence that his or her tations may have in the helping relationship.

It may be hard for you as a helper to anticipate the type of client prc you will be invited to work. As such it may be hard to predetermine hov help or hinder your effectiveness as a helper. Exercise 2.2 is designe awareness of values and bias. As with each of the exercises it is sugges are shared and discussed with your colleagues or classmates.

The challenge for the ethical helper is to use personal values to er process without abusing the power of the relationship or the vulnerab While it is clear that the ethical helper will resist the temptation to becor a particular value, she or he will also be "honest enough to recognize hov mitments may not promote health"(Bergin, 1991, p. 399).

When Values Conflict

The mutual nature of the helping process almost ensures that there will individual values, beliefs, and needs of the helper and client may conflict

EXERCISE 2.2
Areas of Personal Bias

Directions: Part 1: For each of the following identify your belief, your at about the issue presented. Along with a classmate or colleague, discuss your position on each of these issues may have as you engage in the help

Equality of genders
Fidelity in marriage
Children's rights
The recreational use of drugs
Date rape and the responsibility of the person raped
Cheating in school
The viewpoint that one should be able to pull himself or her straps
The sanctity of marriage
A women's right to choose an abortion
Alternative lifestyles

Part 2: Through personal reflection and discussion of your responses to F items in Part 1 for which you have *strong* opinions, attitudes, or values. client problems for which these values may interfere with your ability to r nonjudgmental.

the client and accepting the client's right to choose his or her own vales, a agree with or embrace those values. Consider the Case Illustration 2.2.

Under these conditions, the ethical helper will expose those values then along with the client, review these areas of value conflict in order to may impact the decisions made in the helping process. When the conflic interferes with the helper's ability to effectively assist the client, the ethical pare the client for referral to another helper who is more in line with the cl values (see Chapter 9).

Helper Orientation: A Theoretical Agenda for Helping

In addition to having our practice decisions influenced by personal values a our view of the "reality" of the helping encounter will be shaped by the m we have embraced and employ. The information presented by each clier somewhat disjointed and disconnected. Each helper needs to weave a threa

CASE ILLUSTRATION 2.2
Conflicting Values

Howard is a clinical psychologist who is married with three children, ag Howard married at the age of 20 and worked full-time as he finished his s lege and continued as a graduate student. When his wife, Lisa, became pre mutually decided that Lisa would stop working and would be a stay-at-ho until their children were in high school. Both Lisa and Howard value the im dren having a full-time parent at home, especially during what Howard ca years.

Howard has just received a call from a new client, Tangelique. In intake, Howard learns that Tangelique is 31 years old, a member of a major l to become a partner. Tangelique's husband, Ralph, is a physician completin idency. Tangelique is three months pregnant and, according to Tangelique, s fighting a lot and having "serious marital conflict." The conflict centers on care following delivery. Tangelique wants to return to work as soon as possi the baby can do very well receiving "good, professional child care." Ralph that it is essential for a parent to be at home especially during these early ye he would be willing to stay at home if he had completed his residency, but a half to finish. He wants Tangelique to stay home for the next two years a decide what to do. Tangelique is willing to cut back on her 60 hours a week this is totally unacceptable to Ralph.

As Howard listens to the presenting concern he becomes very aware c ings of agreement with Ralph, even prior to meeting the couple. Tangelique s her husband agree that professional counseling is important at this point in t and they would like to schedule an appointment.

or find a theme within the information so that she or he can understa going on and how best to approach this situation. Most helpers find th of the information provided by the client is aided by the use of a t framework.

Theories of helping such as behavioral theory, psychoanalytic th ory, systems theory, and the like provide frameworks for understandi person's actions as well as offering prescriptions for how to help the pe fully functioning life.

However, just as these theoretical models help us to "make sense provided by the client, we must be sensitive to the possibility that such "sense" on the data offered (see Case Illustration 2.3).

While it is possible that Jimmy is having difficulty resolving iss sexuality, father–son relationship, and so on and therefore acts silly in anxious, it is just as likely that Tom is simply making him laugh. Pegg

CASE ILLUSTRATION 2.3
Finding or Imposing Meaning

Peggy is a recent graduate with a master's degree in counseling. Peggy be a counselor and has been very taken by the psychodynamic view of h to go on for additional training and someday become a psychoanalyst.

Peggy is currently employed as a middle-school counselor. She with Jimmy, age 11. Jimmy was sent to her office by his health-scienc concerned with Jimmy's tendency to giggle and "act silly" during heal about his behavior in class, Jimmy described the following.

> I sit next to Tom. He's my best friend. But he is a goof. He is alwa or saying things about what we are talking about in class—and I car laugh. I always get caught and Tom gets away with it.

Peggy asks Jimmy to tell her what they are studying and what ty say.

Jimmy responds:

> I don't know . . . something to do with becoming a man and a woma like that, I don't know . . .

At this point, Peggy starts to challenge Jimmy and ask other informati ship with his parents.

> Jimmy, you keep saying you don't know. Is it that you don't know or to talk about these type of things?
>
> Jimmy, it would be helpful to me if you could tell me a little about yo tionship with you parents, especially your Dad.

choanalytic theory as well as her own limited training may be directing her t
where none exists.

The ethical practitioner needs to be competent and grounded within
research supporting the helping process (see Chapter 9). Beyond being able
model from which one approaches the helping process, it is also imperative
ical helper, one remembers that theories and models provide only tentative fr
absolute directives, and need to be tested for validity in each situation.

Reflecting and Validating Interpretations

Theoretical models can assist a helper to gather data, connect the information
draw hypothesis and tentative conclusions about the meaning of that dat
helper will keep focused on the "hypothesis testing" nature of this process (s

As data are provided, the effective helper needs to hazard tentative
meanings and connections to previous data. Once these hypotheses have be
the helper needs to go about the process of finding more information to vali
hypotheses or revise these hypotheses as new information is revealed.

The ethical helper will not only continue to identify and articulate hi
of helping but will remain vigilant in his or her evaluation and testing of the
model. Table 2.2 provides a number of questions that should guide the helpe

Helper Competence: Beyond Knowledge and Skill

The ethical helper is a competent helper. While competence implies the po
knowledge and skill required to practice (see Chapter 9), it also implies the a
ment and apply that knowledge and skill. Competence goes beyond simpl
requires doing. As such, helpers need to be self-aware and self-caring so as
best care they can.

TABLE 2.2 Guidelines for Reflections of Operating Model

Our theoretical, operative models help give shape to how we see our clients, their
prognosis, goals and pathways to those goals. It is important to check the utility a
our models for each of our clients and helping encounters.
Questions to consider in reflecting on our operational models of helping:

1. Can I explain the major assumptions and tenets of my model to a colleague?
2. Is it employed by others within the field?
3. Is there support—clinical, anecdotal, empirical—for this model?
4. Can I demonstrate its utility and validity for understanding this current case?
5. What are the limitations and inherent biases built into this model?
6. Are there specific clients, or client problems, for which this model will not be

Care of the Helper—Essential to Maintaining Competence

The failure of the helper to take appropriate care of herself or himself (and burnout which, in turn, will threaten competence and ethical pra helper maintains his or her well-being by seeking physical and psychol(is needed, by being alert to the signs of stress and burnout, and by evalu he or she has made in relation to the needs of his or her clients (Bennet Bos, & Greenwood, 1990, p. 25). The helping process can take a toll example, Farber (1983) found that conducting therapy had decreased th tional investment in their own families as well as their ability to be gen and comfortable with friends. Clearly, such an ongoing experience can r the helper's own emotional well-being but will interfere with her or his competently with her or his clients (Skorupa & Agresti, 1993).

While there may be subtle differences in both the experience burnout, most agree that it is an ongoing process of depletion of energy, and a general debilitation of one's functioning. A number of researche overly stressed, burned-out helpers can actually contribute to the dysfu fering of their clients rather than reduce it (e.g., Emerson & Markos, 19 Various codes of ethics (see Table 2.3) address the issue of practition have application to the stressed and burned-out helper.

It is the ethical responsibility of all helpers to take the steps need(selves, their clients, and even colleagues from the potentially damaging e and burnout (Benningfield, 1994). While professional help may be req impairment resulting from stress and burnout, there are other steps that can do in attempting to reduce the potential negative effects of helper st then simply focusing on the identification of impairment and the introd remedial programs, the ethical helper will attempt to employ preventive tinued education, personal therapy, supervision, and peer interaction (G steps that may help to reduce the potential impact of stress on the functi are the following:

1. *Set realistic expectations.* Ethical helpers recognize that they a Deutsch (1984), in a survey of therapists, found that practitioners with goals often reported high levels of stress. The healthy, ethical helper set tions for him- or herself, the client, and the outcome of any one helping

2. *Take care of self.* It is important for helpers to eat properly, rest, a ing is a energy-draining activity, and the ethical, healthy helper will ta ensure her or his own health is maintained.

3. *Organize and manage.* Boundaries need to be established that not professional day but help to distinguish the professional from the perso life. The ethical, healthy helper will schedule variations into the day, i breaks to take care of paperwork, personal needs, or even to to take a r

4. *Keep perspective.* Helpers need to remember that helping is part (of their life. The effective helper will also establish mechanisms for on support (e.g., supervision, personal counseling, peer involvement) that

TABLE 2.3 Selected Statements on Professional Impairment

American Counseling Association (1995)	C.2.g: Counselors refrain from offering or ac professional services when their physical, me emotional problems are likely to harm a clien are alert to the signs of impairment, seek assi problems, and, if necessary, limit, suspend, o professional responsibilities.
American Psychological Association (1995)	1.13.c. When psychologists become aware of problems that may interfere with their perfor related duties adequately, they take appropria such as obtaining professional consultation o determine whether they should limit, suspend their work-related duties.
National Association of Social Workers (1996)	4.05.b. Social workers whose personal proble social distress, legal problems, substance abu health difficulties interfere with their professi and performance should immediately seek co take appropriate remedial action by seeking p making adjustments in workload, terminating taking any other steps necessary to protect cli (NASW, 1996, 4.05.b.)
American Association of Marriage and Family Therapists (1998)	Marriage and family therapists seek appropri assistance for their problems or conflicts that work performance or clinical judgement.

the helper maintain objectivity and professional distance, especially whe particularly difficult cases.

In addition to these preventive steps, ethical practitioners will be aw ous conditions leading to stress and burnout as well as the warning signs a stress in their own life. In a somewhat classic discussion on the issue of bu berger and Richelson (1980) offer a "burnout scale" in which a helper ca or herself along a continuum from "doing fine" to "in dangerous place." E vides an adaptation of the original scale and, along with Exercise 2.4, can b your own current state of stress and burnout.

Helper Sensitivity to Diversity and Culture

Human behavior—human problems—and the process of helping occur wit cultural context. For a human service professional to view individual concer problems as separate from that person's social, cultural context is to misu

EXERCISE 2.3
Recognizing Burnout—Personal Signals

Directions: For each of the following, check the symptom or signal that you within the last three months. Discuss the symptoms that you have or are e colleague, supervisor, or another professional helper in order to develop st ing such symptoms.

———Hoped that a client would cancel or not show up
———Feel apathetic and uncaring
———Finding it harder to pay attention in the sessions
———Have been forgetting assignments, appointments, etc.
———Don't seem to laugh as much as usual.
———Don't seem to find things as enjoyable as usual
———Lost patience with a client
———Complain about cases to others
———Feel extremely fatigued at the end of the day
———Feel overly tense when with a client
———Experiencing headaches, muscle tension, or stomach problems
———Feel increasingly sad or irritable

Adapted from H. Freudenberg & G. Richelson (1980) *Burn-out: How to beat the hig* York: Doubleday.

EXERCISE 2.4
Assessing Potential for Stress and Burnout

Directions: Consider each of the following questions as they reflect approach to stress and stressful situations. The questions have been adap inally presented by Bennett, Bryant, VandenBos, and Greenwood (1990) terns that may increase your risk of burnout and develop a plan to modif

1. Do you tend to ignore problems because of fear?
2. Have you learned stress management techniques? For example, d ation techniques, time management strategies, etc.?
3. Are you aware of your own personal needs, and are you able to ta sonal needs?
4. Are you familiar with the warning signs and symptoms of stress a sensitive and aware of the appearance in these signs as they m developing level of stress?

5. Do you listen to others (e.g., members of your family, friends, colle attempt to point out their concern for your health and wellfare or w stress may be affecting you?
6. Do you consider seeking help and support when you become aware t riencing stress?

The helper who is culturally unaware and unaware of the values, assumpti that he or she brings to the encounter is vulnerable to unethical practice (S erson, 1996).

All helping is to some degree multicultural. Both helper and client b tural values and social roles to the interaction. As noted by Speight, Myers, len (1991) multicultural helping is not restricted to white helpers work clients. It applies to female counselors working with male clients, lesbi straight clients, Jewish helpers with Buddhist clients, even elderly helpe youth. In fact, it has been argued that counselors who do not integrate cross (e.g., sex, race, age, social class, or sexual orientation) into their practice client's cultural autonomy and basic human rights, and they lessen the cl lishing an effective therapeutic relationship. Clearly, these conditions woul for unethical practice.

All professional organizations emphasize the ethical imperative for tain cultural sensitivity and the importance of practitioners recognizing the diverse client populations (see Table 2.4). The APA Code of Conduc requires psychologists to obtain the necessary training, experience, consul vision "where differences of age, gender, race, ethnicity, national origin, orientation, disability, language, or socioeconomic status significantly affec work concerning particular individuals or groups" (APA, 1992, Standard

To be an ethical helper, one must be open to the values and beliefs of and be aware of how these relate to his or her own values and beliefs. M Sue, Arrendondo and McDavis (1992) proposed standards for multicultural petencies that we believe have relevance to all ethical helpers and, as su cussed in some detail. These include the following:

1. Awareness of their own assumptions, values, biases, and limitation can affect the minority client.
2. Understanding the world view of culturally different clients and h to oppressive sociopolitical forces in the United States and to traditi theories.
3. Development of a wide repertoire of appropriate intervention strate verbal and nonverbal communication and out-of-office activities wh

TABLE 2.4 Selected Statements on Cultural Diversity and Sensitivity

American Counseling Association (1995)	A.2.a. Nondiscrimination. Counselors do not co discrimination based on age, color, culture, disa gender, race, religion, sexual orientation, marita socioeconomic status.
	A.2.b. Respecting Differences. Counselors will understand the diverse cultural backgrounds of t whom they work. This includes, but is not limit the counselor's own cultural/ethnic/racial identi values and beliefs about the counseling process.
American Psychological Association (1995)	1.08 Psychologists should obtain the necessary consultation or supervision "where differences ethnicity, national origin, religion, sexual orient language, or socioeconomic status significantly work concerning particular individuals or group
American Association of Marriage and Family Therapists (1998)	1.1. Marriage and family therapists do not discr refuse professional service to anyone on the bas religion, national origin, or sexual orientation.
National Association of Social Workers (1996)	1.05 Cultural Competence and Social Diversity
	Social workers should understand culture and it behavior and society, recognizing the strengths cultures.
	Social workers should have a knowledge base o and be able to demonstrate competence in the p that are sensitive to clients' cultures and to diffe and cultural groups.

Self-Awareness

The effective helper appreciates that her or his view of life, and more s view of a client and a client's problem, is highly influenced by world o To be an effective, ethical helper, therefore, one must become sensiti own cultural framework and the way it biases his or her attitudes, va approach to helping, and (2) the client's cultural makeup and the role t plays in the creation and resolution of the problem presented. The gc expert and master of all cultural nuance. The goal is to be aware of one' ground as it serves to filter and color client information. The following tion 2.4) illustrates the potentially negative impact one's ignorance of p may have on the accurate understanding of the client's information.

Ms. Thompson, the counselor in this case illustration, was certainly
While she most likely values the family unit, it appears that, unlike Lida,
sees the family as a springboard from which the individual child individu
on. From this perspective, college serves as an excellent resource to stimul

CASE ILLUSTRATION 2.4
School Counselor—Filtering Client Information

Ms. Thompson is a senior high counselor working with college placement. S
ognized as extremely competent and quite successful at assisting her students
to the colleges of their choice. Ms. Thompson also prides herself on being abl
dents gain entrance to the "best colleges."

Ms. Thompson is about to meet with Lida Alvarez, a transfer student
an aptitude for mathematics. Lida's family recently moved to this district, f
neighboring district for the past six years. Lida's family is originally from
family (Lida, an older brother, mother, father, and paternal grandparents) mo
States when Lida was 10 years old.

Ms. Thompson: Hi, Lida. I'm Ms. Thompson, your college counselor.
records that you are and have been a very good student. You appear to have
mathematics. I would be interested in knowing what colleges you have begu

LIDA: I am not thinking about going to college, at least not right afte
high school.

MS. THOMPSON: Lida, if it is a financial issue there are a number of
which you would be a great candidate. I have a lot of success getting

LIDA: No, it's not the money. I'm going to work with my mom and
ily restaurant.

MS. THOMPSON: That is nice, Lida. However, don't you think th
your abilities should consider doing something beyond restaurant

LIDA: It's not just restaurant work—it is our family's restaurant. It w
grandfather's and has been in our family for fifty years. They starte
which my uncle's family continues to run, and we have had this o
States for six years now. This has been my grandfather's dream to
rant to the United States.

MS. THOMPSON: I didn't mean to suggest it is not a good restaura
you may find it more stimulating and challenging to go on to colleg
you work in the restaurant.

LIDA: Ms. Thompson, I am sure you mean well, but this really isn't a
restaurant, money, or any of that . . . it is about family, and for
needs me to work in the restaurant—and I want to be part of the tra
father started. There may be a time, later, when I will want to con
else, including college, but for now I am looking forward to gradua
out with my family. But, thanks for your help.

ual development. Lida, however, values family and her ability to contr nance. Ms. Thompson missed Lida's perspective on family and her rol family commitment and the importance of tradition in maintaining the clearly a value that is directing her decisions, one in which she takes pri of satisfaction.

The ethical helper needs to acknowledge the impact that ethnicity one's behavior and take these factors into account when working with cultural backgrounds. Further, the ethical helper will seek out educa experiences to enhance understanding of the influence of his or her own the variety of values embraced by their clients so that he or she can a these populations more appropriately and effectively.

Understanding the World View of Culturally Different Clients

The ethical and culturally sensitive helper is aware of the limitedness any one single cultural perspective, even if, and perhaps especially wh represents the cultural mainstream. The ethical helper is aware that th colored and is therefore sensitive to a larger worldview.

It is not the intent to suggest that each helper be skilled and knowl tures or that a person abandon his or her own cultural perspective. Nor is gest that to be ethical one should only counsel those of similar culture only would such a suggestion be unrealistic, but evidence for ethnical seling is less than convincing (Atkinson, 1983). What is suggested, how ical helper will accept and *value* as legitimate the culturally diverse pe by clients. To see the client, the client's concerns, and the impact of the through the cultural lense of the client is both a challenge and an eth Exercise 2.5 highlights the challenge posed by such a call to cultural se

Development of a Wide Repertoire of Appropriate Intervention Strategies

In addition to being aware of the biasing influence of one's own cultur culture perspective of the client, the ethical helper will attempt to e strategies that are in concert with the client's culture. The ethical, cultura will understand the institutional and cultural barriers that may interfere v of particular strategies and interventions. Further, the ethical helper w respectful of the indigenous helping practices and intrinsic help-giving various cultures and communities. For example, Sue and Morishima (19 ture-specific intervention that involved the use of an older uncle to ser ary to help resolve a conflict between an immigrant Chinese daughter mother-in-law. Such mediation was a common practice in Chinese reflected a sensitivity and utilization of indigenous helping practices.

EXERCISE 2.5
Cultural Value Preferences

Directions: For each of the scenarios provided use the table below to identi the culture of the helper may interfere with the efficacy of the helping proce

Scenario 1:
Arnold is a first generation Asian American who has come to discuss his ca Mr. Adams, the school counselor. Mr. Adams is very excited about Arnold' ties and is eager to develop a career path that will maximize Arnold's achie

Scenario 2:
Latisha is an African American woman who has come to counseling bec describes as feelings of depression and thoughts of worthlessness. Dr. Jong in a nondirective, client-centered form of therapy. She places emphasis on client's awareness of her experiences and the internal processes she or he er ing a life path.

Scenario 3:
Alex is a bright, upper-middle-class, Caucasian male. Alex is finishing his s lege and has been experiencing panic attacks. Dr. Linda Handsen is attempt Alex, using meditation and guided imagery.

Area of Relationship	Asian American	Native American	African American	Hispanic American
Nature/ Environment	Harmony with	Harmony with	Harmony with	Harmony with
Time	Past-present	Present	Present	Past-present
People	Collateral	Collateral	Collateral	Collateral
Mode of Activity	Doing	Being-in-becoming	Doing	Being-in becoming
Nature of Humans	Good	Good	Good and bad	Good

Source: Adapted from *Family Therapy with Ethnic Minorities* (p. 232) by M.K. Ho, 198 CA: Sage. Copyright 1987 by Sage Publications.

TABLE 2.5 Culturally Sensitive Interventions

Client Reference Group	Culturally Sensitive Intervention	Recon
African American	Involvement of clergy and church network as support resources for families in crisis.	Richar
Hispanic (Latinos)	Minuchin's family systems approach, which emphasizes generational boundaries instead of equal rights of each family member.	Falico
Native Americans	Cooperation with traditional healing approaches of shamans and medicine men and also the involvement of extended family of aunts, uncles, and grandparents.	Thom
Asian Americans	Including family members as agents of therapy. This is based on the cultural belief that the family is supposed to deal with personal problems, thus, such clients may resist talking about themselves.	Sue &

While it is important to note that individual variation *within* cultures single statement or strategy is applicable to all members of that culture, T number of examples of culturally sensitive interventions for a variety of r

The Need for Ongoing Training

The importance of cultural awareness and sensitivity cannot be overem many helpers fail to approach helping encounters with the appropriate and skill. As noted by Sue and Sue (1990), one of the reasons for thera ness in cross-cultural counseling "lies in the training of mental health pr The ethical helper whose previous formalized training failed to provide c ing needs to take steps to not only raise personal awareness of cultural increase understanding and expand techniques that are appropriate for c seling. Cultural competence has been deemed so important that at least vania) has taken a position that mandatory continuing education in cu established for license renewal (Knapp, 1998).

The Ethics of Therapeutic Choice

Licensed and certified mental health providers are required to not only p care that an ordinary, average person should exercise under such circum

vide services that compare to that of their professional peers. A mental he who fails to meet the relevant standard of care, when compared with tha sionals in the same community with comparable training and experience forming unethically but may also be found to be negligent in his or her dut The evidence for such negligence will rest on the clinical correctness ar treatment that was given, along with the practitioner's judgment in choos al., 1990).

Ethically and legally, a practitioner needs to not only be competent application of her or his helping skills but needs to employ those skills an have generally been accepted within the profession as appropriate and c sionals who employ "innovative strategies" not only run the risk of mal the principle of negligence, but at minimal run the risk of failing their et ity to provide the best care possible.

Selecting the Appropriate Treatment

All ethical mental health practitioners attempt to make decisions that approach to use with their clients. Choices within a helping dynamic may itive level as well as a critical evaluative level (Kitchener, 1986). How others (e.g., Corey, Corey, & Callahan, 1993; Kitchener, 1986) reliance intuition alone in professional decision making may result in poor decisi

Practitioners need to move from intuitive decision making to more methods (see Chapter 9). Practice decisions need to be made followin explorations of his or her feelings and beliefs, a review of codes of ethic consultation with colleagues regarding customary and accepted practice, a standing of the current state of theory and research guiding practice.

It is not only an ethical imperative but a legal reality that practitio those strategies demonstrated to be best practice in each given situa niques have some general acceptance and are not used, the practitioner r only performing unethically may also be held legally accountable and fou in their professional duty to provide care. In areas for which there is not direct best practice, or for which the standard of the profession is not clea ethical practitioner will employ those techniques for which there is a theore evidence that at least the local community and the ordinary, average p employ these as customary practice. Awareness of the standards of accepted intervention strategies as well as familiarizing oneself with cus service is essential for ethical practice. Exercise 2.6 has been designed to process.

Professionalization, Professional Ethics, and Personal Response

Professionalization is "the process by which an occupation, usually on th to special competence and a concern for the quality of its work and be obtains the exclusive right to perform a particular kind of work, to contr

EXERCISE 2.6
Customary and Accepted Practice

Directions: For each of the presenting problems listed do the following:

1. Contact a human service professional in your community and inq general approach or strategy employed in this situation.
2. Review the research in the past five years pointing to the efficacy ar cific interventions when employed with this type of problem.
3. Identify your own approach to this situation along with your ration

Problem Area	Human Service Professional	Research	P
Depression	Dr. Wicks: Employs cognitive behavior Therapy (CBT), (Beck, Rush, Shaw, & Emery, 1979)	NIMH studies demonstrating effectiveness of CBT (Elkin, Shea, Watkins, Imber, Sotsky, Collins, et al., 1989)	I pl m w S re pı pı
An 11-year-old child diagnosed with ADHD			
A 35-year-old woman diagnosed with agoraphobia			
A 42-year-old man arrested Driving Under the Influence with longstanding history of alcoholism			
A child (6 years old) who appears (burn marks) to have been and may continue to be abused			
A hostile 28-year-old male, reporting a desire to "severely hurt his boss"			

and access to the profession, and to determine and evaluate the way the w formed" (Chalk, Frankel, & Chafer, 1980, p. 3). Once professionalized develops professional associations or societies that promote the professio rights of their members, and facilitate the exchange of information. Th associations and societies also develop codes and standards of practice th enhance the quality of the professional work performed by their members. dards—these codes of ethics—as applied to the practice of helping that basis for the remainder of this text.

Codes of Ethics

In professional fields, such as helping, national professional organizations c appropriate conduct for their memberships (e.g., American Counseling Ass ican Psychological Association, National Association of Social Workers, ciation of Marriage and Family Therapy). These codes become the mor these groups and provide practitioners with a guide to making ethical decis al., 1990; Corey et al., 1993). These sets of practices and implicitly recog of conduct evolve over the history of every profession (Bennett et al.,199(mechanism to ensure that members of a profession will deal justly with the & Koeppl, 1993; Keith-Spiegel & Koocher, 1985).

The primary reasons for ethical codes are to protect the public fr incompetent professionals and to protect the profession from unethical pra its members (Keith-Spiegel & Koocher, 1985). By themselves, ethical s always provide clear choices for helpers to avoid conflict, make the best involved and maintain freedom from legal entanglement. They are simply require selection and application to individual situations using the helpers b professional judgment. These standards present "only a rationale for ethic can be difficult to apply to specific situations" (Engels, Wilborn, & S p. 115).

Moving Beyond Professional Standards to Personal Response

As mental health and human service providers, we need to have a clear u professional standards along with knowledge of local, state, and federal pol professional practice. Beyond this understanding and knowledge, however, titioner needs to work to move knowledge to action by making these pri values and guided moral responses.

Sadly, for many practitioners, the ethics and practice guidelines that t in school lose definition and impetus as they become absorbed within th daily practice. The pressures of everyday life may lead practitioners to vie ethics as abstract concepts that they think about only when they hear or reac violation by a colleague. Some practitioners view ethics either as rules de practice decisions or to serve as a lever to remove colleagues who may not about themselves, their clients, or the profession as we might be (Bennett e

TABLE 2.6 Eight Steps of Ethical Problem Solving

1. Describe the parameters of the situation.
2. Define the potential ethical-legal issues involved.
3. Consult ethical-legal guidelines available that might apply to the resoluti
4. Evaluate the rights, responsibilities, and welfare of all affected parties.
5. Generate a list of alternative decisions possible for each issue.
6. Enumerate the consequences of making each decision. Evaluate the short long-term consequences of each possible decision.
7. Present any evidence that the various consequences or benefits resulting will actually occur.
8. Make the decision. Consistent with the codes of ethics, helpers accept res decision made and monitor the consequences of the course of action chos

Adapted by Jacob-Timm & Hartshorne (1998) from the model originally articulated by Koocher (1985, pp. 19-20).

We need to move beyond simply seeing codes of ethics as abstract cor hinderances and begin to view them as personal ethical imperatives.

To this end it has been suggested that each practitioner develop strategy that is rooted in ethical principles, concern for the dignity and viduals involved and a concern for the norms of societies (e.g., Haa Jacob-Timm & Hartshorne (1998); Kitchener, 1986; Pryzwansky, 199 Hartshorne (1998) provide an eight-step problem-solving model that Keith-Spiegel and Koocher (1985, pp. 19–20). These steps are outline

Case Illustration

Returning to our ongoing case of Ms. Wicks and Maria, we can see identified a number of values or beliefs that are currently giving shape making. As you continue to read the case, place yourself in the role of sider your position and reactions as they parallel or contrast those exhil After reading the interaction, consider the points raised in the section How might your personal reactions guide your interaction and decision Maria's situation?

MS. WICKS: Maria, let me see if I understand what you are sayin active and you don't care that you are engaged in unprotected of becoming pregnant or contracting a sexually transmitted d doesn't concern you. Is that what you are saying?

MARIA: Well, the way you are saying it—it sounds like I'm stu

MS. WICKS: No, I apologize if that is how it sounded. I guess w that you were engaging in unprotected sex and I assumed you tracting AIDS, that upset me. Maybe that's what you heard in

MARIA: Not that it is any of your business—but I am sexually activ of the becoming pregnant—I would like that. I would like to have h

MS. WICKS: So you feel relatively certain that both you and your bo of any sexually transmitted diseases and that as long as you stay m shouldn't be a problem?

MARIA: Yeah—we've even talked about it!

MS. WICKS: But I don't quite understand your view of becoming seem to want that?

MARIA: Hey—I'm a woman and my man is a man—real macho— be blessed by God. A baby would be proof of our love!

Reflections:

1. What is your current level of competence in regards to working w Latino females? How might that impact your ability to work What specifically might you have difficulty with?
2. Ms. Wicks has accepted that her own values and beliefs may have infl of her response. In an attempt to share her own perspective while valu of the client, she offers the clarification regarding her tone of voice. How would you have responded to Maria's challenge that you thoug pid? The same as Ms.Wicks? More strongly? Not at all?
3. Maria is introducing a number of value-laden issues (e.g., adolescent out-of-wedlock pregnancy, children as evidence of maturity, gifts f How is your perspective similar? Different? How might your perspec to your response?
4. What goal would you have for this encounter? How has that goal bee your own values, family experience, and culture?

Cooperative Learning Exercise

Helping Decisions Shaped by Helper Values

The purpose of the chapter was to both familiarize you with the role that variables—such as values, theoretical orientation, competence, and cultur play in the formation of a helping process, and to have you begin to incre ness of your helper variables as they may inform your professional decisio

Part 1: Identify your own values as they impact your opinion on each of th

a. Divorce
b. Abortion
c. Extramarital sexual affairs
d. Spanking
e. Marijuana

f. Homosexuality
g. Children's rights
h. Importance of schedules and planning
i. Importance of success and achievement
j. Spirituality

Part 2: For each of the following identify a goal and a treatment stra employ. After identifying your own goals and strategies share these wit league, or classmate and attempt to identify alternative goals and strate appropriate and helpful. Finally, identify how your own opinions, bias ture experiences may have influenced your selection of goals and treat each of the following.

a. A woman, age 38, who has been married for eleven years and h of the past eight months, had an affair with her husband's business has resulted in her becoming pregnant. She is stressed and is ask to what she should do.

b. A 12-year-old has been referred to you by his parents who found room. The child disclosed to you that he has been smoking marijua ning of the school year (last three months) and has found that it r stressed and depressed. Further, he disclosed that he is upset beca gay and doesn't know if his parents will accept that. He has asked parents.

c. You are working with a senior in high school who has been refe The student, while having a documented IQ of 148, is currently classes. When confronted, he explains that he is simply placir importance in getting in touch with his spiritual side and his "conn ing things" and that he has decided to learn and attend to things tha evance regardless of grades and class rankings.

Summary

Helper Values

It is neither possible nor desirable to be neutral with respect to values relationship, and to assume such could be ethically dangerous. Ethic increase awareness of their own personal values, beliefs, and expectation play to in giving shape to their professional identity and behavior v dynamic.

Establishing professional boundaries and maintaining profession objectivity in service of the client, while never absolute, remains a goal In service of this process it may be necessary for the helper to not only

articulate his or her personal and professional values and the role they may p
ing process.

When client and helper values conflict, the ethical helper will expose conflict and then, along with the client, review these areas of value conf decide how they may impact the decisions made in the helping process. W is such that it interferes with the helper's ability to effectively assist the cl helper will prepare the client for referral to another helper who is more i client's needs and values.

Helper Orientation

A helper's theoretical orientation and model not only provide a framework ing the information provided by the client, but can also impose meaning on t The ethical helper will not only continue to identify and articulate her or his ing but will remain vigilant in her or his evaluation and testing of the validit

Helper Competence

The ethical helper is a competent helper. Competence goes beyond simp requires doing. As such, helpers need to be self-aware and self-caring so a best care they can. The failure of the helper to take appropriate care of hin result in stress and burnout that, in turn, will threaten competence and ethi

Specific steps that may help to reduce the potential impact of stress (ing of the helper include (1) setting realistic expectations, (2) taking care o nizing and managing personal and professional life, and (4) maintaining professional distance.

Helper Cultural Sensitivity

All professional organizations emphasize the ethical imperative for helpers tural sensitivity and for practitioners to recognize the special needs of dive lations.

To be an ethical helper, one must be open to the values and beliefs of and be aware of how these relate to his or her own values and beliefs. Th will (1) be aware of her or his own values, biases, and cultural orientation the world view of culturally different clients; and (3) develop a wide repe ally appropriate intervention strategies.

Therapeutic Choice

Licensed and certified mental health providers are required to not only prov care that an ordinary, average person should exercise under such circun provide services that compare to that of their professional peers. A menta sional who fails to meet the relevant standard of care, when compared w professionals in the same community with comparable training and experi performing unethically but may also be found to be negligent in his or her care.

Practice decisions need to be made following a practitioner's explo her feelings and beliefs, a review of codes of ethics and guidelines, consu

leagues regarding customary and accepted practice, and critical underst
rent state of theory and research guiding practice.

Professionalization

Professionalization is the process by which an occupation, usually on tl
to special competence and a concern for the quality of its work and t
obtains the exclusive right to perform a particular kind of work, to conti
and access to the profession, and to determine and evaluate the way the
formed.

The helping professions have established practices and implicitly
ples of conduct that serve as a mechanism to ensure that members of a p
justly with the public. The primary reasons for ethical codes are to prote
unethical or incompetent professionals and to protect the profession fr
tices by any of its members.

IMPORTANT TERMS

burnout
codes of ethics
competence
cultural sensitivity
customary practice
decision-making strategy
hypothesis testing
indigenous helping practices
multicultural
practitioner
professiona
professiona
professiona
self-determi
standard of
theoretical r
value-free

SUGGESTED READINGS

Haas, L.J., & Malouf, J.L. (1989). *Keeping up the good work: A practitioner's guide t*
Sarasota, FL: Professional Resource Exchange.
Hopkins, W.E. (1997). *Ethical dimensions of diversity*. London: Sage Publications.
Rave, E.J., & Larsen, C.C. (1995). *Ethical decision making in therapy: Feminist per*
Guilford Press.
Sue, D.W. (1990). *Counseling the culturally different* (2nd ed.). New York: Wiley.

PART TWO

Ethics and Standards of Practice—The Profession's Response

CHAPTER

3 Ethical Standards: Guidelines for Helping Others

Maria: Gee—being a counselor is a great job!

Ms. Wicks: Yes, it is, Maria, I enjoy it very much.

Maria: I mean you get to sit in this office and just listen to people complain—you AND get paid for it!

It is not that unusual to find individuals who believe that "helping" is sir of social chatting and that helpers—be they counselors, psychologists, soci so on—are at best nice people and at worse frauds. Contrary to this vie helping profession know and appreciate that as a formal process and a pr ing is a powerful, awesome, process that carries with it equally powerful responsibilities.

Sadly, it is all too easy to find examples of helpers who have abused responsibility. One need only to turn on a television talk show to find exam cal therapists who have sexually abused their clients, counselors who hav clients' suicidal pleas for help, or even medical and social service workers sonally gained from the misfortune of others. As helpers, we are given the r care for individuals, who by definition of needing help are often those wh nerable to manipulation. Given the potential vulnerability of their clients an the helping, helpers need guidelines for professional decision making that n but care for those seeking their help. Professional ethics and codes of c those guidelines.

Chapter Objectives

The decision making of the professional counselors, psychologists, socia marriage and family therapists is formed through training and acquired k skills and guided by their professional codes of conduct and ethics. The cha duce you to the ethical guidelines employed by counselors, psychologists family therapists and social workers. While the uniqueness of each of these reflected within their own ethical principles and codes of conduct, each

concern for the welfare of the client. The current chapter discusses ethical principles and highlights the commonality of ethical principles : professions.

After reading this chapter you should be able to do the following

1. Describe common values and points of concern evidenced in v codes of ethical practice
2. Describe what is meant by autonomy, beneficence, and nonmalef
3. Describe what is meant by informed consent, competence, confi fessional boundaries

Formal Ethical Standards: The Evolution of a Profession

Ethics, including professional ethics, are articulated values and beliefs help make sound moral judgments (Bersoff & Koepl, 1993). Professic and conduct do not bloom from a vacuum. They reflect the meaningful e cussions of the members of a profession. In fact, in a very real way th standards of practice or codes of behavior help to establish a particula fession. These standards, these codes of conduct, communicate to the p of these associations and these professions, are competent and act in harm to those they serve. These professional codes of ethics serve to edu the members of that profession as to the specific responsibilities and e role, thus providing a mechanism for monitoring professional accountal for improvement of practice. For example, the American Counseling As Ethics and Standards of Practice (1995), states:

> The specification of a code of ethics enables the association to clarify members, and to those served by members, the nature of the ethical re common by its members (Preamble).

Similarly, the American Psychological Association's Ethical Pri ogists and Code of Conduct (1992) states:

> This Code is intended to provide both the general principles and the de most situations encountered by psychologists. It has as its primary goal tection of the individuals and groups with whom psychologists work.

Codes of ethics not only serve to communicate competence to t profession but also to provide practitioners with guidelines for jud actions against a standard accepted by the members of that profession.

Thus, when confronted with choices, a practitioner can decide as wrongness of each option, using the code of conduct and ethical princi sions as the guideline (see Case Illustration 3.1)

CASE ILLUSTRATION 3.1
Making an Ethical Decision

Dr. Louise Thompson is a licensed clinical social worker in private practi working with Alfonso a 52-year-old, construction worker who was self-ref sion. Dr. Thompson has been working with Alfonso for approximately eigh course of her work she has identified a primary contributor to Alfonso's dep is currently on physical disability from his job and now that his physical con be healing, he has many self-doubts about his ability to return to work. As s "he wishes that he could stay on disability forever."

Dr. Thompson has just received a certified letter from the disability in asking her (1) to assess and report on her client's ability to return to work a of her records for their review. Dr. Thompson is concerned that while Alfons dition is on the mend, his depression impairs his ability to problem solve, problem and potential danger given his line of work. Further, Dr. Thompso her notes some of Alfonso's quotes regarding his disdain for his foreman a to stay on disability, and his fantasies about damaging the current constructi worried about how these will be interpreted by the company's insurance fir

Dr. Thompson is not sure if she should even respond to these reques being completely sure of her competence to judge capability to return to wo of her clinical notes, she wonders if she should edit her notes or refuse to sen mation. It appears that in some ways what is best for the client may be not to or to do so after carefully filtering the information. But her concern is wheth it ethical? Dr. Thompson wants to do what is best for her client, while prac standards and codes of conduct for her profession. But the standard is not cle so she is unsure what to do. Luckily, Dr. Thompson belongs to the Nation Social Workers. She has contacted the association and its legal/ethical cons logue with them has decided on a plan of action. Without her awareness of t these requests or her ability to refer to her professional association, Dr. Tho decided in ways that not only would harm her client, but legally and ethical ability to practice.

Professional associations, however, are not attempting to govern so morality. In fact, it is possible for an action viewed as ethical within a profes itating a therapeutic abortion) to be considered immoral by another group within society (e.g., religious organizations) or even by an individual mem fession. Even though these codes do not attempt to dictate morality, as pro of conduct they serve as a base from which associations can govern ethical that profession. Behind each profession's code of ethics is a mechanism of gives substance to the ethical principles. Through the use of articulated educ ments, members of a profession are guided in the development and ena professional roles. Further, when these members fail to perform or pra established standard, procedures for disciplining and sanctioning these m enacted (see Case Illustration 3.2).

CASE ILLUSTRATION 3.2
Sanctioning a Member

While it is rare, any single incident of sexual misconduct is one too many operates on the implicit trust of its clients. The following reflects one cas have been modified in order to insure anonymity), in which the sexual practitioner came to the attention of a second.

Dr. L., a clinical psychologist, was working with a new client who depressed and anxious. In ascertaining some background material, Dr. L client had been in therapy, for the past four years with a certified marria pist. Additional data gleaned over the course of the next five sessions re apist had seen the client and her husband for marriage counseling but counseling, referred the husband to another therapist and began treatin "sexual dysfunctions."

As revealed by the client, the previous therapist started a sexual aff tinued for one year while she was still under his professional care. The cli become increasingly depressed in the past few months as a direct result apist terminating both the sexual contact and the therapeutic relationship. provided was simply that she was too needy and too dependent for him t matters worse, she works in the same organization as the therapist, and n currently having an affair with another client.

The client expressed her anger and disgust as well as guilt over the on helping her understand that maintaining appropriate boundaries was n but that of the therapist. As a result of their sessions together, the client, desiring any legal recourse, shared her concern that this man had access female clients and that she would not feel good unless she could stop tha Dr. L. contacted the American Association of Marriage and Family Thera professional association of the previous therapist. After an exhausting fac AAMFT Board concluded that not only was this claim valid, but that a hi ior existed. The board revoked his certification, provided him with a treat plan, and forwarded their decision to local state board of licensing. The t to holding a certificate as a marriage and family therapist, also was licens his state. As a result of AAMFT's action, his license was revoked.

Thus, these codes of conduct, and these ethical principles exist n ments of aspiration but are in fact mandates and standards of profession

Codes of ethics are continually evolving and developing. The eve our arts provides the base from which professional ethics similarly evolv knowledge and general consensus of the profession at a given time. F codes of conduct prior to the 1990s didn't provide for increased sensitivit sity and multicultural issues, (2) responding to clients with HIV/AIDS, tionships between helper and clients following termination of th relationship. The ongoing awareness among professionals about the in issues has been given voice within the latest editions of these evolvin Because the codes are evolving, it is important that practitioners mai

within their professional associations and remain informed about the latest
erature regarding the ethics of practice.

Across the Professions: A Review of Ethical Standards of Practice

Typically, practitioners within a profession also hold membership within
representing that profession (see Appendix A). Most counselors, for examp
American Counseling Association (ACA), psychologists, to the America
Association (APA), marriage and family therapists, to the American Ass
riage and Family Therapy (AAMFT), and Social Workers, to the Nationa
Social Workers (NASW). These professional organizations provide thei
specific statements of guidelines for ethical practice (see Appendix B) an
fication to the uniqueness of the role and function of that profession.

The Ethical Principles and Codes of Conduct included within this te
B) reflect the latest versions of these standards. It is important for the pr
only know these standards but to review association news and updates reg
codes of conduct.

Common Concerns and Shared Values Across the Professions

The specific codes of conduct as articulated by each professional organiza
dix B) constitute the mandatory ethics of that profession, reflecting the unic
responsibilities of those within that profession. However, beneath these sp
lies certain fundamental principles and values that appear to cut across th
each individual professional organization

Kitchener (1984) described four fundamental principles that serve t
of these professional codes of conduct (Table 3.1).

Autonomy: The value of self-determination (autonomy) serves as a f
professional decisions reflecting the need to reduce client dependen
client informed consent throughout the relationship.

Beneficence: While concerned with client self-determination, all pro
attempt to promote the health and well-being of the client. This prom
others is considered beneficence and is reflected in each of the code

Nonmaleficence: Nonmaleficence means to do no harm. Professi
steps to ensure that their decisions do not intentionally or inadverte
clients. This includes the imposition of helper values and persona
helping dynamic.

Justice: The ethical professional will respect and protect human an
not knowingly participate in or condone unfair discriminatory pract

TABLE 3.1 Fundamental Principles Underlying Professional Codes of Conduct

Professional Organization	Autonomy/ Self-Determination	Beneficence/ Promote Good	Nonmaleficence/ Avoid Harm	Justice/ Equal Treatment
American Psychological Association (1995)	PRINCIPLE D: RESPECT FOR PEOPLE'S RIGHTS AND DIGNITY Psychologists accord appropriate respect to the fundamental rights, dignity, and worth of all people. They respect the rights of individuals to privacy, confidentiality, self-determination, and autonomy . . . and they do not knowingly participate in or condone unfair discriminatory practices.	PRINCIPLE E: CONCERN FOR OTHERS' WELFARE Psychologists seek to contribute to the welfare of those with whom they interact professionally. In their professional actions, psychologists weigh the welfare and rights of their patients or clients, students, supervisees, and human research participants.	1.14 Psychologists take reasonable steps to avoid harming their patients or clients, research participants, students, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.	1.10 Nondiscrimination. In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law.
American Counseling Association (1995)	A.1.b. Counselors encourage client growth and development in ways that foster the client's interest and welfare; counselors avoid fostering dependent counseling relationships	A.1.a The primary responsibility of counselors is to respect the integrity and promote the welfare of the client.	C.5. Public Responsibility e. Unjustified Gains. Counselors do not use their professional positions to seek or receive unjustified personal gains, sexual favors, unfair advantage	A.10.c In establishing fees for professional counseling services, counselors consider the financial status of clients and locality. In the event that the established fee structure is inappropriate

National Association of Social Workers (1996)	1.02 Self-Determination Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to self-determination when, in the social worker's professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.	1.01 Commitment to Clients Social workers' primary responsibility is to promote the well-being of clients. In general, clients' interests are primary. However, social workers' responsibility to the larger society or specific legal obligations may on limited occasions supercede the loyalty owed clients, and clients should be so advised.	1.06 Conflicts of Interest (b) Social workers should not take unfair advantage of any professional relationship or exploit others to further their personal, religious, political, or business interests.	4.02 Discrimination Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, or mental or physical disability. 4.04 Dishonesty, Fraud, and Deception Social workers should not participate in, condone, or be associated with dishonesty, fraud, or deception.

Thus, while each specialty in the helping field may emphasize on principle of practice, it is clear that primary to each of these codes is th consideration of, the welfare and well-being of the client (see Exercise

Each of the values listed above serve to underpin the rationale and of conduct to be discussed within this text. More specifically, each o have taken shape in a common concern and articulated principles that p the welfare of the client. It is commonly held across the various helping

EXERCISE 3.1
Identifying Core Values of Ethical Conduct

Directions: For each of the following identify the core value (i.e., aut nonmaleficence, justice) being demonstrated and whether the helper's a (s) or in violation(v) of that core value.

Illustration	Core Value	Supp "S
The helper directs the client in terms of what needs to be done and what goals will be set for each session.		
The helper cancels an appointment with a client because she pays on a sliding scale and he has the opportunity to schedule a full-pay client in that time slot.		
The helper explains to the client that the type of things the clients wishes to discuss and the goals he, the client, wishes to achieve require techniques for which the helper is not trained and therefore a referral might be in order.		
The client called in crisis. The client was feeling very hopeless and, while apologetic about calling the counselor, expressed her fear that she may hurt herself. Even though the helper was in middle of a family celebration, she spent the time needed to assess the level of crisis and to insure that the client felt safe and was with someone who could continue to monitor her, offered support, and set up an immediate appointment for the following day.		

helping relationship exists for the client's benefit, for their care and NOT needs or benefits of the helper. The helper who uses the helping relationsl self or himself feel powerful, important, or needed is placing her or his ne of the client and is being unethical. It is in placing the rights and needs of mary, that an ethical helper begins to establish the general framework for The ethical helper—regardless of the specific helping profession—demo macy of the rights and needs of the client by providing the client with *in* establishing *confidentiality*, and creating *boundaries* that maintain a *profe tent* relationship.

Informed Consent

The ethical helper will demonstrate a respect for the rights of the client to be Clients need to be provided with information that enables them to make in

Clearly, this can pose a challenge in that the helper needs to attain a viding the information needed for informed decision making at a time and the client can understand and successfully use that information. Too much soon, can prove overwhelming, anxiety provoking, and even destructive process. The goal of informed consent is to promote cooperation and par client in the helping process. The specifics of such an informing process, i to present and how to present it, often create delicate situations and ethical c sented in Exercise 3.2. These will be more fully explored in Chapter 6.

EXERCISE 3.2
An Issue of Informed Consent

Directions: Below you will find a number of scenarios involvi client for whom informed consent is an issue. As you read the what, if anything, you would tell the client.

Scenario 1: Allison has been directed by her employer to go to c Employee Assistance Program (EAP) because of her "attitude at has been directed to evaluate Allison for drug use and to mak employer. What, if anything, should the EAP counselor tell the

Scenario 2: Timothy walked into his high school counselor's off that he is thinking about running away from home. Further, he unable to get away from his parents, he will "kill himself." should the counselor convey to this client?

Scenario 3: A child psychiatrist is working with an 8-year-old attention deficit with hyperactivity. The child's parent told hin "allergy doctor" who may give him some "allergy" medicine. the psychiatrist should tell the client?

Confidentiality

For helping to be effective, the client must feel free to disclose and share For such a sense of freedom to exist, the client needs to feel that the inte is *confidential.* As with other areas of practice, confidentiality is not abs sions to hold in confidence always black and white (see Exercise 3.3). dentiality requires professional judgment, which at times can be very ch 7 provides a detailed look at the issue of confidentiality, its limitations, lenges.

Appropriate Boundaries for Professional Relationship

Finally, it is generally agreed that the client has a right to enter a *profes* with the helper. Relationships in which the helper is using the interactio meet his or her own personal needs, or situations in which there exists between the helper and the client—such as may be the case when the hel social and personal relationships—threaten this principle of professiona all of the ethical guidelines, it is not a simple, cut-and-dried matter. times—situations—when one may be a friend and yet be able to gai objectivity to assist the client. Under these situations it is important for th

EXERCISE 3.3
Confidentiality?

Directions: Along with a classmate or colleague, read each of the followi Identify those in which you feel confidentiality should be maintained, a information needs to be disclosed. After reading Chapter 7, review your this exercise and see if they change.

1. A school counselor is told by a 13-year-old that she is going t older boy.
2. A husband, in marriage counseling with his wife, calls the counse counselor that he is currently having an affair with a man but doe closed in their couple sessions.
3. An irate worker informs a counselor that "if I don't get a raise I'm g (the worker's boss).
4. A young woman informs her therapist that she has herpes and ref she is about to marry.
5. A 14-year-old student tells his counselor that he is gay and is inter ing a homosexual relationship.
6. A depressed elderly man tells the nursing home social worker that his medications and intends to overdose on them.

to define and maintain some control or boundaries on the types of informa cussed or on the nature of the relationship as it may be appropriate to eac roles (e.g., friend or helper) (see Case Illustration 3.3). The issues of boundar ical use of power is discussed in detail in Chapter 8.

CASE ILLUSTRATION 3.3
Maintaining Boundaries and Clarifying Roles

Alex is a school counselor working at Mt. Helena High School. Alex was ask a female student, Nguyen, who was new to the school, and for whom the tea some "serious concerns." Alex liked to consult with teachers whenever pos meeting with the student, he went to talk with Mr. E. In conversation wit covered that Mr. E was concerned that this girl "looked just like his girlfrie just recently discovered that his girlfriend "was a liar and cheat." When ask the relevance, Mr. E became very upset—started to cry and said, "It's n needs the help, it's me—I can't get over her, I can't believe she was cheati like such an idiot."

Alex asked Mr. E to come down to his office. Alex felt that he neede his colleague in crisis and attempt to assist him in calming down and maybe dealing with his own emotional upset. The following dialogue insued:

ALEX: It is clear that what has happened with you and Kim has bee to you. It even seems to be carrying over into your work?

MR. E (crying): It is. I can't sleep. I haven't eaten in the last two days. more.

ALEX: It can certainly feel crushing when you lose someone you ca

MR. E (gaining some composure): Alex, I feel like such a fool, she ing about getting married. But apparently she thought there was s with me sexually or I couldn't . . . .

ALEX (Interrupting): Joe, it sounds like you have a lot of questions answered. Questions about your relationships, maybe even questior and the types of relationships you find yourself in . . . I know this i but sometimes these are the times when, with the help of another, w some insight and grow.

MR. E: I know. Gads, it hurts. You said, with the help of another, with me?

ALEX: First of all, Joe, I'm honored you've asked. But you and I ar need to work together all of the time, plus I am trained as a schoc really not able to provide you the counseling that would be best fo people who are excellent for these kinds of experiences and I coul names and maybe even help you make a connection, if you would

MR. E: Yeah . . . think I really need to do this. Thanks, Alex. I w those names. And (smiling) you don't have to call Nguyen down,

CASE ILLUSTRATION 3.4
Knowing Limits of Competence

Lewis is a marriage and family therapist certified through AAMFT. Lewi practice for two years and has already developed a reputation as an ethi A couple called and asked to make an appointment because they were l lems "communicating." During the intake interview, Lewis discovered th sexually abused by both her father and her uncle from the age of 4 thro The woman revealed that, while she had never had counseling or ther abuse, she felt that she had resolved this issue and no longer had any prc

As the interview continued it became clear to Lewis that Elsa (th depressed and gave evidence of problems much deeper than the mari problem originally presented. Since Lewis didn't feel competent to diag problems or the possible existence of a personality disorder, he felt that pr ple requested to investigate communication issues might be a disservic might even cause harm to the wife, should it engage her in painful mer explained to the couple his concerns and helped them understand the va was making.

Through careful, sensitive dialogue with this couple and an aware his own competence, Lewis was able to help this couple, and more speci assistance that they needed.

Helper Competence

A final ethical principle shared across the various helping professions is be aware of the limitations of his or her own professional competence ar limitations in the delivery of his or her service.

It is all too easy for a helper to find himself or herself alone in an o of practice without teachers, mentors, or supervisors looking over her c assume that she or he can try this or that new technique or approach or all problems or situations presented. Such is not the case. New te approaches need to be learned and practiced under the appropriate supe we cannot be everything to everybody (see Case Illustration 3.4).

Knowing the limits to our competence, being willing to seek on supervision, and knowing when to seek consultation from a colleague another helper are all characteristics of an ethical helper and are all dis Chapter 9.

From Professional Behavior to Personal Being

It is clear that to be an ethical practitioner one must be fully aware and kn the specific codes of conduct governing one's profession. However, a ously, these codes of ethics reflect the ever-changing demands and nee

of that profession and the experiences of competing rights and responsibiliti course of professional practice. As such, the codes are continually review The ethical helper needs to keep current on his or her understanding of the l ing the issues involved in ethical practice. Further, ethical practitioners nee knowledgeable colleagues or members of their associations' boards of ethi have a concern about the ethical conflict of their practice decisions. This le and level of knowledge is the minimum for the ethical practitioner.

However, as noted, the goal is not simply to know the ethical princip fession. The call is for each professional to assimilate and incorporate thes their decision-making process (e.g., Corey et al., 1993; Forester-Miller & D organization's code of conduct and articulated ethical principles represe concern and values of the members of that organization. However, until th the practitioner, they remain only nice ideas and wishful guidelines. As ea ops within his or her professional practice, he or she will not only gain incre and skill but will also begin to formulate internal values and standards of p ical helper must be willing to reflect on the guidelines provided by their pr as relevant dialogue with colleagues, and then continue to formulate his o that will then direct his or her helping interactions. In this way, the code from nice ideas or even meaningful statements to becoming embodied wa

The goal is not simply to "know" ethics, but rather to *be* ethical. The book is devoted to help you in the process of moving from knowing ethics

Case Illustration

Returning to our ongoing case of Ms. Wicks and Maria, Ms. Wicks has i ber of values or beliefs that are currently giving shape to Maria's decisio the helping relationship that is beginning to take significant shape.

As you read the exchange below, begin to identify explicit or implici tial ethical conflict. While no specific violations of ethics may have occu a number of issues are revealed for which an understanding of the code ethics would be essential as a guide for Ms. Wick's decision making. Th vided at the end of the exchange are provided to guide you in your reflecti

MARIA: You know I just realized that you got me talking about s and stuff that I don't tell nobody.

MS. WICKS: I truly appreciate your willingness to share things a really . . .

MARIA: (interrupting) Yeah . . . but you are not going to tell any you know my aunt.

MS WICKS: Your aunt?

MARIA: Yeah, Gloria Enrique. She was a teacher in Elsewhere I used to work . . . anyway . . . she told me you guys are like a pri say anything to anybody about what I tell you. Like, now this is ju

but, what if I tell you I'm going to run away and go live with m dying of AIDS—you can't tell my mom or my aunt?

MS. WICKS: Your boyfriend has . . .

MARIA: (again, interrupting) Yeah, we talked about it and stu pened before he met me . . . so like I'm the only one who kno with him and take care of him.

Reflections

1. Does the fact that Ms. Wicks previously worked with Maria's au fessional values? Create a possible boundary conflict?
2. Maria sees the mental health practitioner as protecting her confi way a priest may regard material shared in the confessional. Wha about this? What do you think Ms. Wicks should say? Do?
3. What should Ms. Wicks do about this new information regardin run away? Is that something she should hold in confidence? How tion about the boyfriend having AIDS? Should she disclose this to whom? If not, why not?
4. Of all the information, both explicit and implied, that Ms. Wicks point what, if anything, should be documented and recorded?

Cooperative Learning Exercise

The purpose of this chapter was to introduce you to the role and funct ethics. But beyond this cognitive purpose the hope was also to stimul value the need for a professional code of ethics and a desire to embrace sion. The following is intended to assist you in this valuing process.

As with all of these cooperative exercises, the benefit that comes fr sonal reflection is augmented by the sharing of this perspective with otl

Directions: Read each of the following scenarios. Identify areas of ethic issues of autonomy, beneficence, nonmaleficence, and justice may be o

1. In the Case Illustration the client, Maria, shared the possibility t unprotected sex with a boyfriend whom she identified as having is a medical condition and sexual activity is a personal decision, sh issues be of ethical concern for Ms. Wicks?
2. Given your current level of training and the ethical concern fo one's level of competence, what type of helping or for what type o do you currently feel competent to assist? What else will you nee your level of competence to be an ethical professional?
3. If codes of ethics are commonly shared guidelines to be employe of a specific profession, what role and level of responsibility does monitoring that his or her colleagues practice ethically?

4. Identify two forms of unethical practice that you feel deserve maxim by one's profession. What form should the sanctioning take?

Summary

Formal Ethical Standards: The Evolution of a Profession

Ethics, including professional ethics, are articulated values and beliefs that assist in making sound moral judgments (Bersoff & Koepl, 1993). These pro of ethics serve to educate the public and the members of that profession as responsibilities and expectations of that role and thus provide a mechanism professional accountability and providing for improvement of practice.

Across the Professions: A Review of Ethical Standards of Practice

Most counselors, for example, belong to the American Counseling Asso psychologists, to the American Psychological Association (APA), marri therapists, to the American Association of Marriage and Family Therapists Social Workers to the National Association of Social Workers (NASW). The organizations provide their members with specific guidelines for ethical pr give clarification to the uniqueness of the role and function of that professi

Common Concerns and Shared Values Across the Professions

There are four fundamental principles that serve to underpin each of these pro of conduct (Kitchener, 1984). These are (1) autonomy or the value of self- (2) beneficence, or the promotion of good for others; (3) nonmaleficence, m harm; and (4) justice. These appear to take concrete form within the various governing the helping professions in the directives to provide the client with *sent*—establishing confidentiality—and boundaries that maintain a *professic* relationship.

From Professional Behavior to Personal Being

The goal is not simply to know the ethical principles of one's profession. each professional to assimilate and to incorporate these principles into their ing process.

Ethical helpers must be willing to reflect on the guidelines provided l sions, dialogue with colleagues around the guidelines, and then continue tc reformulate their own values, which will then direct their helping interactic

IMPORTANT TERMS

American Association of Marriage and Family Therapists (AAMFT)
American Counseling Association (ACA)
American Psychological A (APA)
autonomy
beneficence

boundaries
codes of conduct
competent
confidentiality
decision-making process
ethics
informed consent
justice
marriage and family th
National Association o
(NASW)
nonmaleficence
power
professional relationsh
sanction

SUGGESTED READINGS

Ahia, C.E., & Martin, D. (1993). *The danger-to-self-or-others exception to confiden*
American Counseling Association.
Bersoff, D.N. (1994). Explicit ambiguity: The 1992 ethics code as an oxymoron. *Pr*
Research and Practice, *25*, 382–87.
Coale, H.W. (1998). *The vulnerable therapist.* New York: The Haworth Press.
Forester-Miller, H., & Davis, T. E. (1995). A practitioner's guide to ethical decisi
VA: American Counseling Association.

CHAPTER

4 Ethics and the Law

Mr. Harolds: Hi, Michelle. what's up?

Ms. Wicks: Tom, could I talk to you about some legal concern?

Mr. Harolds: Legal concerns? Certainly, but I'm not a lawyer.

Ms. Wicks: No, I know that—but you seem to stay current with laws and regulatic counseling and to tell you the truth, I'm not sure if it is a problem or r

Mr. Harolds: Well, you certainly sound concerned. What's up?

Most mental health practitioners enter the profession intending to emplo edge and skills to assist those in need—not concerning themselves about the cations of the issues and the people with whom they work. The reality is th are ethical principles and guidelines that need to be considered when makir decisions, there are also legal mandates and implications of which the ethic must be fully aware.

Laws, including legislation, court decisions, and regulations, have presence and importance in the practice of human service (Dickson, 1998). I the rights of clients, the rights of the practitioner, the way in which services a provided, and the nature of the relationship between the practitioner and clie shaped by the professional codes of conduct and now by extension of those c Some complain that law has made practitioners more concerned for persona client welfare. Bergantino (1996), for example, states: "In our current p world . . . we only have left brains, and . . . only what is 'appropriate' is tho tute therapy. Forget 'excellence' . . . Our profession is now defined by thos make the world safe for mediocrity!" p. 31).

The sad truth is that practitioners are vulnerable to legal action, and ma to play it safe at the expense of providing the best service for their clients. W is a reality that now must be placed within the mix of professional decision are not meant to make practitioners feel threatened. Quite often the law par ther codifies sound ethical practice and, as such, need not induce anxiety or c the ethical practitioner. But there are times when the relationship between et ity is not clear or in fact may appear in conflict. At those times, the ques "What's the ethical helper to do?"

The current chapter focuses upon the unique and ever-evolving relatio professional codes of conduct and the law, in hopes of helping practitioners to this question.

Chapter Objectives

The relationship of professional ethics and the laws governing prof
the focus of the current chapter. After reading this chapter you shou
following:

1. Describe the obligations incurred by a helper who has establis
tionship" with a client.
2. Explain what is meant by "duty to care" and what defines that ol
3. Describe how licensure and/or certification may lend legal powe
codes of conduct.
4. Provide examples of ethical practice that may be illegal and leg
may violate professional codes of ethics.
5. Describe one model for identifying and resolving conflict betwee

The Helping Process as a Legal Contract

As a result of malpractice suits and legal actions, it is generally recog
sional relationship, or even the perception that the relationship is a pr
stitutes the basis of the existence of legal duty to provide appropriate c
professional help giver, by the very nature of holding himself or her
implies that he or she will conduct himself or herself in a skillful and
and will follow the dictates of that profession's code of ethics.

The issue of whether helping is contractual and thus a minimum c
lished rests with the courts' decision as to whether a "special relatic
would be sufficient to create a "duty of care." Such a special relations
created with the use of formal treatment contracts in which the "dutie
specified (see Exercise 4.1). However, the establishment of a formal c
the relationship between client and practitioner or the rendering of a b
money for services is not necessary in order to provide evidence of a
and a duty to care.

A special relationship between helper and client can be establ
implicit acts. Courts, for example, may determine that a special relation
to care was established by the helper's action of taking notes, schedul
ments and even advertising as one who can provide unique, helping ser
can be interpreted as reflecting an intent to render service and thus c
establishing the intent to form a special relationship and thus a contract
As with many areas of law and ethics, there is no singular court case or
determines what actions, beyond a formal contract, can be used to dem
form a special relationship and thus a duty to provide care.

While there has not been a single court definition and ruling that
sal standard regarding implicit contract or duty to care, numerous state
to give shape to this contract of professional service. For example, in a
Supreme Court of Wisconsin (*Bogust v. Iverson*, 1960), the court ruled

EXERCISE 4.1
The Use of Contracts: Formal–Informal

Many mental health practitioners, as a reflection of their concern to assist cl informed, have begun to provide clients with "contracts" of service. These c more or less formalized, ranging from simple information sheets with identif lation policies, etc., to a formal statement requiring signatures and witnesses involved.

Directions: Contact each of the following: (1) a residential treatment pital, (2) a free clinic, (3) a private practitioner, (4) a university counseling ce mentary or high school counseling center, and (6) a local church. For each providers identify each of the following:

a. Do they employ some form of agreement or contract when providing se ing, mental health) to their clients? If so, why? And what is included?
b. Do they provide informational brochures or materials? Do these desc services that are offered and any requirements or responsibilities of th
c. When they see a client do they maintain records? Collect a fee? Schedu (versus simply walk in service)?
d. Do they feel that their clients perceive that the services they offer are nature, even if no fees are collected?

Share your data with you colleagues or classmates. Discuss which providers appear to employ contracts or actions that would characterize them "special relationships" with their client and therefore incurring a duty to care

---

of a student, Jane Dunn, who filed suit against the director of student perso Stout State College. The parents alleged there was negligence because the di provide proper guidance or protection for the student, who committed suicid against the parents, the Wisconsin Supreme Court referred to the defendant a not a counselor and as such reported that no special relationship had be "To hold that a teacher who has no training, education, or experience in m required to recognize in a student a condition the diagnosis of which is in a s technical medical field, would require a duty beyond reason" (*Bogust v. I* Another court ruling that seemed to suggest that specialized training and cre needed prior to the establishment of a special helping relationship and the d *Nally v. Grace Community Church*. In *Nally v. Grace Community Church* (ents of a 24-year-old, Kenneth Nally, sued the Grace Community Church an negligence when their son committed suicide after receiving several years of seling. Kenneth also saw secular psychologists and psychiatrists during these lowing an unsuccessful attempt at suicide in 1979, his parents rejected the rec of a psychiatrist to have him committed. This recommendation was also mac pastors of the church and similarly rejected. The California Supreme Court r the church and its pastors because it found that there was no duty of care tha

by them and no special relationship that would create such duty. In this court made a distinction between nontherapists, counselors, and professi as psychiatrists or certified psychologists and counselors. Since the therapists without the requisite special relationship, the court did not f duty of care. These two rulings appear to point to the essential need to professional helper as defined by one's credentials, such as licensure as cial relationship, and to identify that thus duty to care has been estabi *Eisel v. Board of Education of Montgomery County* (1991) new legal pr

As noted, previously the courts did not find a duty of care in si non-professional attempted to provide help to a client. This was true e which an outpatient client who may have been suicidal was seen by However, in *Eisel*, the court noted a special relationship sufficient to c when an adolescent in a school setting expresses an intention to com counselor becomes aware of such intention. In Eisel, the court noted result of standing in loco parentis does have a special duty to exercise protect a pupil from harm. Further, the relationship of school counsel devoid of therapeutic overtones, as suggested by the counselor's job d addition to pointing to special training, licensing, and certification, the cial relationship and the duty to care can be established based simply o from which one provides service.

Another approach to the definition of a special relationship betwe bases it on the principle of fiduciary responsibility. Any time an individ trust in a party who has the potential to influence his or her action, a fic exists (Black, 1991). Given this definition, it could be reasonably arg sional helping relationships have this fiduciary potential and thus bring to the benefit of the other individual in any matters related to an underta (Black, 1991).

While there is an inherent logic in using this fiduciary argument helping has a contracted special relationship, the courts have not made the fiduciary nature of each professional relationship but noted that it w nature of each relationship to determine that (*Hodgkinson v. Simms*, 199 1992; *McInerney v. MacDonald*, 1992). When a fiduciary relationship e has these obligations:

a. To act with good faith and loyalty toward a client (*McInerney v.*
b. Not abuse the power imbalance by exploiting the client (*Norber*
c. Act in the best interest of the client (*Hodgkinson v. Simms*, 1994; 1992)

While the anxiety surrounding the possibility of litigation may se practitioners to be more fully aware of the law applicable to their practi awareness of the law is a professional responsibility regardless of an codes of conduct direct practitioners to know and practice in ways cons For example, psychologists are directed to "plan and conduct research i tent with federal and state law. . . ."(APA, 1992, 6.08).

The Legal Foundation of Ethical Practice

The process and relationship between health and human service profess clients is increasingly shaped by law (Dickson, 1998). Issues such as in confidentiality, and competency as well as mandates, such as mandated re abuse and duty to warn, are significant influences on the practice of hun Case Illustration 4.1). In addition, courts of law can employ regulatory a dards for health and human services professionals, as ways of identifying r practice, and liability.

CASE ILLUSTRATION 4.1
The Changing Face of School Counseling

The following was the result of an interview with Mr. L, an elementary s Legal precedents relative to Mr. L's comments have been inserted:

Well, I've been a elementary school counselor now for over 23 years and I and my strategies in working with children have changed dramatically as a I mean there was a time when I first started that if a kid was acting out or a classroom we could simply have him removed, suspended, as a way of pro call." Try that now and you will find yourself sued. Everything requires DU

In 1975, the Supreme Court ruled in *Goss v. Lopez*: "Due process re tion with a suspension of 10 days or less, that the student be given oral or w charges against him and, if he denies them, an explanation of the evidence t and an opportunity to present his side of the story" (581).

This even gets to the point that you start to worry about using "tim because it may be argued that you are excluding a child from his right to he don't know, I feel like I should have become a lawyer rather than a counse

Goss v. Lopez focused on exclusion from an education, and while i give examples of de minimus punishments that would not require due proc would include practices like after school detentions or "time outs" or even te from extracurricular activities.

And another area that you have to be supercautious about is record used to be that my records were confidential—no one had access. Now I fe waltz in and see my files, since they are school files. Where's the privacy? selors in our district, simply keep special files or school-only files that pa have access to.

The Family Educational Rights and Privacy Act (FERPA) provides p 18 and older with certain rights with regards to the inspection and dissemin records." As a federal law, it applies to school districts and schools that rec cial assistance through the U.S. Department of Education. FERPA makes c tion records, no matter where they are stored or how they are identified (i must be made available. However, not all information obtained by a cour closed. The legislative history of FERPA clarifies that education records "personal files of psychologists, counselors, or professors if these files are e not available to other individuals" (120 Cong.Rec. 27, 36533 (1974)).

Codes of ethics provide guidelines for practice decisions; how binding unless they are otherwise codified or incorporated into law. Gr associations have the power to sanction their members for unethical pr ishment, suspension or expulsion. But the extent of the sanctions is limi tioning does not automatically imply legal action. The professions' however, do often provide the basis, or at a minimum a standard, for de regulations that govern the practice of that profession. In most states th and standards of practice have been incorporated into laws or regulation ern requirements for certification or licensure, but serve as consumer l practice of mental health services (Bennett et al., 1990). For example, i code of ethics for psychologists has the force of law in that licensed practice in Pennsylvania are legally responsible for adhering to this co (see Exercise 4.2).

While the professional codes of conduct have been incorporated cases the reverse has been true; that is, the legal system has stimulated fessions to develop and enhance their ethical standards. Mental health pr sensitive, and careful ethical practices to ensure that clients will not hu ers. The steps taken to warn and protect potential victims of dangerous integrated into all professional standards of conduct and were stimulate decision surrounding the *Tarasoff v. The Regents of the University of C* (see Chapter 7). An illustration of how case law has given shape to e practice can be found in Case Illustration 4.2.

EXERCISE 4.2
State Laws Codifying Professional Ethics

Directions: Licensed psychologists who violate the State Board of Psyc Ethics in Pennsylvania not only run the risk of facing sanction of the Bo prosecuted by the Commonwealth of Pennsylvania. The Pennsylvania C Psychologists has the force of law in Pennsylvania. Licensed psychologi Pennsylvania are legally responsible for adhering to this Code (Bricklin,

Contact the department of state, the attorney general's office o license and measurements for your state and do the following:

1. Inquire if your state licenses mental health professionals. If so, What does the law say about the practice of those within that pro licensed? Or, for those from other profession who practice within
2. Request a copy of the licensing law within your state.
3. Inquire if the code of ethics for your profession has the force of la

CASE ILLUSTRATION 4.2
The Issue of Duty to Warn

Jonathan was referred to Dr. Ranklin, a licensed psychologist who pro employees of company L as part of its Employment Assistance Program. In t Dr. Ranklin explained his role and the fact that he was contracted by Comp employees with brief, solution-focused counseling and referral. Dr. Ranklin conditions of confidentiality and provided Jonathan with an information sh vices available.

During the initial session, Jonathan revealed his intent to "get ever immediate supervisor). When asked what "get even" meant, Jonathan state

> Alex has been on my case ever since he became a supervisor. He thinks h than the rest of us. He keeps calling me lazy and asks if I've seen the shri he made the referral to you. Anyway, he does this stuff in front of the other g it. I'm just going to wait for him one night this winter, when it's dark, and parking lot.

When asked if he could provide more information about what it was Jonathan went into great detail:

> I know where he parks and he always leaves just around 5:45, after mos cleared out of the lot. I'm going to be waiting for him. I'll just hide in the goes to get into the car I will whip him terribly. I've got an ax handle with h I crack that dumb head of his and then we'll see who's crazy. If he dies, th

Throughout the session, Dr. Ranklin attempted to gain a guarantee th wouldn't do what he was saying, but each time Jonathan insisted that he wo deserved it. When reminded of the "limits of confidentiality" that Dr. Rank that were listed in the handout, Jonathan said "I don't care." "You can tell h deserves it and I'm going to give it to him."

Since all attempts to persuade Jonathan to commit to not harming cessful, Dr. Ranklin felt duty bound to protect his client (Jonathan) from le identified victim (Alex) from potential harm. Thus, he made an appointm Alex to disclose this information.

Dr. Ranklin's actions were stimulated by the now famous Tarasoff ca state case laws in Nebraska where he practiced. Dr. Ranklin knew that whi was an ethical directive, in Nebraska therapists are required to initiate whatev necessary to protect the potential victims of the patient (*Lipari v. Sears, Roeb*

Many of the ethical principles to be discussed and illustrated withi chapters have strong legal foundations. Thus in addition to providing a re ciples, some of the laws and court decisions that tint or give further shap tion of these principles will be discussed. Table 4.1 provides a thumbnail of these legal decisions and their impact on professional practice.

TABLE 4.1 Examples of Laws as Foundation for Ethical Practice

Boundary violations	A number of rulings (e.g., *Mazza v. Huffaker*, 300 S.E *Horak v. Biris* 474 N. E. 2d 13 (1985)) argue that due differentials within the relationship and the potential f sexual relationships between client and practitioner ar malpractice.
Competence	The foundation for negligence as based, in part, on th knowledge, skill, and care ordinarily exercised in simi established in *Wilson v. Corbin*, 41 N.W. 2d 702.
Confidentiality	Duty to break confidence in service of the duty to war in *Tarasoff v. The Regents of the University of Califor*

Ethical Does Not Always Equal Legal

While codes of ethics most often overlap with legal requirements, they them and in some cases may be in conflict. The potential for conflict ha within the American Psychological Association Code of Ethics (1992), v

> Psychologists accord appropriate respect to the fundamental rights, digni people. They respect the rights of individuals to privacy, confidentiality, and autonomy, mindful that legal and other obligations may lead to inco flict with the exercise of these rights. (Principle D).

Unethical, Yet Legal

Conflict can occur when a practitioner's decisions are unethical and yet example, in most states it is not legally mandated that a practitioner info limitations to confidentiality or how confidential information may be us fessional codes of ethics require that such limitations be clearly describec Table 4.2).

Ethical, Yet Illegal

There are times when a practitioner's actions may be considered illegal y codes of ethical conduct. Consider the situation in which a client with inform an identified sexual partner about the AIDS or take steps to pro Although disclosure of a client's status as having AIDS or being HIV pos client's permission is illegal in many states, the ethical duty to protect t harm may direct the practitioner to disclose this information to the curre

TABLE 4.2 Notification of Limits to Confidentiality

Professional Ethical Standards	Statement of Notification
American Psychological Association (1995)	5.01 Psychologists discuss . . . (1) the relevant limitations confidentiality, including limitations where applicable in and family therapy, or in organizational consulting; and (2) the foreseeable uses of the information generated by tl Unless it is not feasible or is contraindicated, the discussio confidentiality occurs at the outset of the relationship and new circumstances may warrant.
National Association of Social Workers (1996)	1.07 Privacy and Confidentiality Social workers should inform clients, to the extent possib disclosure of confidential information and the potential cc when feasible before the disclosure is made. This applies workers disclose confidential information on the basis of requirement or client consent. Social workers should discuss with clients and other inter nature of confidentiality and the limitations of clients' rig confidentiality. Social workers should review with clients where confidential information may be requested and wh confidential information may be legally required. This dis occur as soon as possible in the social worker–client relat needed throughout the course of the relationship.
American Counseling Association (1995)	A.3.a Client Rights Disclosure to Clients. When counseling is initiated, and tl counseling process as necessary, counselors inform client purposes, goals, techniques, procedures, limitations, pote benefits of services to be performed and other pertinent ir Counselors take steps to ensure that clients understand th diagnosis, the intended use of tests and reports, fees, and arrangements. Clients have the right to expect confidentia provided with an explanation of its limitations, including and/or treatment team professionals; to obtain clear infor their case records; to participate in the ongoing counselin refuse any recommended services and be advised of the c such refusal. B.3. Minor or Incompetent Clients When counseling clients who are minors or individuals w give voluntary, informed consent, parents or guardians m the counseling process as appropriate. Counselors act in t of clients and take measures to safeguard confidentiality.

TABLE 4.2 Continued

Professional Ethical Standards	Limitations to Confidentiality
American Psychological Association (1995)	5.05 Psychologists disclose confidential information v of the individual only as mandated by law, or where p for the valid purpose, such as (1) to provide needed pr to the patient or the individual or organizational client appropriate professional consultations, (3) to protect tl or others from harm, or (4) to obtain payment for serv instance disclosure is limited to the minimum that is n that purpose.
National Association of Social Workers (1996)	1.07 Privacy and Confidentiality (c) Social workers should protect the confidentiality o obtained in the course of professional service, except f professional reasons. The general expectation that soc keep information confidential does not apply when dis to prevent serious, foreseeable, and imminent harm to identifiable person. In all instances, social workers sh least amount of confidential information necessary to purpose; only information that is directly relevant to tl which the disclosure is made should be revealed.
American Counseling Association (1995)	B.1. Right to Privacy c. Exceptions. The general requirement that counselor does not apply when disclosure is required to prevent danger to the client or others when legal requirements confidential information be revealed. Counselors cons professionals when in doubt as to the validity of an ex
American Association of Marriage and Family Therapists (1998)	2.1 Marriage and family therapists may not disclose cli except: (a) mandated by law; (b) to prevent clear and in person or persons; (c) where the therapist is a defendant or disciplinary action arising from the therapy(in whicl confidences may be disclosed only in the course of that there is a waiver previously obtained in writing, and the may be revealed only in accordance with the terms of th circumstances where more than one person in a family r each such family member who is legally competent to e must agree to the waiver required by subparagraph (d). waiver from each family member legally competent to e therapist cannot disclose information received from a fa

TABLE 4.3 Interaction Between Ethics and the Law

Interaction	Description	Illustration
Ethical and legal	Professional follows a just law	Keeping client disclosure when such is also protect
Ethical and illegal	Professional disobeys an unjust law	Refusal to breach confid court ordered
Ethical and alegal	Professional decision to do good in the absence of law	Providing pro bono (free clients
Unethical and illegal	Following an unjust law that conflicts with professional ethic	Employing testimonials that is allowed by the Fe commission but is viewe principles as unethical
Unethical and illegal	Failing to abide by a just law	Sharing confidential infc such information is legal ethically required
Unethical and alegal	Making a harmful decision that is not prohibited by law	Fostering client depende enhancing one's own fee

Note: Adapted from *Guide to Ethical Practice in Psychotherapy* by A. Thompson, 1990, New York: John
Copyrighted 1990 by John Wiley & Sons. Adapted by permission.

It is clear that the relationship between law and ethics is not always cl son (1990) identified six ways in which law and ethics may interact. Tl examples of each, are presented in Table 4.3.

Ethical and legal standards are by their very nature broad in spirit an open to situational interpretation. As a result, practitioners must remain inf legal interpretations of the applications and misapplication of the ethics practice decisions as they continue to unfold through legislation and court

When Ethics and Legalities Collide

When ethics and law collide, the practitioner will need to use his or her ov ment about the issues and directions to be taken. Such judgment should be rate understanding of the specific ethical principles involved and the practice decisions. While the mental health practitioner is not called up expert, it is important that the practitioner have some knowledge of cou state, and federal), since such rulings provide the precedents for future actic Clearly, the better informed a practioner is, the more likely conflicts betwe ical principles can be resolved.

It is generally believed that mental health professions have an ob the legal requirements of the situation. This obligation is most often c facie, meaning that the legal obligation needs to be considered in ever aside when ethical and/or legal reasons of greater importance compel ever, the uniqueness of each situation and the characteristics of each cli decision to be made.

There may be situations in which even with the greatest unders law and the ethical principles, a clear path resolving the conflict cannot sible that the action mandated by law may not appear to be in the best et client. Such a conflict places the mental health practitioner in quite a mo dilemma. Under these situations it is the responsibility of the professio the pertinent information, discerning which avenue both upholds the in essence of the professions ethics while providing the maximum benefit

Remley (1996, p. 288) provides four steps for counselors to take v an apparent conflict between ethics and the law. These steps have be listed below:

1. The practitioner should identify all of the forces that are impacting i professional decision and behavior. That is, while the conflict may cer of an ethical principle or a legal mandate, other forces such as polic within a specific workplace, accreditation rules or requirements and e funding may be the source of the conflict, rather than the law.

2. When the question is one of law, legal advice should be obtained. C or national associations may provide legal consultants who are trained health field and the legal profession. Another source of legal advic through one's liability insurance company.

3. If there is a problem in applying an ethical standard or in understandi of an ethical standard, the practitioner should consult with a colleague a as experts within the field. Again, it is also useful to contact the loca associations and speak to members of the ethics board.

4. If a force other than law or ethics (for example, employment require ing that a practitioner take some action he or she perceives as illegal, th obtain legal advice to determine whether such action is indeed illegal recourse or protection is available should the counselor refuse to follow t form this illegal act (see Chapter 5).

The need for ethical practitioners to remain informed as evolving force of the law through court decisions and/or evolving law gives new conduct cannot be overemphasized. Fortunately, practitioners are not alc and their quest. State and national associations, along with liability ins provide continuing education programs to update the practitioner's kr even provide consultation services in case of conflict. The final exercis provided to help increase your awareness of the supports available to as ing both an ethical and legal practitioner.

EXERCISE 4.3
Resources in Support of the Ethical-Legal Practitioner

Directions: It is essential to remain informed about the changing face of law a fessional conduct as you continue to develop and practice as a helper. Ongo and continuing education programs are often provided by state and natio along with the various companies providing liability insurance for your profe these same resources oftentimes provide "hotline" consultation for their me feel conflicted about a practice decision.

1. Contact your state organization and inquire about its web site or ways informed about state legal decisions that may impact your own profe Ask if you can be placed on a mailing list announcing continuing edu geared to updating practitioners on relevant law and ethical principles
2. Contact your national organization and inquire about its web site or w be informed about recent legal decisions impacting your practice and cation programs geared to updating practitioners on relevant laws and e of practice.
3. Contact your liability insurance carrier and inquire whether it provides cation program on issues of ethics and legality and if it provides a di who attend.
4. Contact each of the above and inquire about the availability of leg ethical-legal consultation should you have a question or conflict. Ider for connecting with this service as well as any fees that may be involv

Case Illustration

Returning to the scene with which we opened the chapter, we find Ms. V counselor) sharing concerns with a colleague. As you read the exchange, lo an ethical nature, issues or concerns that may, in your opinion, have le and/or implications, and the existence of conflict between Ms.Wicks' ethica the law.

MR. HAROLDS: Hi, Michelle. What's up?

MS. WICKS: Tom, could I talk to you about some legal concerns?

MR. HAROLDS: Legal concerns? Certainly, but I'm not a lawyer.

MS. WICKS: No, I know that—but you seem to stay current with la tions regarding counseling and to tell you the truth, I'm not sure if or not.

MR. HAROLDS: Well, you certainly sound concerned. What's up?

MS. WICKS: Well, I'm not sure actually. I've been counseling a stud with me that she is currently dating and having unprotected sex wi

she reports as having AIDS. She's 18 and the information wa
my role of counselor. I am not sure if I am legally responsible

MR. HAROLDS: Did you share your concern with your client?

MS. WICKS: Yes, and she simply states that she doesn't care. Yc
and God wouldn't punish her by letting her get AIDS.

MR. HAROLDS: Wow, that's sad. Michelle, when you first n
instructions did you give her regarding the limits to confidenti

MS. WICKS: Tom, I know I explained about disclosing informat
me of her intent to harm her herself—but I'm not sure how thi

MR. HAROLDS: This is tough. After all, she's your client, not th
viduals with AIDS have a right to privacy, but she is placin
way. I don't really know. Why don't we call the state board
one their ethical-legal consultants? Remember, I told you I wa

MS. WICKS: Tom, I just appreciate you hearing me out and con
this is not so clear-cut. I agree that calling may be the thing to

Reflections:

1. Do you feel that Ms.Wicks should have gotten Maria's consent t
2. Do you feel that the specific information shared with Tom was a v
right to confidentiality?
3. Do you feel that the potential for conflict be between law and e
case? If so, where? If not, why not?
4. How do you feel about the fact that Ms. Wicks contacted a colle
like this? Is there anything else she should have done instead? Or

Cooperative Learning Exercise

The purpose of the chapter was to familiarize you with the unique and s
ual relationship between law and professional codes of ethics. Becaus
stated, both ethical and legal standards are open to situational interpret
ing chapters provide more detailed information about specific ethical p
applying to those guidelines.

Below you will find three scenarios. Along with your colleagues
and identify whether you feel they present issues that are free of conflict
flict of law and ethics. Where conflict exists, identify the nature of the
and unethical, illegal and ethical, or unethical and illegal? Next, contact a
titioner in your area and ask him or her for an opinion about the natu
Finally, as you read more about specific ethical principles in the upcomi
to these scenarios to see if your initial opinions change.

Scenario 1: A girl, age 13, comes to a school counselor and asks fo
tion on where and how to go about securing an abortion. The school cour
names and numbers of a number of agencies that counsel women seekin

school counselor also promises the student not to inform her parents. Wa conflict of law and ethics? If so what was the nature of the conflict? Which p selor's behaviors or decisions were conflictual?

Scenario 2: A Vietnam war veteran voluntarily contracted for cou licensed social worker for what was determined to be posttraumatic stress process of therapy the vet reported his intention to kill some college studen ing to the vet, prolonged the war through their protests. When asked to iden students, the client simply said, "It doesn't matter as long as they are in col apist did not take steps to inform anyone about this threat. Should he? Is th law with ethics? If so, what is the nature of that conflict?

Scenario 3: Dr. Ortez works in the counseling center at a local unive had provided career counseling for a graduate student named Liz. It has be Liz has graduated and over 15 months since her last session with Dr. Ortez. Liz to inquire how she is doing and while on the phone, asks her on a date violate any ethical principles? Any laws?

Summary

The Helping Process as a Legal Contract

In performing one's practice, the helper provides implicit agreement of hi the client. The issue of whether helping is contractual and thus a minimum established rests with the court's decision as to whether a "special relationsh would be sufficient to create a duty of care.

Further, any time an individual places his or her trust in a party who h to influence his or her action, a fiduciary relationship exists (Black, 1991). inition, it could be reasonably argued that all professional helping relation fiduciary potential and thus bring with them a duty to act to the benefit of vidual in any matters related to an undertaking between them (Black, 1991

The Legal Foundation of Ethical Practice

Codes of ethics provide guidelines for practice decisions; however, they a unless they are otherwise codified or incorporated into law. In most states, t ciples and standards of practice have been incorporated into laws or regulatio govern requirements for certification or licensure, but also serve as consum ing the practice of mental health services. While the professional codes o been incorporated into laws, in some cases the reverse has been true; that is tem has stimulated mental health professions to develop and enhance their et

Ethical Does Not Always Equal Legal

While codes of ethics most often overlap with legal requirements, they ar them and in some cases may be in conflict. Thompson (1990) identified si ethics may interact, (1) legal and ethical, (2) legal and unethical, (3) alegal alegal and unethical, (5) illegal and ethical, (6) illegal and unethical.

When Ethics and Legalities Collide

When ethics and law collide, the practitioner will need to use his or her ment about the issues and directions to be taken. Such judgment should rate understanding of the specific ethical principles involved and t practice decisions. Remley (1996) provided four steps that counselor confronted by an apparent conflict between ethics and the law: (1) Ide are at issue, (2) obtain legal advice, (3) consult with colleagues or exper fessional ethics, and (4) seek legal advice, when forces other than law core, in order to understand available options.

IMPORTANT TERMS

Bogust v. Iverson
contractual
duty beyond reason
duty to care
Eisel v. Board of Education
ethical, yet illegal
implicit acts
legal precedent
Nally v. Grace Commu
prima facie
principle of fiduciary r
unethical, yet legal

SUGGESTED READINGS

Fischer, L. & Sorenson-Paulus, G.(1996). *School law for counselors, psychologis (3rd ed.)*. White Plains, NY: Longman Publishers.

Swenson, L.C. (1997). *Psychology and law for the helping professions*. Pacific Gr

Woody, R.H. (1997). *Legally safe mental health practice: Psycholegal questions* CT: Psychosocial Press.

PART THREE

The Nature of the Helping Relationship

CHAPTER

5 Ethical Conflicts: The System and the Interests of Others

Ms. Wicks: Hi, Tom it is me again.

Mr. Harolds: Hey, how are you? Did you get that information from the state assc

Ms.Wicks: Not yet. They are supposed to call me. But, things are getting more co

Mr. Harolds: Really?

Ms. Wicks: Ms. Armstrong, the principal at the school, informed me that it is und district that we are not to counsel students regarding sexual issues. She said it is policy, just something that "we" all know not to do. So now I'm not sure if I brok violated a code of ethics or may have stepped over the line in terms of my job def confused!

When working with a client, a helper needs to be aware and sensitive to vidual issues and concerns presented by the client. In addition, the helper a fully cognizant of the ethical and legal implications of his or her own profess in relationship to these client concerns. Now, to complicate matters even practitioners working within an organization or a system, be it a school, agency or a company—individual practice decisions must also reflect an with policies, procedures, and informal standards and values operating with

The current chapter looks at the ethical culture of social systems and exerts on the practice decisions of those helpers working within that syste will discuss the impact of working for and within an organization. Further, we will look at situations in which conflicts arise when what the professio for the individual client falls outside of or even runs contrary to policies, pro ues of the organization. Under these conditions, what's a practitioner to do

Chapter Objectives

The chapter will review the process and implications of making ethical pra within an organizational or system context. Attempting to balance the ne vidual client with the requirements of the employing organization and othe ties (e.g., managed care organizations) is not an easy or clear-cut process. A chapter you should be able to do the following:

1. Define what is meant by "system culture."
2. Discuss the impact of system culture on ethical decision making.
3. Identify possible points of ethical conflict when working in a mai ment.
4. Identify possible points of ethical conflict when working with thi

Serving the Individual Within a System

Professional practice does not occur within a vacuum. At a minimum, p occurs within the social context of a client and a helper. But for those organization, professional practice and ethical decision making occurs dyadic system, but also within the context of the larger system or organi helper works. Ethical problems in professional practice are often the r ence of context, setting, and standards of practice.

Practitioners who work in schools, clinics, hospitals, and/ or thos viders for managed care can find themselves in conflict with these comp (see Case Illustration 5.1).

Certainly the school psychologist presented in Case Illustratio with a serious ethical and potentially legal dilemma. As in this case, prac

CASE ILLUSTRATION 5.1
A Diagnostic Dilemma

Linda Alfreds is a new school psychologist, the first ever employed by District. Linda's job involves performing all psycho-educational assessm required for special education placement. Linda was informed, however tion of a few "slower" children, the district really didn't have childrer which according to the superintendent was a blessing since they have ve providing such services.

Linda was asked to see Marquis, a transfer student, who was rep culty keeping up with the work in a number of his classes. The test data an impulsive child, with a significant receptive language problem. From ous school district, Linda knew that Marquis would benefit from placem ing disabilities room or a resource room with a special education teach disabilities and language disorders.

Linda discussed the situation with her department chairperson a District did not have a LD class nor resource room personnel. Howev school in the district did provide a classroom for "slow learners." The Linda to record Marquis as being retarded rather than as having a lang this would at least get him some special services. It was clear to Linda th support this diagnosis, but identifying the child as LD might fail to provi ing assistance to Marquis.

clearly reflect not only the needs of the client as well as the characteristics of the helper, but also the unique characteristics and demands of the context in which the helping occurs. Balancing all of these unique needs is not a clear-cut. The ethical practitioner needs to be aware of the system and the s times not so subtle influences that a system can exert. Such an awareness understanding of the nature of systems.

A system is "an entity made up of interconnected parts with recogr ships that are systematically arranged to serve a perceived purpose" (Ku 369). The specific nature of these parts and the type of relationships they h the specific purpose for which the system exists, all need to be viewed as e: on the decision making of those within that system, including the professi Beauchamp and Childress (1994) suggested, a professional role, as well as t of professional behavior, are shaped in response to the organization's e: needs and, therefore, incorporate these expectations as standards and gui decision. Therefore, understanding this context—which includes not only volved (i.e., clients, families, professionals), but also the values, meaning, a the specific and global milieu in which the services are being delivered—is is to function as an ethical practitioner.

It would appear that divided loyalties could be the problem especia such as Employee Assistance Programs in which the professional is unde the organization. Under these conditions information regarding the clien related to job performance may be within the need to know and thus co client's right of privacy and confidentiality. The practitioner, while respe dentiality of the information gathered needs to be sensitive to the obligatic contracts with the organization. The EAP counselor described in Case appears to have developed a plan for balancing the needs of the organi rights of the client.

Ethical Culture of Social Systems

Organizations or, for that matter, any social system develop their own valu that guide decision making and practice within that system. These values p tem's view of the importance of certain goals, activities, relationships, and f Whitt, 1988) and serve as the basis for what has been described as a s (Schein 1990). Schein (1990) described system culture as (1) a pattern of tions, (2) invented, discovered or developed by a given group, (3) as it lear its problems of external adaptation and internal integration, (4) that has work to be considered valid and, therefore, (5) is to be taught to new members a way to perceive, think, and feel, in relationship to those problems (p. 111). T which serve as the base for the development and maintenance of a system's unquestioned, nondebatable truths and reality of people within the system. when a solution or procedure works repeatedly. As a result those involved for granted to the point where what was once only a hunch or possibili viewed and treated as a reality. These basic assumptions then serve as the f

CASE ILLUSTRATION 5.2
Balancing the Needs of the System and the Client
A Case of Confidentiality

Hanna Johannson was a private practicing mental health counselor wh EAP (Employee Assistance Program) counselor. In addition to seeing cl provided EAP services to the members of a local school district. In this received a contracted fee and was to provide three to five sessions f school district employee who desired such counseling. In addition, sh seling be desired or required, Hanna would make a referral to anoth employee would then be responsible to continue on a fee-for-service ba

As part of the contract with the school superintendent, the EAP vide monthly reports that included (1) the number of people seen, (2) which the employee worked, (3) the job class (i.e. teacher, administrato type of problem presented, (5) the number of sessions utilized, and (6) outcome. While the specific names of clients and any details of the natu sented were not to be disclosed, Hanna felt that the information reque could jeopardize the confidentiality of those who utilized this EAP serv

Hanna worked out a compromise with school administration so could be made completely confidential. In that first session, as part of s of confidentiality, Hanna explained to each client the types of data sh superintendent and asked the client for their informed consent befor appointments. If the client would not give that consent, Hanna would and no information about the contact would be shared with the central c

which the system defines structures and processes to guide its operation tant concept for the ethical practitioner to grasp because when member embrace these assumptions, they in turn shape what the members value values take (see Exercise 5.1).

The cultural values of a system become enacted in the way mem function—shaping policies, decision making, and other operations. therefore, may begin to reflect institutional values and organizational et represent "best practice" or codes of professional conduct. While it is p zational ethics can parallel those of the profession, in view of the fact an organization may be different than the purpose of any one helpin organizational ethics may not only be conflictual but may act to undern ethics of the practitioner (see Exercise 5.2).

While it is clear that the ethical practitioner must be aware of th influence of a system's culture on his or her practice decision, the qu enculturated, how does one identify the operating assumptions, values,

EXERCISE 5.1
Making Culturally Compatible Choices

Directions: Below is a table that provides a social context, a focus for a practitioner, and t sion options. Along with a colleague, select the options which you feel would most likel and/or supported by that particular social context and provide your rationale for your sele

Social-Organizational Cultural Context	Focus for Practice Decision	Practice Decision Options	Selecti Ration
(sample) Catholic High School	Increased evidence of student pregnancy	1. Guidance unit on sexual behavior, safe sex, and sexually transmitted diseases 2. Guidance unit on self-esteem and value of abstinence	Option school' outside unacce immor
A free-standing clinic that is funded primarily through managed care contracts	A client diagnosed as depressed, with the possibility of having an early history of sexual abuse	1. Referral for anti-depressant medication 2. Contract for long-term, "recovered memories" therapy	
A military industrial complex, making "sensitive" technical equipment	A personnel director who is approached by an upper-level manager experiencing extreme financial pressures and who has had fantasies of "selling technology" to other governments	1. Respect the confidentiality of the relationship and work with the employee on stress reduction 2. Report the fantasies to his supervisor	
A public school, with limited special education facilities and funding	A school psychologist who believes a student is in serious need of ongoing individual psychotherapy	1. Recommend therapy to his family as part of an Individual Education Program . 2. Suggest that his family may find it useful to contact an outside therapist	

EXERCISE 5.2
Goals—Values and Decisions

Directions: As noted within the chapter, decisions are made that not only reflect th goals desired. Below you will find a scenario, system and practitioner goals, and d task is to identify the decisions preferred by system along with those preferred by identify the situations in which these are parallel and/or conflict.

Scenario	System Goals	Practitioner Goal	Decision Preferred by System	Decision Preferred b Practitione
1. (sample) Star football player has a very bad sprained ankle	Win the big game	Rest the ankle	Allow the student to play	Sideline the student for one game
2. The top salesman for a corporation has embraced his alcoholism and is committed to a treatment program	Maintain sales	Maintain salesman's health	Adjust sales region to allow sales-man to attend meetings while continuing sales	Encourage and support attending meetings
3. A social worker noted that a Fifth grade teacher who is approaching retirement has a number of physical problems, has been falling asleep in class, and often verbally abuses the children for making noise	Educate children in fulfillment of the schools mission	Protect children from verbal abuse and show concern for an aging teacher with ill health	Try not to make too public for the remainder of the semester and then provide the teacher with an early retire-ment package	Work with t teacher in developing some cooperative learning uni while providing supportive counseling around the benefits of retirement

Scenario	System Goals	Practitioner Goal	Decision Preferred by System	Decision Preferred by Practitioner
4. A residential setting for individuals with severe emotional problems	To provide therapy while at the same time reducing patient disruption	To provide therapy geared at empowering individuals to take responsibility for their own actions	Reliance on medication including sedatives	Using the minimum amount of medication in order to support the client's development of cognitive/behavioral methods of control

It has been suggested that the use of interpretation of the artifacts an basic assumptions (Finney & Mitroff, 1986; Schein, 1991). Artifacts would ible, tangible, or concrete manifestations, be they the physical surroun appointments, the stories or oral histories still shared and even the rituals practiced whereas a system's values are revealed in what the system views terms of goals, activities, relationships, and feelings (Kuh & Whitt, 1988). B way those within the system traditionally and continually address specific by the situations they face in common, the ethical practitioner can begin tc system's values (Parsons, 1996; Van Maanen & Barley, 1985).

Who Is the Client?

One seminal question that needs to be addressed when working within an "Who is the client?" While this at first may appear to be a simple question ancing a practitioner's responsibility to the employing organization wh time servicing the individual helper seeker is not always that clear-cut or ous professional organizations are aware of this potential confusion and and have attempted to provide practitioners with guidelines for their practic Table 5.1).

Although the various professional organizations address the issue of uals and organizations, it is still for the individual practitioner to resolve qu Does the ethical practitioner, when working with individual members of make decisions that are best suited for the goals and objectives of the instit in the best interest of the individual care seeker? Or does the individual and well-being take primacy? (see Case Illustration 5.3)

TABLE 5.1 Ethics of Practice Serving Client and Organization

Professional Ethical Standards	Statement on Serving Client and Organization
American Counseling Association (1996)	D.1.a: Counselors define and describe for their em employees the parameters and level of their profes:
	D.1. c.: Counselors alert their employers to condit potentially disruptive or damaging to the counselor responsibilities or that may limit their effectiveness
American Psychological Association (1995)	8:03 If the demands of an organization with which affiliated conflict with this Ethics Code, psycholog nature of the conflict, make known their commitme Code, and to the extent feasible, seek to resolve the that permits the fullest adherence to the Ethics Cod
National Association of Social Workers (1996)	3.09 a: Social workers generally should adhere to to employers and employing organizations.
	3.09.b: Social workers should work to improve em policies and procedures and the efficiency and effe services.
	3.09 c: Social workers should take reasonable step employers are aware of social workers' ethical obli in the NASW Code of Ethics and of the implicatior obligations for social work practice.
	3.09.d: Social workers should not allow an employ policies, procedures, regulations or administrative with their ethical practice of social work.

For Col. Wipps (see Case Illustration 5.3), questions existed abou ual confidentiality should be respected or whether this individual posed rity risk and thus should be identified to appropriate personnel. In part, question rested on who Col. Wipps identified as his client, D.L. Kingsley

Most guidelines, like that of the American Counseling Associati indicate that the client is the primary concern for the ethical helper and ondary. But it could be argued that accepting a position within an org agreement to serve as its agent and to embrace its values and standards the American Counseling Association Code of Ethics advised that acce ment is essentially an agreement with the principles and policies of the selors are also admonished that if there is a conflict between the instituti those standards established by the code, resignation from employment considered. In a somewhat more conciliatory tone, the American Psychol states: "If the demands of an organization with which psychologists are

CASE ILLUSTRATION 5.3
Who Is the Client?

Col. R.J Wipps was a clinical psychologist working in service of the U.S. Arn vice Division. Col. Wipps provided testing and individual counseling to tho Special Services.

Col. Wipps was approached by D. L. Kingsley, an officer in charge c tive military project. D.L. came to Col.Wipps because of what he reported to l as a result of financial difficulties that he was currently experiencing. D.L. n concerned that his wife would leave him if something didn't happen soon lifestyle. When asked what he was attempting to do to resolve the financia was quick to note that "nothing short of something illegal" could help. W directly about whether he had considered illegal activities, D.L. stated: "Of c I've been drinking a lot lately and God only knows what I could do if I get c

Col. Wipps recommended that D.L. take a medical leave while he wen program for the alcohol and also received some individual and marital coun he would think about it, but really did not feel that was necessary. D.L. aske able to see Col.Wipps for some counseling during this really stressful time. I to be sure that the relationship would be confidential.

---

with this Ethics code, psychologists clarify the nature of the conflict in a w the fullest adherence to the Ethics Code" (APA, 1992).

It would appear, therefore, that the ethical practitioner needs to be a responsive to both the system of employment and the individual clients ser system. As such it is essential that the practitioner not only understand but a mission of the organization, as well as the specific values underlying that i ways it becomes manifested in the procedures, policies and decision makir

This does not mean to suggest a blind allegiance to the organization a individual. In fact it can be argued that the ethical helper will attempt to ch tional policies and procedures that are not healthy for those within the sys ple, the American Counseling Association Code of ethics states : "Members employers to conditions that may be potentially disruptive or damaging" (AC

Similarly, it does not mean absolute and blind protection of the seeker. Thus, while some practitioners find themselves feeling responsit oning the client's right to confidentiality in the face of the organization's ri tions, in some situations this is neither legal nor ethical. For example, confidentiality is guided by federal statutes, Department of Defense regu specific service (i.e., Army, Navy, Air Force) regulations, a point that nee ered by Col. Wipps (see Case Illustration 5.3). While supporting respect fo the individuals, these directives also mandate access to confidential mate employees on a "need to know" basis (Jeffrey, Rankin, & Jeffrey, 1992).

An ethical practitioner attempts to resolve conflicts between orga and individual need in a way that not only reflects the desire of the pr

supportive of his or her organization, but also upholds the professic Thus, when confronted by the desire to protect the care seeker's priva the rules and regulations of the organization in which one is employed, warning on the limits of confidentiality would be essential as a means organization of employment and the care seeker.

When There Are Multiple Masters

Ethical practitioners will not only know the mission, objectives, and v zations within which they work but will also make known to their emp their own professional ethical commitments. Beyond this, it appears th tioner will also share with his or her clients the obligations of fidelit employment and how these may flavor the helping relationships and the sions. This is especially important when an organization's disclosure tional limits on the confidentiality between client and helper (see Case

Recently, the issue of multiple clients, or conflicts between the r ing organization with those of the client, has taken on a new dimensio tion of managed care. Managed care is a term applied to a widesprea contain health care costs. The term has been used to describe "any typ the delivery and financing of health care that is intended to elimina inappropriate care and to reduce costs" (Langwell, 1992, p. 22). Ur third-party payers review requests for the initial delivery of services, de of services to be provided, and review any subsequent requests for se Given the level of involvement in the professional decision process, it c in managed care situations the practitioner has in fact two clients, the p the person seeking assistance and the secondary client being the mana The potential for conflict arises in that the needs and goals of these t always be congruent.

Managed care is essentially an economic strategy designed to pr or better quality for less money. While the concept of cost containment is that often the goals of managed care are in conflict with those of the 1992). Shore (1996) critically suggests that "[m]anaged care favors cli ate a profit and cause no trouble. Skill, training, and ethics matter less th managed care procedures" (p. 324). The question becomes at what poir cost containment interfere with the client's needs and the helper's ethic

Managed care may challenge the practitioner's ability to provi Managed care stresses time-limited interventions, cost-effective treat toward preventive rather than remedial processes (Cummings, 1990). Pr raises several concerns about the impact of managed care on the effecti provided (Denkers & Clifford, 1994; Hipp, Atkinson, & Pelac, 1994; noted by Miller (1996), managed care could result in clients' receiving that they may go underdiagnosed, experience restricted referral, and ha low-up. Thus, the policies of managed care may conflict with the dec practitioner, especially when utilization review decisions are contrary tc

ment, or when short-term or limited interventions are inadequate form
(Reamer, 1997). Ethical rules and standards are often incongruent with the r
ment situations. Many of the standards of care promulgated by professions i
cedures that require long-term contact for implementation (Coale, 1998). In
environment with restrictions to the number of sessions allowed, adhering
guidelines for risk management and standard of care service may simply b

In addition to potentially restricting treatment choice, the third party
compromise client privacy (Alperin, 1994; Brown, 1994; Schlesinger, 19
1995). For example, Edwards (1995) reported that the number of individ
managed care system who have access to records has increased dramatica
threatens the fundamental concept of confidentiality.

Given these potential areas of conflict what is the ethical practitio
minimum, the ethical practitioner needs to inform clients how their deliv
may be influenced by managed care policies and restrictions. Reamer (1
clients should be fully informed about the potential invasion of their privac
process employed by many managed care agents. Further, practitioners
willing to balance the requirements of managed care's cost containment pr
ethical concern of providing quality of care (Newman & Bricklin, 1991). H
plished is truly the dilemma faced by all managed care providers. Do ther
pro bono? Do they challenge the managed care gatekeepers about arti
needed care?

While the limitations to the number of sessions to be paid by insura
good economic and business sense for the insuring body, the question rema
pens to the client once these limits are reached? Should the client continue t
helper is ethically bound not to abandon him or her. The helper could refer
ing additional treatment or provide pro bono services. Both strategies invit
How does one refer if referral sources are limited? How does one provide pr
to so many and survive financially? The answer may lie in the decisions a
tioner makes before engaging in managed care service. Haas and Cumming
therapists to consider the question of how to provide service to the client ar
abandoning clients without going bankrupt before one joins a managed ca
standing the nature of the managed care contract and resolving areas of pr
dards of practice and care with those of economic necessity is a must for th
(see Exercise 5.3).

Beyond Professional Standards: A Personal Moral Response

While it is easy to grasp and comprehend the dilemmas one may face
demands, needs, and responsibilities of client, profession, and system
converge on a practitioner, positioning oneself to make the ethical decisio
another story. The existence and potential impact of these forces is not a sim
or academic issue. It is a real-life dilemma that has the potential to impair no
but the practitioner, a point poignantly described by Doherty (1995):

EXERCISE 5.3
Serving Clients in a Managed Care Environment

Directions: Contact two private practitioners who provide clinical servic managed care organization. Ask the practitioner each of the following qu

1. What are the limits to the types and/ or length of services you can p aged care clients?
2. Are there are any unique limitations to the confidentiality of your ing with managed care clients?
3. What, if any, avenues of appeal do you have regarding the decisior aged care utilization review boards?
4. How do you inform your clients of the special conditions regardin service, utilization review, confidentiality, etc. that may exist by tl ing managed care services?
5. Have you turned down any opportunities to join a particular m because you found it too restrictive?
6. Have you been able to change any policies, procedures, or requirem care organization of which you are a part as a way of better servici
7. As a provider in managed care, what do you find to be the most c your ability to provide ethical, professional care for your clients?

> Unsupportive and alienating work settings inevitably affect therapists' a cially for difficult clients at the end of a long workday or workweek undermined by other professionals in positions of greater institutional vation and investment in clinical care. Seeing too many clients during a same, as does having to fit the client's needs to the rigidly enforced restı care contracts. Therapists start to go through the motion, it shows, ar become negative about our clients, we hope for no-shows and cancellatic ing declines, and our ethical caring begins to feel like martyrdom.

Doherty (1995) suggests that under these conditions the ethical p with few options: either to change the context or get out, since one canr damental virtue of caring. This author concurs. Acceptance of employmer agreement with the principles and policies of the institution. When confl the institution's practices and the standards established by the code, eth need to clarify and resolve conflicts in a way that maximizes adherence of their profession. This can be facilitated by establishing a pre-plan of r conflicts between organization and professional ethics and values, includi tracts and contract demands so that they are in line with system goals A standards. When this is not possible, then it is this author's contention tha titioner should consider resignation. Exercise 5.4 is provided as a stimu development of such a pre-plan.

EXERCISE 5.4
Recontracting or Resigning

Directions: Part 1: Below you will find a number of organizational policies or procedu tioner would need to follow. Identify those you find objectionable. How would you attemp policies/procedures before you would resign your post?

Organizational Directive (Policies/Procedures)	Rework or Recontract	Resign?
1. All clinical records, including notes, are open to inspection by anyone identified as an executive administrator within the organization.	1. Attempt to specify the specific types of data open for review and tie each level of data to a specific administrator with a "need to know." Further, all clients would be informed as to the access to records.	Yes, if r
2. Allowed only to utilize a brief therapy form of service. Therapy restricted to eight sessions maximum.		
3. Prior to providing service all intake information must be shared with a review board in order to achieve permission to continue. Further, a specific treatment plan and progress reports must be completed after every four sessions.		
4. As an employee you are required to provide service, in-house for all the clients you see, regardless of their needs and your level of training.		
5. You are required to acquire a minimum of thirty continuing education credits in your profes-sional field every two years.		

Part 2: Ask an individual care provider who is a member of a managed care program to her contract and statement of responsibilities, policies, and procedures governing service c this contract and identify areas that you feel may potentially compromise your ability tc practice.

Case Illustration

Returning to the scene with which we opened the chapter, we find M counselor) expressing her felt conflict among the informal values and r within the system in which she works, her concern for her client, and h her professional code of ethics. As you read the continuing dialogue, t of the values and/or underlying assumptions existing within that school to identify where and how these may conflict with this particular coun ing of her professional code of conduct. The questions in the reflection the exchange should help you in this process.

MS. WICKS: Hi, Tom, it is me again.

MR. HAROLDS: Hey, how are you . . . did you get that informa association?

MS.WICKS: Not yet—they are supposed to call me. But, thing confusing. . . .

MR. HAROLDS: Really?

MS. WICKS: Ms. Armstrong, the principal at the school, infc understood in the district that we are not to counsel studen issues. She said it is not a formal policy, just something that " do. So now I'm not sure if I broke a law, or violated a code of stepped over the line in terms of my job definition. I am so co

MR. HAROLDS: Well, Michelle, this is a very conservative comn is that with so many of our students having Latino backgrour want to impose mainstream cultural values where they don't b

MS. WICKS: But, Tom, it is not like I'm going to promote a here—I am just very concerned that she is making some d prove harmful and even potentially lethal to her.

MR. HAROLDS: It is clear you are concerned about your clie understand something. In the past we attempted to help the stuc thought were value decisions. In fact, in health class we used tc uality and sexually transmitted diseases. Well, five years ago the health teacher, the principal and the school superintendent posedly "imposing moral values" on their children. As a result, from our curriculum, replaced it with something on career ch parent supervisor board for the school who reviews curriculur

So the superintendent is like extremely sensitive about anythin preted as promoting a set of values or beliefs. I guess Ms. Arms ing to avoid pressure from the central office. No sense rocking

Reflections

1. Assuming that Mr. Harold's depiction of the way the system operat would be the primary value or motive driving decisions around c

2. When it comes to decision making, which of the following would yc primacy in the culture of that school? Do what's expedient? Avoi costs? Be politically correct? Do what is best for the students?
3. Could you identify an artifact that reflects the operating values a within that school?
4. What do you feel Ms. Wicks should do? In relationship to her client? Her principal? Her job definition and contract?

Cooperative Learning Exercise

Directions: With a colleague review each of the following scenarios and

1. Identify potential areas of conflict
2. Decide if the behavior of the practitioner is ethical
3. Identify decision options available for the practitioner
4. Discuss possible pre-plan options that could have been implemente potential of conflict.

Scenario 1: High School Counselor

A high school counselor has been working with a student who w because of his concern about his tendency to steal and his desire to risk exp drugs. The student expressed genuine concern over both of these tendenci willing to work with the counselor in order to curtail both the desires a Working throughout the first part of the school year, the student made sign defined by the reduction of the number of times he had taken something t Prior to the Christmas break the student was asked by the school nurse to "messenger" during his study hall. Part of the role of messenger would l office, take phone calls, and record students' names who came in when th of the office. As with many schools, the nurse's office is where many of the ications are kept—including stimulants used for children diagnosed with AI selor feels that he should warn the nurse about the student's tendencies things and experimenting with drugs.

Scenario 2: An EAP Provider

Dr. Livingston is a licensed social worker working in private practice also provides short-term counseling to employees of a local manufacturi capacity as an Employee Assistance Counselor, she has agreed to provide s imum of five visits) counseling to all employees and offer referral services ing more extended care. Further, her contract calls for her to consult with m to increase their effectiveness when working with their employees.

In working with Helen, Dr. Livingston discovered that Helen and her been punching in and out for each other and, as a result, have developed a sy can cut approximately eight hours a week off their actual work while recor ing pay for a full forty-hour week. Helen is a little troubled by this proce that is what everybody does. Dr. Livingston feels that she should report t to Mr. Hansen, the owner of the company, since it is he with whom she has

Summary

Serving the Individual Within a System

Practice decisions made must clearly reflect not only the needs of the istics and orientation of the helper, but also the unique characteristics context or organization in which the helping occurs.

A professional role, as well as the expectations of professional l in response to the organization's expectations and needs; therefore, th incorporated as standards and guides for practice decision.

Ethical Culture of Social Systems

System culture is a pattern of basic assumptions invented, discoverec given group as it learns to cope with its problems of external adaptation tion. The pattern has worked well enough to be considered valid and is bers as the correct way to perceive, think, and feel, in relationship to t

Once enculturated within a system it is easy for the cultural value in the way members prioritize and function—shaping policies, decisic operations. As such, practice decisions may begin to reflect institutior nizational ethics more than they represent "best practice" or codes of p

Who Is the Client?

Most guidelines, like that of the American Counseling Association, in is the primary concern for the ethical helper and the institution seconc argued that accepting a position within an organization is a tacit agree agent and to embrace its values and standards of practice.

The ethical practitioner needs to be accountable and responsive t employment and the individual clients served within that system.

When There Are Multiple Masters

Ethical practitioners will share with their clients the obligations of fi employment, and how these may flavor the helping relationships an decisions. One special situation in which it is clear there may be more the case of managed care.

Managed care is essentially an economic strategy designed to pı or better quality for less money. The policies of managed care may co sions of an ethical practitioner, especially when utilization review deci professional judgment or when short-term or limited interventions are treatments

Understanding the nature of the managed care contract and res fessional standards of practice and care with those of economic necess ethical helper.

Beyond Professional Standards: A Personal Moral Decision

Acceptance of employment is essentially an agreement with the princi the institution. When conflict exists between the institution's practice

established by the code, the ethical practitioner needs to clarify and resolv
way that maximizes adherences to ethical dictates of his or her profession. Tl
itated by establishing a pre-plan of resolving potential conflicts between or
professional ethics and values, including adjusting contracts and contract d
they are in line with system goals AND professional standards. When this
then it is this author's contention that the ethical practitioner will consider r

IMPORTANT TERMS

artifacts
basic assumptions
client
cultural values
ethical culture of social systems
limits of confidentiality
managed care
need to know
organizational ethics
pre-plan
system
utilization review

SUGGESTED READINGS

Bersoff, D.N. (Ed.). (1995). *Ethical conflict in psychology*. Washington, DC: Americ
Association.
Clark, R. W., & Lattal, A.D. (1993). *Winning the integrity revolution*. Lanham, MD: Rowı
Weinberger, L.E., & Screenivasan, S. (1994). Ethical and professional conflicts in correct
Professional Psychology: Research and Practice, *25*, 161–167.

CHAPTER

6 Informed Consent

Ms. Wicks: Hi, Maria, have a seat. I really appreciate you coming down to see m
share some things with you and ask you for a favor.

Maria: A favor?

Ms. Wicks: Well, not really a favor, just your permission to do something.

Ms. Wicks is apparently about to speak to Maria about her desire to do so which she feels Maria should be fully informed. While we are not clear Ms.Wicks is going to seek permission for, it is clear that she respects Maria full participant in those helping decisions that may impact her. Seeking inf is an ethical imperative and requires that a helper be fully versed and skille ing the conditions that will allow a client to provide fully informed consent.

Chapter Objectives

The chapter will discuss the rationale for seeking clients' informed consent mentation of one's helping decisions. Further, the chapter will discuss the cc which such informed consent is not required and the conditions that may n informed consent difficult. Finally, the chapter will review specific issues rel mat and content of informed consent procedures. After reading this chapter able to do the following:

1. Define informed consent as applied to a helping relationship.
2. Explain the rationale and utility of gaining informed consent while v client.
3. Identify the essential elements required to ensure informed consent.
4. Discuss the special considerations and difficulties incurred while gai consent working with minor and cognitively impaired clients.

The Rationale for Informed Consent

Informed consent refers to the client's right to agree (and/or disagree) to pa various forms of helping and the specific procedures and services to be app tice of gaining informed consent for treatment has its origins both ethically

the medical profession. According to Dickson (1998), the term *inform* appear in an American court decision until 1957 (*Salgo v. Leland Sta Trustees*, 317P.2d 170). In this case a California court found that a phy disclose the facts required for a patient to make an intelligent choice. (1991) noted: "The doctrine of informed consent was originally design cians and surgeons to explain medical procedures to patients and to war or dangers that could result from treatment. The intent of the doctrine patient to make an intelligent, informed choice as to whether to undergo ment or procedure" (p. 50).

The doctrine of informed consent involves the right of the client and refuse the procedure(s) that are contemplated (Winick, 1991). Impli tice is the assumption that such consent is provided freely, without co from the participating professional. The freedom to choose to participa procedures requires that the client understand the nature of the proce benefits and detriments of these procedures, and the training and comp ing professional.

Ethically, the concept of informed consent is grounded in the beli to self-determination and the right to benefit from treatment. In addition obligations, informed consent is generally viewed as good clinical pra of informed consent reflects the profession's belief that the client has t ported in autonomous decision making regarding his or her own trea Stone, and Claiborn (1993) noted that "viewing informed consent as power with the client can have clinical significance, especially for clie previously victimized. For such clients, issues of power and control can cern" (p. 159).

The assumed value of a client's informed consent has been suppor The use of proper informed consent procedures have been reported to anxiety, an increase in client compliance with treatment and ultimately ery (Pope & Vasquez, 1991). Further, Sullivan, Martin, and Handelsmar clients "may be more favorably disposed to therapists who take the tim vide informed consent information" (p. 162).

Informed Consent Across the Profession

While the concept of informed consent has traditionally been applied t medical decisions, it can occur in any place that a patient or client is aske decision (e.g., consent for treatment, voluntary participation in a treatme gram etc.). All mental health professionals recognize the importance of and require practitioners to disclose to clients the various risks, benefits, the proposed treatment (see Table 6.1)

The provision of information upon which a client can make inform with the initial contact. In fact, helpers should begin the informed consent tial intake, almost as a "pre-helping" screening and information session. contact, basic information about the process of helping, the policies an

TABLE 6.1 Informed Consent

Professional Ethical Standards	Statement Confidentiality
National Association of Social Workers (1996)	1.03 Informed Consent (a) Social workers should provide services to clie context of a professional relationship based, when valid informed consent.
American Counseling Association (1995)	A.1. c Counselors and their clients work jointly in integrated, individual counseling plans that offer r promise of success and are consistent with abilitie circumstances of clients. Counselors and clients re counseling plans to ensure their continued viabilit effectiveness, respecting clients freedom of choice
American Association of Marriage and Family Therapists (1998)	1.8 Marriage and family therapists obtain written clients before videotaping, audiotaping, audioreco permitting third-party observation. 2.2 Marriage and family therapists use client and/ materials in teaching, writing, and public presenta written waiver has been obtained in accordance w when appropriate subprinciple steps have been tak client identity and confidentiality.
American Psychological Association (1995)	4.02 Psychologist must obtain informed consent t related procedures in understandable language.

cally employed (e.g., billing, scheduling, and canceling appointments, lim
tiality, etc.) helper competency, and the initial client issues and objectives c
But the issue of informed consent is not something restricted to the begin
fessional contact. It continues throughout the professional relationship. An
icant change in the treatment or procedure being carried out is cont
imperative to obtain informed consent for the change (Anderson, 1996; C
From this perspective informed consent is an ongoing dialogue regardin
treatment issues.

The specific content and the manner and timing of presentation (e.g., early, pre-, etc.) may vary as a function of legal requirements, agency poli characteristics of the client, and/or the setting in which services are provide conditions or elements essential to informed consent appear to hold across or clients. Most agree that informed consent requires that the client be c knowledge of what will occur, and engage in treatment voluntarily (Ander nett et al., 1990; Crawford, 1994; Stromberg and Colleagues in Law Firm, these components is discussed in some detail below.

Competence

Implicit in any discussion of informed consent is the assumption of a cli to make informed decisions that are in his or her own best interests. Cor the client's ability to make decisions for himself or herself (Beauchamp & A client judged to be competent to make these judgments is then also v right to be fully informed about the nature of the treatment, the alternati sible risks and benefits of each, and the practitioner's competency to prc

This sense of competency is not an all-or-none proposition. The competence will fluctuate as a function of the context or the decision crite petence (see Case Illustration 6.1). Clearly, while George lacks the cor business decisions, he appears able to understand the nature of the relatic sent to the process.

Competency may also be temporarily impaired as a result of psy physical trauma, or could be more permanently impaired as a result

CASE ILLUSTRATION 6.1
A Limited Competence

George is a 43-year-old who has been a successful owner of a mid-sized r pany. Over the course of the past month, George has gone on a spending only jeopardized his own financial well-being but has actually placed h brink of bankruptcy.

In addition to purchasing a new foreign sports car and refurbishing h with expensive European furniture, George has recently placed an order f plane. The truth is that George's business does not require him to travel n afford the multimillion-dollar expenditure. In addition to the spending spr been sleeping, exhibits a general restlessness, and has been developing p company to the level of an international conglomerate.

In response to a confrontation by his wife and the chair of his b George agreed to go for a psychiatric evaluation. Following general introd ing exchange occurred:

DR. WINCOCK: George, I can understand that you feel that peopl to your recent purchases and behavior, but it does appear that yc well and that a number of the decisions, for example, placing a d company jet, may not reflect the best of your business and perso

GEORGE: Well, it may look like the business can't afford it, but I as well. We are going to grow the business—significantly! I know ness to be an international concern within the next year and can p bottom line. I am even thinking about writing up my business pl it. I think it can revolutionize the way business is done.

DR. WINCOCK: Well, perhaps that is something we could talk abou being, I would like to thank you for coming and explain a little at what I hope we can do during the session. Would that be okay?

GEORGE: I really don't think I need to do this, but if it helps ease family and friends, then I am willing to give it a try—hell, maybe I' change my career—this seems to be a pretty cushy job.

DR. WINCOCK: Well, as you know I am a psychiatrist, and in addition here in the professional building, I am also on staff at the hospital her university. I have been working in the field of psychiatry for over f while I am able and do often prescribe medication to my clients who it, I also am trained in a type of therapy called cognitive-behavioral t

GEORGE: I am little familiar with that type of therapy . . . I mean I re I can't remember his name . . . it was a little yellow book on depre

DR. WINCOCK: Was the book *Feeling Good* by David Burns?

GEORGE: Yeah—I think that was the title. I liked the concept—you k laying down stuff and talking about your childhood . . . just get to tl

DR. WINCOCK: Well, I'm glad you are somewhat familiar with cogn we go along I would like to explain a little more about the approac ble benefit of combining it with some medication.

GEORGE: Well, no meds for me, Doc, that stuff slows you down . . whackos.

DR. WINCOCK: Well, before we talk about the pros and cons of m case, let me explain that I would like to spend the remainder of o which is about 50 minutes, to find out about some of the decisions been making as well as how you've been in general.

Now, I know that you read my little brochure, "Welcome to m describes my fees, length of sessions, policies regarding cancella etc. Did you have any questions about that information?

GEORGE: No—it was real clear, in fact, I'm going to make somethir my own business . . . great idea. . . .

DR. WINCOCK: Okay. Now I do know that pamphlet talked about information you share with me will be held in confidence, and if page 3 it points out a number of exceptions to that principle of c general, if you share information with me that seems to suggest tha dizing your own life or intend to harm someone else then I may h information as a way of protecting yourself or anyone you may seek understand that?

Do you have any questions about what I just shared or what is the

GEORGE: No, I got it—it makes sense . . . no fear I'm not gonna hu one else unless you consider the fact that my business is going to w petitors . . . "doing harm to others." Hell, maybe you should w kidding, Doc. Actually I've been through this before so I think I and I'm okay with it.

DR. WINCOCK: Well, that's good but if there is any question now about what we are doing or why we are doing it, I really want you to a and I work together the better it will be. You mentioned that you w this information since you've been through it before. Would you te

disease or irreversible brain damage (see Case Illustration 6.2). Whe judged not to be competent enough to understand the nature of the help to fully consent to participation in the helping, a legal guardian or parer fied and provide consent.

Comprehension

In addition to having the general cognitive competency and ability to p the client must be able to comprehend the information being presented. such information is transmitted is truly open to the discretion of the he and abilities of the client. Information could be presented in writing and cern that such disclosure is documented, acknowledgment of understan umented by way of a client's signature. Regardless of the specific f principle is that this information needs to be provided in a clear, compr is presented at a level that the client can understand (Handelsman, Kem McLain, & Johnsrud, 1986). Interestingly, Handelsman and colleague the readability of many consent forms employed in therapy were at t reading equivalency, similar to that found within an academically o Clearly, such a level of writing could restrict the ability of clients to full therefore, consent to the information provided.

It is essential that a helper present information in a way that m comprehension of both what is being suggested and the possible impacts The standard is that the practitioner share the information in a way that vidual in the client's position would be able to understand and make a re decision (Simon, 1992a). The information should be provided in simp tences that avoid jargon (Everstein, Everstein, Hegmann, True, Frey, et 1987). The ethical helper must be sure that the form of the information is comprehensible to the client, that the language is one in which the cli and that the timing is sensitive to the client's fatigue, emotional stat tractibility (see Exercise 6.1).

As a measure of ensuring comprehension, the ethical helper will elicit evidence of the client's comprehension (see Case Illustration 6.2).

In deciding what type of information should be provided, the comm as much information is required as would be needed by a "reasonable p make this decision. But when the practitioner believes that the disclos would be harmful to the client, it may be restricted. Such nondisclosu support in the courts (see *Canterbury v. Spence*, 464 F.2d772, 1972), wh sometimes disclosure can cause such emotional distress that it could co the treatment or even pose psychological damage to the client. In this cas for restricted disclosure.

Voluntariness

As noted in the various codes of ethics, consent is to be given and solicit out undue influence (see, for example, APA 4.02 a, Table 6.1). Whil

EXERCISE 6.1
Was the Client Informed?

Directions: After reading the following scenarios, discuss the cases with identify if you feel the duty to inform and gain informed consent was achie else do you feel should have been done?

Scenario 1:

An individual is referred by his employer because of what his employ a drinking problem. At the first meeting the counselor informed the client th poses for them coming together was for the counselor to make an assessmen possible alcohol abuse. The counselor informed the client that he was asked to assess the employee and to determine if he had an alcohol problem and i the degree to which it would it impair his work performance. The counselor expected to give this information in a written report to the employer as a employee's return to work. The counselor suggested that any specific inform their interview would not be shared with the employer but that his clinical im ing the existence of a possible drinking problem and the degree to which tha could impair the employee's work performance would be shared with his em ician presented the steps he would take in writing and asked the client if he he would sign the paper as evidence of his informed consent to release that i employer.

Scenario 2:

Enrique is a 14-year-old freshman who asked to see his school coun selor met with Enrique and in the process of the initial interview found o Enrique described himself as feeling very sad and lonely and that while he tained thoughts of hurting himself, he just wished his "down feelings" Enrique said that he started feeling this way a long time ago. He was ver maybe he is "strange," not like the other boys and that maybe he's "gay." The Enrique if he would like to talk again, especially about his feelings of being so sad. Enrique agreed. Following the initial interview the counselor consul son and shared the information he received from Enrique. The chair suggest selor call Enrique's parents and inform them of his sexual-orientation concer calls and sets up an appointment to meet with the parents.

---

which clients are seeking treatment on their own initiative, the condition is easy to ensure, there may be situations in which the client is "sent" to tre dated to participate in assessment or therapy. Under these conditions conser coercion, undue influence, misrepresentation, fraud, or duress being applied decision making (Simon, 1992b; Stanley 1987)—may be hard to obtain. U ditions voluntariness, while perhaps difficult to ensure, is still an essentia informed consent (Case Illustration 6.3). However, even when court ordere to inform the client that he or she is free to withdraw from treatment or e time, while explaining the potential consequences of such a decision.

CASE ILLUSTRATION 6.2
Ensuring Comprehension

Dr. Federico is a marriage and family therapist in private practice. She Anthony and Carol for an initial session. About 10 minutes before the ses to begin, Dr. Federico went out to greet the couple. She introduced herse couple that she would be with them in about five minutes. In the meantime with a little brochure that described her practice. She invited them to revie to their session. She explained that this would help them understand her provided answers to some of the typical questions often asked by clients.

At the scheduled time, Dr. Federico came out to invite the couple i some initial chatting, Dr. Federico asked the couple if they were able to r and if they had any questions.

CAROL: Yes, we both looked at it. It is very clear. We are b because we've never done this kind of thing before.

DR. FEDERICO: Well, I am glad you reviewed the brochure an how this may be a little anxiety provoking. How about if we just to try to relax and get some general information as well as answe may have about me or the practice?

CAROL: That would be fine, but I don't think we have any quest

DR. FEDERICO: Anthony, I can see you nodding in agreement? brochure, you understand I am certified as a marriage counsel private practice for nine years. Our session will be 50 minutes per session. Do you have any questions about the fee or abou insurance reimbursement?

ANTHONY: Carol and I talked about it before even coming and w insurance carrier. They don't cover marriage counseling but lu this, and we both think it is important enough to do even witho

DR. FEDERICO: That's a good start, with both of you valuing y marriage enough to commit to counseling. The other issue th often concerned about is whether the information we talk ab private.

ANTHONY: We are not ashamed about coming here.

CAROL: We actually have shared with our family we were doin thrilled.

DR. FEDERICO: Well, the fact that you come here would be some hard to keep private, given the public nature of the office buildin have a right to know that what we talk about will be held in cor of the restrictions that were noted in the information I provided.

CAROL: We actually underhand that in order to protect us you m information, but we don't see that as a problem (Anthony noddi

ANTHONY: We also saw in your brochure that sometimes with when it ends in some legal action, that often one spouse may ha poenaed by a lawyer. We really have no intention of going to

know we have to work on some things to improve our marriage understand that if court ordered you will release the records.

DR. FEDERICO: Well, you guys certainly did read the information understand it. But as we proceed I want to encourage you to ask if doing is unclear or if you have any questions about the process you a

CASE ILLUSTRATION 6.3
Compulsory Treatment

Warren was recently arrested for driving while under the influence. As part of of his sentence, he was required by the judge to attend a 14-week group cour At an individual session scheduled prior to the first group meeting, Warren the drug and alcohol counselor.

WARREN: What do I have to do?

LINDA: I'm not sure what you are asking.

WARREN: Just tell me what to do and I'll do it.

LINDA: Warren, this is a session that we set up for the people gc group program. We want to explain to you what we are intending group, let you know that we are required to make an assessment foll ticipation in the group program and then provide a written report dations to the court. So we need to be sure that you understand all to it before beginning the process.

WARREN: Agree? You gotta be kidding. I have to be here. Look la do what I gotta do.

LINDA: Warren, I am aware that you are here because it was part of But I want you to understand that we really have found that if you program, and have a feel for what you can get out of fully participati can be beneficial for you. Now—while it may not seem it, you d Even though this was mandated by the judge, you can choose not t participate. However, you know that decision would result in your

WARREN: Yeah, great choice. Do this or go to jail!

LINDA: Well, it is a choice and it is yours. Further, the degree to whicl in the group or not participate is also your choice. But again, we hav you will hear from others who have attended that the more you put i eficial it . . . that the more you put in, the more beneficial it is for you be describing your level of participation in our report to the court.

WARREN: I get it, and yeah, I guess I have choices to make . . . le things unfold.

LINDA: Well, that sounds a little more open and that's good. After ou sion I want to meet with you again so that we can evaluate your exp time maybe we could find other options or choices available to ma as beneficial as possible for you. How about that?

WARREN: That sounds like a plan . . . thanks.

TABLE 6.2 Areas of Informed Consent

Nature and Orientation of Helping	It is important to inform the client as to orientation and tl the practitioner. Further, it is important to inform the clie negative experiences one may encounter (e.g., anxiety, de process of therapy. Finally, goals and steps anticipated ne
Therapist-Credentials	Details regarding the therapist's specific training, educati unique credentials should be disclosed to the client. Simil involvement with consultants and supervisors regarding tl discussed with the client.
Fees and Insurance	All costs and fees for service should be discussed at the b relationship. Procedures and processes involved in seekin reimbursement along with limitations of the specific cove discussed along with an agreed upon plan addressing any coverage. When the helper is part of a managed care proc to inform the client (1) that a financial policy may exist tc type of service provided (Newman & Bricklin, 1991); (2) requirement for disclosure to the managed care agency; a limitations on service the agency may impose (Haas & Cı
Record Keeping and Access to Files	Records are kept for the benefit of the client, and clients g provided access as long as the information would not be r detrimental to the client. While the type of information st decision to share this information with the client may var setting, the client and the helper, the nature of a practition access policies should be clearly explained to the client.
Limits to Confidentiality	All of the professional codes note the importance of provi the limitations of confidentiality from the outset of the rel the helper needs to inform the client about the distinction confidentiality, privileged communication, and privacy of
Treatment: Benefits, Risks, and Alternatives	Even though research is limited, causing it to be difficult t benefits and risks of various treatment forms (Bednar, Bec Waite, 1991), it is important to discuss what is known in t what has been experienced by the helper.

EXERCISE 6.2
Comprehensibility?

Directions: Below you will find descriptions of the form, timing, ar providing a client with information needed to gain informed consent. R each scenario and identify what may be modified to increase the com information.

Scenario 1: Mrs. Lewis, an elementary school counselor, is sitting with mother of Tommie, a third grader who recently wrote in his journal: "I wish

MRS. LEWIS: Mrs. Robinson, I'm glad you could come right in.

MRS. ROBINSON: Yes, I left work immediately after you called. sounded serious.

MRS. LEWIS: Well, as you are aware we have a policy in the district that we inform parents anytime we (counselors) wish to work with it is important that parents know that we are counseling their chil stand how we would like to handle issues such as confidentiality.

MRS. ROBINSON: Counsel Tommie? Why? What happened (anxiou

MRS. LEWIS: Well, Tommie has given some evidence of having suici I would like to begin working with him immediately.

MRS. ROBINSON: WHAT? Suicide?

Scenario 2: R.L. Linquist is a social worker providing community servic migrant farm workers. Juan is a 38-year-old farm worker who came to the c tal health center because of his concern about possibly having a drinking pr meeting with Juan, the social worker went to the waiting room and handed J booklet explaining the policies and processes employed at the center. The soci Juan to read the document and to sign before they began their session.

Scenario 3: Rene is a psychiatric nurse assigned to do intake at a residentia ter. Tony and Harriet Bledshoe brought their 83-year-old father in because, a Bledshoes, he seems to be drifting off, has become incommunicative and found wondering outside the house without his shoes and/or pants. Rene met shoe (the client) and the following dialogue occurred:

RENE: Hello, Mr. Bledshoe, have a seat.

MR. BLEDSHOE: Hi, Harriet.

RENE: Mr. Bledshoe, my name is Rene and I am a nurse here at Tay

MR. BLEDSHOE: Yes, dear. Where is your mother?

RENE: Mr. Bledshoe, this is Taylor Manor and you were brought h and his wife. They are concerned about you.

MR. BLEDSHOE: Is Tony coming to lunch?

RENE: Mr. Bledshoe, I would like to ask you some questions and the with our psychiatrist. It may be a good idea for you to stay with us

MR. BLEDSHOE: Of course . . . anything you say.

RENE: So you understand and are willing to sign yourself into our h

MR. BLEDSHOE: Of course . . . Harriet. Is Tony going to be here wi

Special Challenges to Informing for Consent

Most agree that all information relevant to the understanding of the nat process should be provided to the client. However, while providing th information, it is important not to overwhelm the client with too much i the balance and the timing of information is an important consideration professionals. Further, without full understanding, the process of helping This last point demands that the clinician present the material in a m standable to the client so that the client's choices are free and noncoerc

Working with Minors

Competency, as noted above, refers to the ability to make a rational must have the cognitive capacity to make a competent decision conc relationship and/or the procedure(s) contemplated (Everstein et al., 1 Winick, 1991). When a client is not competent to make the decision, to make substitute consent on behalf of the client is required (Everstei

With the exception of emancipated minors, most states recognize t lack the capacity to give informed consent. When this is the case, the c consent goes to the parents or guardian. Emancipation is defined differer but in general it refers to an individual living independently and sup *Smith v. Seilby*, 72 Wash.2d 16, 1967). However, there are exceptions tc minors are allowed to seek birth control counseling and counseling relate pregnancy/abortion, and substance abuse without consent of a legal gua

For the practitioner who feels that client participation and autonom viding appropriate information to clients—even minors—to encourage ticipation in the helping process is good therapeutic practice. This the limits to confidentiality in a way that they can fully understand. It is stand the state laws governing such service to minors as they may in regarding provision of service. Thus, while it is good therapeutic practic bered that in most cases it is not required and may not be sufficient. It is to understand the policies and mandates of the organization in which he as well as any state or federal laws governing the need for parental cons minors.

Third-Party Involvement

A second area in which the issue of informed consent can be complica third-party referral. A client may be directed to therapy by a third party situations could have taken place involuntarily or compulsorily (e.g., c in these cases of compulsory treatment, a client has the right to refuse s is important for the practitioner to fully inform the client of the process that will be enacted should he continue and/or terminate the treatment or legal proceedings the client also has the right to know the helper's rc helper disclose information? Testify? If so, the client needs to know before accepting treatment.

An interesting variation on the theme of "voluntarism" comes when ir is viewed within the context of managed care. Managed care requires t information and disclosure of information for initial and continued care There is a potential problem with maintaining helper–client confidentiality understood and agreed upon by the client. This limitation of a helper's abili fidentiality needs to be fully disclosed and consented to before the establisl ing relationship.

Working with the Cognitively Impaired or the Elderly

A final population for whom informed consent is sometimes difficult t elderly and/or cognitively impaired (Pepper-Smith, Harvey, Silberfeld, St 1992). The elderly with diminished cognitive capacities may be considered tent but still have difficulty understanding the nuance of treatment. Often i gain a consent to inform and consult with family members so that appropria be monitored (see Case Illustration 6.4).

CASE ILLUSTRATION 6.4
Competent Yet Cognitively Impaired

Maryellen is a social worker specializing in gerontology. Maryellen has be with Louise, a 74-year-old woman who recently lost her husband and whc depressed. Louise was brought to the session by her daughter who also acco the office. Maryellen asked Louise if it would be all right if just she and Mar out the presence of her daughter. Louise said that would be fine, but noted t lems with remembering things and that if Maryellen needs some informati may need to provide it. According to her daughter, Louise has been diagno gists as giving evidence of mild dementia, a condition that in the last month l lowing the death of her husband.

Maryellen began the interview with Louise and noted that Louise was her daughter's address or phone (where she has been living for the past mor of her current physician or neurologists. Throughout the interview, Louise off and have to ask Maryellen to repeat a question or to tell her again what sh it was clear that Louise had a diminished cognitive ability, when asked wl why she was there, Louise was very clear that she came to a counselor beca she was having a difficult time feeling okay after her husband's death. Be stood both the need and nature of the reason she was with Maryellen, Mar explain the process and policies she would be using . In the course of de would like to proceed, Maryellen asked Louise for permission to contact Louise said: "That would be fine . . . I can't remember who he is, you shoul ter, she'll know." Maryellen thanked her and said that at the end of the s invite Louise's daughter in and ask her for some information, like her hom number, and doctor's names if that would be okay. Louise, responded p "Actually—I appreciate you letting my daughter give you the information. l me upset when I can't remember."

Beyond Professional Standards: A Personal Moral Response

Gaining client informed consent is clearly an ethical and legal mandate informed consent is more than a process of practice. It is a reflection helping relationship that is respectful of the client' autonomy and valui participation. Moving from the mandates of law and ethical codes to th ship is the hallmark of the ethical practitioner. It demonstrates that fc informed consent has moved from an ethical principle to a persona response in relationship with the client.

Moving beyond professional standards to a personal moral respor scious effort on the part of the practitioner. The following checklist is a l the ethical helper. The information presented has been adapted from ma Bertram and Wheeler (1994) in their workshop "Legal Aspects of Co Lawsuits and Legal Problems," Alexandria, VA: American Counseling items are useful both in developing informed written consent procedure tantly, in reinforcing the basic trust and fundamental valuing of the clier ethical helping. They are presented here as a mechanism to be used by each client and in so doing will facilitate elevation of informed consent and a moral response.

1. *Voluntary participation*: Assisting clients to commit to treatme knowledge that termination can occur at any time without penalty
2. *Client involvement:* Identify the level and type of involvement ex from the client.
3. *Helper involvement:* Describe the level and type of involvement helper along with information regarding the hows and whys for co especially in the case of emergencies.
4. *Model and approach:* Describe the helper's particular model anc how this will affect treatment.
5. *Risks and benefits associated with helping:* Identify potential ben well as possible risks, if any, associated with a particular approac
6. *Confidentiality, privilege, and limitations:* Specify how confiden dled and maintained along with the conditions under which con leged information will be released.
7. *Helper credentials:* Disclose training and experience relevant to t special credentials, certifications, and licenses held.
8. *Fees and reimbursements:* Identify all fees and charges, describe lected, and what involvement the helper will take in terms of insur filings.
9. *Cancellations:* Inform client as to cancellation policies and wheth
10. *Consultation and supervision:* Describe any required supervisc relationships in which the helper is engaged, along with the specif relationship on the current client–helper relationship.

11. *Disputes and complaints:* Inform the client of the address and phone r credentialing departments (certification, licensing) should complain service result.

Case Illustration

We began the chapter with a brief dialogue between Ms. Wicks and Maria. A continuation of the dialogue, which is presented below, observe Ms. Wicks reflects or fails to reflect the principles discussed within this chapter. Furthe brief questions for your reflection are offered following the case to stimulat tion of your knowledge on informed consent.

MS. WICKS: Hi, Maria, have a seat. I really appreciate you coming d I need to share some things with you and ask you for a favor.

MARIA: A favor?

MS. WICKS: Well, not really a favor, just your permission to do som

MARIA: I don't understand.

MS.WICKS: Well, after we met last time, I was very concerned about that you may be engaging in dangerous behavior, something that c So I went to Mr. Harolds, the chairperson for the counseling dep him for some advice.

MARIA: Wait—what are you saying? You're blabbing everything I t people?

MS. WICKS: No, that's not what happened and in fact that's what I with you about. In speaking with Mr. Harolds, I didn't let him student was, and I was careful not to disclose any information could identify you. But I asked him if I needed to contact anyone or about the risk you are running by having unprotected sex with a AIDS.

MARIA: Okay—so you didn't call my mom or anything, right? An doesn't know you are talking about me?

MS. WICKS: That's correct, but the truth is I don't feel real comfort you are doing. I care about you and I feel you are really endangeri having unprotected sex with a person with AIDS. Maria, I woul some information about this situation with Ms. Armstrong. I will n you are by name and I will try not to share any identifying informat her permission to refer you to a clinic for some blood work, as well mation on safe sex. I would be willing even to go with you, if you but I need Ms. Armstrong's permission to give that type of inform

MARIA: I think you are overreacting—but I would be willing to go to if you would come with me.

MS. WICKS: I will if it is permitted as part of my work here, but f to Ms. Armstrong. I outlined the type of information I would li Armstrong as a way of convincing her of the importance of all Let's go over this list so that I can explain each item and make you. Okay?

MARIA: Okay!

Reflections:

1. Do you feel this discussion was even necessary or could/should have discussed this issue with Ms. Armstrong, the principal?
2. Ms. Wicks spoke with Mr. Harolds without receiving Maria's inf she violate confidentiality? Did she need Maria's consent?
3. Ms. Wicks is going to discuss a list of points that she wishes to c strong. Is there anything in addition to that which you feel she sh
4. Should Ms. Wicks have Maria sign a formal consent form?
5. What is the rule for providing information to a minor regarding fa sex, and venereal disease in your state?

Cooperative Learning Exercise

The purpose of this chapter was to introduce you to the concept of info with the elements involved in obtaining such consent. As noted thro gaining client informed consent is not always necessary or even possibl Working with a colleague or classmate, contact a person working as a ((2) drug and alcohol counselor, (3) court-appointed mental health practi riage counselor and ask each of the following questions. Share your inf colleagues and/or classmates looking for common areas of practice an

1. Do you gain informed consent from all of your clients? If not, v that decision determined? If so, when and where within the help seek informed consent?
2. When you seek informed consent, how do you ensure (a) capac comprehension, and (c) voluntarism?
3. How do you document that you have gained informed consent?
4. What value, if any, do you find in gaining informed consent?

Summary

The Rationale for Informed Consent

The doctrine of informed consent involves the right of the client to bot refuse the procedure(s) that are contemplated. Ethically, the concept of i grounded in the belief of a client's right to self-determination and ri treatment.

Informed Consent Across the Profession

Most agree that informed consent requires that the client be competent, ha what will occur, and engage in treatment voluntarily.

The identification of competence will fluctuate as a function of co criteria defining competence. In ensuring comprehension the practitioner n information in a way that a reasonable individual in the client's position understand and make a reasonably informed decision. Finally, consent is solicited freely and without undue influence.

Special Challenges to Informing for Consent

Working with minors presents a challenge to the principle of competency. tion of emancipated minors, most states recognize that minors generally l to give informed consent. When this is the case, the capacity for informed the parents or guardian. In some states, minors are allowed to seek birth co and counseling related to venereal disease, pregnancy/abortion, and subst out consent of a legal guardian or parents.

The issue of voluntary consent is potentially compromised when directed to therapy by a third party, which can take place involuntarily (e.g., court ordered). Even in these cases of compulsory treatment, a clien refuse service.

Comprehension can be challenged in situations in which a practiti with a client with diminished cognitive capacities. It is possible that the cl sidered legally competent but still have difficulty understanding the nuan Often it is important to gain a consent to inform and consult with family appropriate treatment can be monitored.

IMPORTANT TERMS

client compliance
competency
comprehension
context
decision criteria
emancipated minors
impaired
informed consent
legal guardiar
mondisclosur
pre-helping s
power
self-determin
third party
voluntariness

SUGGESTED READINGS

Handelsman, M.M., Martinez, A., Geisendorfer, S., & Jordon, L. (1995). Does legall to psychotherapy ensure ethical appropriateness? The Colorado experience. *Eth* 119–129.

Koocher, G.P., & Keith-Spiegel, P.C. (1990). *Children, ethics and the law: Professio*
Lincoln, NE: University of Nebraska Press.
Melton, G.B., Koocher, G.P., & Saks, M. (Eds). (1983). *Children's competence to*
Plenum.
White, M.D., & White, C.A. (1981). Involuntarily committed patients' constitutional
ment: A challenge to psychology. *American Psychologist, 36*, 953–962.

CHAPTER

7 Confidentiality

Maria: It's okay. You can talk to Ms. Armstrong as long as you don't tell her wh want anyone knowing what I told you. Besides, I thought talking to you w to a priest in confession . . . you know, a major secret?

Maria understands the fundamental nature of the helping relationship. It the individual's right to privacy is respected. However, as with most thing: sion the issue of privacy or confidentiality is not simply yes or no.

While confidentiality is a value held and practiced by all ethical pı extent of such confidentiality can and will vary as a result of the context, c istics, and the nature of the information shared. The concept and ethical pri dentiality, along with those conditions that define the extent and limits of will serve as the focus for the current chapter.

Chapter Objectives

After reading this chapter you should be able to do the following:

1. Describe what is meant by the terms confidentiality and privilege
2. Identify the conditions under which confidentiality and privilege shou
3. Discuss the conditions that need to exist for the Duty to Warn to be i
4. Describe the special challenges facing practitioners working with b those with HIV/AIDS in regards to confidentiality.

Confidentiality: What and When Warranted?

Privacy and the right to decide for oneself the time and circumstances und close personal beliefs, behaviors, and opinions is a cornerstone to our ir under the Constitution of the United States. It is this constitutional right serves as the legal basis of privileged communication and the professional fidentiality (Kurpius, 1997).

Confidentiality Is Not Privileged

Confidentiality refers to the ethical principal that conveys that the info within the context of the professional relationship will not be disclosed informed consent. As defined, confidentiality is "the general standard of duct that obliges a professional not to discuss information about the cl (Keith-Spiegel & Koocher, 1985, p. 57). Confidentiality is essential to th ing relationship. The helping relationship requires a client to place his helper, knowing that the information will remain confidential. Research ple are less apt to seek help and to self-disclose if therapy is not confide Brischetto, 1983; Miller & Thelen, 1986).

Confidentiality should not be equated with privileged communi communication is a "legal term that describes the quality of certain spec tionships that prevent information, acquired from such relationships, fro in court or other legal proceedings" (Keith-Spiegel & Koocher, 1985, p.

Confidentiality is the broader concept that includes the expectatior not be divulged, whereas privileged communications carry a strong adm rial will not and may not be divulged even in court. While confidential ma of what transpires between the client and the practitioner, privilege belor defined "protected relationships" such as physician and patient; lawye chologist, social worker, and psychiatrist and their clients. The privilege necessity to receive permission from the client, the holder of the privileg sure (see Case Illustration 7.1).

CASE ILLUSTRATION 7.1
Release Only with Consent

Dr. Ramerez is a licensed psychiatrist. Dr. Ramerez is currently working w been diagnosed as having a post traumatic stress syndrome as a result of a s in which thirteen people were killed. Alfred was the only one of four peopl survived. The accident, which involved an oil truck and seven cars, was ca truck driver, who had fallen asleep at the wheel. An insurance company r the other victims in the crash in a lawsuit against the oil company subpoer records reflecting his diagnosis and treatment of Alfred.

Dr. Ramerez, respectfully declined to honor the subpoena, claiming be privileged and stating that he would release this information only whe consent to its release. The lawyer representing the complainant in the lawsu company explained that the only purpose of the request was to demonstr psychological impact that his client could experience well after her phy healed and he wanted to use Alfred's case as an illustration of PTSD. Dr. I the request to Alfred, who wanted to sign a consent to release the infc Ramerez still felt that releasing the information was neither required nor Dr. Ramerez understood that privilege belonged to the client and not to t Alfred consented to release the information, he did.

For communication to be privileged it is generally held that the comn satisfy four criteria (see Wigmore, 1961):

1. The communication must originate in confidence that it will not be d
2. The confidentiality of information must be essential to the full and sa tenance of the relationship.
3. The relationship must be one that should be sedulously fostered in th community.
4. Injury to the relationship by disclosure of the communication must be benefit gained by the correct disposal of litigation regarding t (Schwitzgebel & Schwitzgebel, 1980).

With these criteria as backdrop it would appear that the legal concept of munication does not apply in group situations or even couple therapy, since the third person makes ensuring the origination of confidence difficult to en (1996) suggests that therapists inform their clients of the ethical need for conf highlighting the lack of legal privilege concerning disclosures made in the pr party. Further questions regarding who can claim the privilege, what type c privileged, and what the limitations to privilege are can vary extensively s such, it is imperative for each practitioner to know the answers to these ques within the state in which they practice. Exercise 7.1 is provided to assist in tl

Confidentiality Across the Professions

The provision of confidentiality is common throughout human service pr widely held as a therapeutic necessity. All professional organizations add confidentiality (see Table 7.1). While the specific wording varies, the inte

EXERCISE 7.1
A Question of Privilege?

Directions: As suggested in text, the nature of privileged communication state. Contact either your state professional organization or the state boar affairs and gather information to the following questions:

1. Who can claim privileged communication, or under what conditions claimed?
2. What type of communications are covered by privilege?
3. Which professions and professionals have privilege?
4. What are the limitations to privilege?
5. What constitutes a waiver of privilege?

TABLE 7.1 Confidentiality

Professional Ethical Standards	Statement Confidentiality
American Psychological Association (1995)	5.02 Psychologists have a primary obligation and t precautions to respect the confidentiality rights of they work or consult, recognizing that confidential established by law, institutional rules, or professio relationships.
National Association of Social Workers (1996)	1.07 Privacy and Confidentiality (c) Social workers should protect the confidentialit obtained in the course of professional service, exc professional reasons. The general expectation that keep information confidential does not apply when necessary to prevent serious, foreseeable, and imm client or other identifiable person. In all instances, should disclose the least amount of confidential inf to achieve the desired purpose; only information th relevant to the purpose for which the disclosure is revealed.
American Counseling Association (1995)	B.1. Right to Privacy a. Respect for Privacy. Counselors respect their cli privacy and avoid illegal and unwarranted disclosu information.
American Association of Marriage and Family Therapists (1998)	Section 2. Marriage and family therapists have uni concerns because the client in a therapeutic relatio than one person. Therapists respect and guard the c individual client.

principle of confidentiality articulated by the various professional orgar to that presented by the National Association of Social Workers (1996):

> Social workers should protect the confidentiality of all information obta professional service, except for compelling professional reasons. The that social workers will keep information confidential does not apply necessary to prevent serious, foreseeable, and imminent harm to a client person or when laws or regulations require disclosure without a clie instances, social workers should disclose the least amount of confidenti essary to achieve the desired purpose; only information that is directly pose for which the disclosure is made should be revealed.

Neither confidentiality nor privilege is an absolute. Since both are of the protection of the client, not the helper, both can be waived by t client waiver, conditions exists that limit the degree to which communica tained as confidential. Conditions such as those dictated by local laws a

regulations, as well as situations in which a client or an identifiable person i should confidentiality be maintained, necessitate the breaching of confide ilege. These conditions and other complicating factors are discussed in the

Limits and Special Challenges to Confidentiality

Since confidentiality is not an absolute, in addition to respecting the confi client's information, the ethical professional is directed by standards of pr the client, when appropriate, of the limits of confidentiality. The Code of I Workers (1996), for example, states: "Social workers should inform clier possible, about the disclosure of confidential information and the potentia when feasible before the disclosure is made." (NASW, 1996, 1.07.d).

It is essential that the professional helper explicate the restrictions o and assist the client to understand the unique conditions under which infc shared in the course of providing service. The American Psychological As of Ethics states that disclosure of the limits of confidentiality should occu a professional relationship: "unless it is not foreseeable or is contraindicate of confidentiality occurs at the outset of the relationship and thereafter stances may warrant" (APA, 1995, Standard 5.01b).

Beyond the client's consent to waive privilege or disclose confiden courts and the various professions have identified a number of conditions closure of this information may be required. These conditions include sh sional support when a client is a danger to self or others, in child abuse situ court ordered.

Since breach of confidentiality may be mandated in these and othe clients should be adequately informed about the limitations of confidentia the relationship (see Chapter 6). Once informed, it becomes the client's share such personal information, knowing that confidence may not be mai

The ethical professional will maintain that breach of confidentiality issue that the basis needs to be strong and justifiable. Further, because a dentiality that is outside of these conditions may make the professional sus and ethical sanctions, ranging from sanctioning by the professional organ practice suit, it is essential for the practitioner to be fully versed in the laws dards existing for one's profession and in one's state of practice.

Professional Support

It is generally accepted that confidential material may be shared with colle visors for professional purposes. However, only that material essential to or supervision should be disclosed. Additionally, the conditions under wh tion is shared needs to reflect the respect for client privacy and the attempt imum confidentiality. Case Illustration 7.2 demonstrates how in professional interactions we may become somewhat insensitive to the which we share confidential information.

CASE ILLUSTRATION 7.2
Faculty Room Chatter

Allison is a secondary school counselor. She has been working with Ri student who has been speaking with Allison about his concern and anxiet entation. Ricky has started to accept the fact that he is homosexual and ha the school counselor to determine ways in which he can disclose this inf ents. Because of the anxiety he has been feeling and the amount of psychi giving to this concern, Ricky's academic performance has fallen off quit

Ricky is very concerned that his two honors teachers may feel stopped caring about their courses, and he would like them to write hi mendation. Thus he asks Allison if she would explain to the teachers abo gle so that they will better understand his falling grades. Ricky gives pe the information they have discussed, including his own coming out.

Allison sets up a meeting with Mr. Hansen and Ms. Wallace, the t She explains that she has been working with Ricky and would like to sha that may better help them understand his current academic difficulty. B concern for Ricky and are glad to have the meeting. The three meet at a lounge, where Allison begins to share the information with both teache having them more fully understand Ricky's change in performance. W aware that other teachers are in the room, she feels that if they speak in a that no one else will either overhear or care to listen.

Client as Danger to Self or Others

While it may be obvious that the ethical practitioner concerned for the w her client will break confidence if doing so can protect a client from s what may not be as obvious is that a break in confidence may be require ing reasonable care to protect others who may be in jeopardy of harm client. The professional obligation to warn a third party of a potentia widely discussed starting with the now famous case of *Tarasoff v. The R versity of California* (1976). In this case, the California Supreme Cou warn and to protect an identifiable and foreseeable victim. The case fo Poddar, the defendant charged with the 1969 killing of Tatiana Tarasoff. alleged that two months prior to the murder, Poddar confided his intent to a psychologist employed by the Cowell Memorial Hospital at the Uni nia at Berkeley. The psychologist had Poddar detained by the campus p was later released. No one warned Tarasoff of the possible peril to her l appeal, the court ruled that a duty to warn existed, stating:

> When a therapist determines, or pursuant to the standards of his profe mine, that his [client] presents a serious danger of violence to another h tion to use reasonable care to protect the intended victim against such da of this duty may require the therapist to take one or more of various ste

> the nature of the case. Thus it may call for him to warn the intended victim to apprise the victim of the danger, to notify the police, or to take whatever reasonably necessary under the circumstances. (*Tarasoff*, 131 Cal. Rptr. at 7

The courts in this situation concluded that:

> Public policy favoring protection of the confidential character of [client], p communication must yield to the extent to which disclosure is essential to a others. The protective privilege ends where the public peril begins (*Tarasoff* at 27).

This case has served as the foundation for the concept of duty to warn. tal health professionals responsible for assessing the risk of danger that the present to others and assessing the need to breach confidentiality and to warn sions of the Tarasoff case are presented later within this chapter. One sp which Tarasoff continues to be debated is in working with clients with HIV/

Persons with AIDS

Traditional approaches to client confidentiality have certainly been challenge duction of the issue of AIDS and at-risk behaviors (Erickson, 1993). There guidelines to help professionals determine when or how to inform a potentia threat of HIV transmission (Erickson, 1993).

The law in most jurisdictions protects the confidentiality of a perso There have been exceptions to this rule, including public health reporting and disclosure to a spouse or sexual partner. There have been attempts at applyin decision to AIDS-related cases (Ahia & Martin, 1993; Cohen, 1997; Kna Creek, 1990; McGuire, Nieri, Abbott, Sheridan, & Fisher, 1995). With T framework for decision making, it would appear that therapists have a duty to the following conditions (see McGuire et al., 1995; Totten, Lamb, & Reeder

- When a special client–therapist relationship exists.
- When there is clear and imminent danger—which would be a function medical diagnosis, the extent to which the person engages in high-risk the degree to which safe sex procedures are or are not employed.
- When there is an identifiable victim. This is compounded with HIV in can remain dormant for years and the number of persons with whom sexually engaged is difficult to determine. However, when there is a sive partner, the identification of the potential victim is easier.

The lack of case law, however, makes clear-cut decisions and rules har ther, the application of Tarasoff has not been generally accepted as the stand differ regarding HIV and the limits of confidentiality and vary according to fessional license. Some states may forbid disclosure of any HIV status to whereas other states may allow for some disclosure or restrict that free

professions (e.g., physician, psychiatrist). Cohen (1997) suggests that j legal precedent, state statutes and professional codes of ethics when a the HIV disclosure dilemma (see Exercise 7.2).

The American Psychological Association did pass several re clients who are HIV positive (APA, 1992) and concerning Tarasoff con tection of others. In summary, the APA suggests that unless there is a who refuses to behave in a manner that protects this person, the cover ity should not be broken. Specifically, the APA's position is that

1. A legal duty to protect third parties from HIV should not be imp
2. If, however, specific legislation is considered, then it should pe when the provider knows of an identifiable third party whom the pelling reason to believe is at significant risk of infection; the pr able belief that the third party has no reason to suspect that he c the client/patient has been urged to inform the third party and ha considered unreliable in his or her willingness to notify the third
3. If such legislation is adopted, it should include immunity from ci bility for providers who, in good faith, make decisions to disclo information about HIV.

The issue of disclosure and the duty to warn when in relation HIV/AIDS client are not at all clear-cut. The professional's response ce that needs to reflect the current position of her or his profession and t

EXERCISE 7.2
The Duty to Warn and Clients with AIDS

Directions: The application of Tarasoff to situations involving clients w not been clarified within the courts.

Part 1: Contact a professional in practice within your local comm lowing questions to the professional and share your findings with your cl

a. Are you familiar with the Tarasoff case?
b. If you had a client who expressed an intention to seriously harm a what would you do? Has this ever happened in your practice?
c. What would you do if your client, who had AIDS, was actively en sex with an identifiable partner? Has this ever happened in your p

Part 2: Contact your state professional organization and ask for t applying Tarasoff and the duty to warn in situations involving a client w HIV positive.

EXERCISE 7.3
To Disclose or Not to Disclose?

Directions: Given the lack of clarity and directions regarding the issue of disc to warn in cases of working with clients with HIV/AIDS, individual decisior of colleagues are important reference points for the practitioner attempting t cal decision. Contact at least two professionals currently working in your p: sional arena and pose to them the following scenarios. Record their response findings with a colleague or a classmate in an attempt to identify the standard rently enacted within your locale.

Scenario:
Assume you are working with a client who has admitted having AIDS and eng tected sex. Further assume that the client refused to give you consent to dis mation.

1. Would you warn the client's spouse?
2. Would you warn the client's current, live-in lover (assuming the married)?
3. Would you warn individuals whom your client identified as recent sex
4. Would you warn individuals who your client identified as having sex o years?
5. Would you continue to work with the client, if he or she refused to b safe sex?

---

local and federal courts. Exercise 7.3 is presented to give you a "practitioner difficult area of professional decision making.

Child Abuse

The Child Abuse Prevention and Treatment Act of 1974 defined child abu and set the standards for state mandatory reporting laws. Since that time the been broadened to include various types of maltreatment. Under these condit is mandated. However, resolving the complex conflicts among protecting c taining confidentiality, protecting the integrity of the professional relationshi and abiding by statutes and laws is difficult.

While professional standards direct the practitioner to protect the in closed within the helping process, breaking the law by not complying with a to report is in itself unethical. The American Psychological Code of Eth example, states that "psychologists disclose confidential information withou the individual only as mandated by law, or where permitted by law for a (Standard 5.05a). The tension and conflict between professional values and legal requirements is not easy to resolve. But, as with any ethical dilemma, issue of mandated reporting can be approached by consulting with a colle

situation. Kalichman and Brosig (1993) reported that over 80 per cen chologists discuss cases of suspected child maltreatment with collea need to have a level of certainty that maltreatment has occurred prior to man & Craig, 1991).

Records—Court Ordered

All professional codes of conduct provide for the maintenance and utili well as the maintenance of privacy of these records (see Chapter 10). maintained in a secure manner in order to protect the client's confid maintain adequate records may be seen as a breach of the standard of as a basis for a malpractice suit (Anderson, 1996).

In the case of educational records, confidentiality is protected ur U.S.C. 1232g, the Family Educational Privacy Act (also referred to as ment). This law applies to any educational agency (public or private funds. It specifies that parents have access to student education records of educational records requires parental or student (if over 18) writte consent, only "director information"—limited to name, address, telep major, and date of attendance—are released. This is not an open file po such as those maintained by a physician, psychiatrist, psychologist, or ot fessional or paraprofessional acting in his or her professional and para ity, are made, maintained, or used only in connection with the provisior student. These are not available to anyone other than persons provid (20U.S.C., sec. 1232(a)(4)(B)).

While records, including educational records, may be requested b or legal professionals, the only request to which the practitioner mu client consent is one issued in the form of a court order. Often recorc insurance companies or others in legal proceedings, often in the form while it is important for a mental health specialist to respond to a subp can be in the form of a request. Rather than disclosing the information can request that the agency or individual seeking the information obtain information from the client. However, if a practitioner is issued a *duces* court order, then the practitioner must appear in court and bring the clie this condition a claim of privilege could be offered at the court and wou to either honor the privilege or demand a breach.

Another condition in which a breach of confidentiality and priv when a client files a lawsuit or ethical grievance against the practitione ditions the practitioner has a right to reveal relevant information about her own defense.

One final area in which release of information may invite a breacl is in the case of providing information for insurance claims. Clients ne that information released to insurance companies for the purpose of th may remain within their records. Typically, the information required in name, services provided, dates of services, and a diagnosis. The import that once these data are conveyed to the insurance company, the practitic

have control over access to these records and thus cannot restrict to whom c
mation is used.

Confidentiality and Working with Minors

Although children and adolescents increasingly have been granted rights
informed consent and privileged communication in counseling these issues
in practice and often confusing to practitioners. There is a lack of general a
the profession (e.g., Anderson, 1996; Hendrix, 1991; Salo & Shumate,
confidentiality when counseling minors, specifically in reference to shar
with parents. Herlihy and Corey (1996), for example, warned that althoug
may belong to the parents or guardian, there is an ethical responsibilit
minor's permission before releasing information.

For those working with minors in a school setting, the minors' rights
ity are protected by the Family Educational Rights and Privacy Act, knowr
Amendment (1974). While this act provides for access by parents to studen
exempts counselor notes, assuming that they are not considered part of the
record. Because this final designation of "official school record" is open t
tion of each school district, counselors should be aware of their own di
regarding counselor notes and minor confidentiality.

In a number of states minors over the ages of 12, 13, and 14 have ri
ing in the specific area of drug and alcohol abuse and venereal disease wi
parents. Some states have even provided for free choice and informed conse
counseling without requiring them to inform parents (Corey et al., 1993).
that such right to privacy and freedom to choose increases the likelihood t
adolescents needing counseling will seek it.

Recent Legal Decisions: Confidentiality and Privileged Communications

Professionals with Privilege

Psychotherapist–client privilege has been supported by a Supreme Cour
case involved the ability of a clinical social worker licensed in Illinois to ass
communications between herself and her client in a lawsuit. The client, Ma
was a police officer who killed Ricky Allen, Sr. The officer responded to
and found Mr. Allen allegedly poised to stab another individual. The
against Officer Redmond, the City of Hoffman Estates, and its police dep
rie Jaffee, the administrator of the Allen estate, alleged that excessive force
In the course of the legal proceedings, the family petitioned to obtain not
therapist in counseling sessions with Officer Redmond after the incident. R
to provide consent, and the therapist refused to respond by providing note
that case informed the jury to assume that the notes were unfavorable, anc
for the plaintiff. On appeal in the U.S. Court of Appeals for the 7th circuit,

was thrown out and the case was remanded for a new trial with the court trial court had erred by not protecting the confidentiality of the records. J decision to the U.S. Supreme Court, which in a ruling in *Jaffee v. Redm* standard of privileged communication. The justice wrote: "Effect depends upon an atmosphere of confidence and trust in which the p make frank and complete disclosure of facts, emotions, memories and fe This decision upheld the ability of licensed psychotherapists to maintain their clients in federal court cases.

While the *Jaffee v. Redmond* ruling directly applies only within th tem, it does extend psychotherapist privilege to another group of lice clinical social workers. Many believe that opens the door to the extensi to other mental health professionals. Each state has laws that govern the relationships under which a communication is considered privileged. A tioner should check on the specific laws and court rulings defining the lege for practitioners within their state of employment.

Extending the Duty to Protect

While the release of educational records under the conditions set fo Amendment generally require the informed consent of the parent or the the need to breach confidence appears to extend to situations involving when the client appears to be in danger of harming himself or herself. In *v. Board of Education* (1991), the Maryland Court of Appeals applied confidentiality to school counselors if a client is judged to be at risk fo case a child threatened suicide in the presence of schoolmates. These sch the parents of the child and the school counselor. The counselor intervie denied the threat. The counselor did not follow up or notify the parents tration. The father sued the counselors and the school following the chi ing breach of duty to intervene to prevent the suicide and the court fo plaintiff (Anderson, 1996).

Extending Tarasoff

At least fifteen states enacted "Tarasoff statutes," including Alaska, Ca Florida, Indiana , Kansas, Kentucky, Louisiana, Massachusetts, Minnes Hampshire, Ohio, Utah, and Washington; at least five other jurisdictions theory (Reaves & Ogloff, 1996). More recent court cases have attempte the elements of "foreseeable danger" and "identifiable victim." While th defines "foreseeable danger" are still being debated, the courts have ge such foreseeable danger is present when there is a readily identifiable v diction of danger is based on professional standards such as the existenc possession of a weapon, and the individual's having a clear plan of act *Philadelphia Center for Human Development*, the Pennsylvania Supre based upon the special relationship between a mental health professio patient, when the patient has communicated to the professional a speci

threat of serious bodily injury against a specifically identified or readily id party and the professional determines that his or her patient presents a seriou lence to the third party, then that professional bears a duty to exercise rea protect by warning the third party against such a danger (Tepper & Knapp, subsequent court decisions have expanded and clarified the duty to warn ar dangerous clients. For example, victims who are not specifically identified b who could be considered foreseeable, likely targets of client violence (such in close proximity to an identifiable victim) should be warned according the *lund v. Superior Court of Orange County* (1983) and *Jablonski v. United St*

Other court cases have extended this duty to warn even when the victi identifiable. In *Lipari v. Sears, Roebuck & Co.* (1980), the court ruled th failed in the duty to protect others by not detaining a potentially violent clien chased a gun, even though no identifiable victim was named. And in a Ver Court ruling in 1985 (*Peck v. Counseling Services of Addison County*), the T warn was extended to cases involving property—and not just personal— case, the client was viewed as posing a serious risk of danger in that the cl arson represented a "lethal threat to human beings who may be in the vicin flagration" (*Peck v. Counseling Services of Addision County*, 146 Vt. 61, Sup.Ct. 1985, at 424 n.3.)

Protecting the Practitioner

Violations of confidentiality and privilege are determined by statutes, court professional codes of ethics. These violations may be responded to with crimi action, and/or professional sanctioning. However, because of the increasing for breach of confidentiality in the protection of others (identified or not), ma California, Colorado, Kentucky) have legislation protecting mental healt from civil liability if they issue warnings in attempts to protect others harm (Herlihy & Sheeley, 1988). Again, it is essential for the ethical helper to laws existing in his or her state of employment that govern such disclosures tection.

Beyond Professional Standards: A Personal Moral Response

As noted, confidentiality is essential to the nature of a helping relationship. feel safe within the helping relationship and trust that their disclosures will fidence. The ethical principle of confidentiality is founded on the fundame a client's privacy and the helper's concern for maintaining client welfare. T respect for privacy and the valuing of the welfare of the client need to be mc the rationale for the ethical principle of confidentiality. Both need to be per

The ethical professional, who values client privacy and welfare, will m breach of confidentiality is such a strong issue that the basis needs to be str able. However, even with this as a personal value, balancing client need, prof

and legal mandate is not always easy nor clear. Thus it is essenti
tioner to keep current on the profession's stance and application
the laws governing practice and practice decisions. Specifically
commit to:

- Knowing state laws mandating reporting or breaching of c
- Understanding thresholds and criteria for breach of confid
- Providing disclosure to clients regarding the limitations to
- Keeping thorough and detailed records
- Seeking consultation before disclosure
- Maintaining current knowledge of legal and ethical decisic
  of information
- Seeking ongoing education on the issue of confidentiality a

Finally, fear of litigation or concerns about adhering to leg
the motivation for committing to each of the above. However, the
who has assimilated the ethical principle as personal value, will h
welfare as the motive for such a commitment. A similar concern f
serve as the guiding light for all practice decisions regarding disc

Case Illustration

We began the chapter with Maria, the client in our ongoing cas
counselor, permission to talk with Ms. Armstrong about her case
uation of the dialogue, which is presented below, review Ms. Wic
or fails to reflect the principles discussed within this chapter. F
questions are presented as a stimulus to your application of yc
principles guiding confidentiality and its limitations.

MARIA: It's okay. You can talk to Ms. Armstrong as long
I am. I don't want anyone knowing what I told you. Be
you was like talking to a priest in confession . . . you kn

MS. WICKS: Thank you for the permission to speak with
certainly don't want to break your confidence or reveal
may have had, but your welfare and you well-being are
I want to do all that I can do to keep you safe.

MARIA: But you gotta promise me you ain't gonna tell he

MS. WICKS: Remember the first day we met? I know yo
didn't want to speak with me. But after a while you seem
share some of your story. Well, when we had that meeti
we spoke about would be kept private. In fact, I said I wo
without your permission.

MARIA: Yeah, I remember that . . . that's what I mean . . .

MS.WICKS: I'm glad you remember that. Maybe you also remembe while I will respect your privacy that some things just can't be] dential. I said if you are thinking about hurting yourself. . . .

MARIA: I am not going to hurt myself . . . I know you said that but it since I knew I wasn't planning on hurting myself. . . .

MS. WICKS: Again, I am glad you remember that and happier that y ing that you would like to hurt yourself. But, I also said that if yc about hurting someone else that I may have to inform that per could be protected and you would be safe, as well. Do you remer

MARIA: Yeah. . . . but I'm not sure what this has to do with anythi

MS.WICKS: Well, even though you are telling me that you have hurting yourself, I am very concerned that having unprotecte boyfriend, who has AIDS, is endangering your life. And the truth what I am supposed to do with this information. You know I w 'cause I care about you. I'm just not sure if I have to tell someo reasons.

MARIA: Legal reasons. . . . It's my life. . . .

Reflections:

1. Does Ms. Wicks give evidence of providing Maria with the limits t early within the sessions?
2. In addition to discussing with a colleague and the principal what else gest Ms. Wicks do?
3. What would you do? Does Maria's actions constitute a basis for l dence?
4. If Maria refused to refrain from engaging in unprotected sex witl should Ms. Wicks continue to work with her? Would you?

Cooperative Learning Exercise

The purpose of this chapter was not only to introduce you to concepts of co privileged communications, but also to introduce you to the many elemei decisions to maintain or breach confidentiality. Translating theory to pract an easy process.

Directions: Contact two professionals operating in one of the followir them the questions that are listed below. Discuss your findings with a league, or classmate, looking for common approaches shared across profe

a. School counselor
b. Licensed marriage and family therapist in private practice
c. A mental health counselor

d. A clinical social worker currently employed with a county agency
e. A therapist who does custody evaluations in divorce cases

Questions:

1. When meeting with a new client, do you explain the concept of cor do you also describe the limits to confidentiality or the conditions fidentiality may be breached? How do you present these issues?
2. Have you ever had your records subpoenaed? How did you respor
3. Have you ever had a situation in which you believe a duty to warn e did you do? If not, what do you think you would do?
4. If you work with minors, how do you address the issue of confi minor? With their parents?
5. In your professional role do you have privilege? If so, have you e ilege as a basis for not disclosing client information?

Summary

Confidentiality: What and When Warranted?

Confidentiality is the general standard of professional conduct that oblig not to discuss information about the client with anyone. Privileged cc legal term that describes the quality of certain specific types of relation information acquired from such relationships from being disclosed in c proceedings.

Questions about who can claim the privilege, what type of inform and what the limitations to privileges can vary extensively state to state.

Confidentiality Across the Professions

The provision of confidentiality is common throughout human service widely held as a therapeutic necessity. Most statements echo the belief pelling reasons, confidentiality must be protected. Compelling reasons fc dence include preventing serious, foreseeable, and imminent harm to identifiable person or when laws or regulations require disclosure without

Limits and Special Challenges to Confidentiality

Neither confidentiality nor privilege is an absolute. Beyond the client's privilege or disclose confidential material, the courts and the profession identified a number of conditions under which disclosure of this inf required.

Conditions Limiting Confidentiality

Professional support

Client as danger to self or others

Child abuse

Records—court ordered

Recent Legal Decisions—Confidentiality and Privileged Communicatic

The *Jaffee v. Redmond* (1996) ruling extends psychotherapist privilege to licensed professionals, clinical social workers. Many believe that this ope extension of that privilege to other mental health professionals.

In *Eisel v. Board of Education of Montgomery County* (1991), the M Appeals applied the duty to violate confidentiality to school counselors if to be at risk for self-harm.

Several subsequent court decisions have expanded and clarified the protect from dangerous clients (see *Hedlund v. Superior Court*, 1983; *Ja States*, 1983; *Lipari v. Sears, Roebuck & Co.*, 1980). *Peck v. Counseling Se County* expanded Tarasoff duty to warn in cases involving property—not p

Beyond Professional Standards: A Personal Moral Response

The ethical principle of confidentiality is founded on the fundamental respec vacy and the helper's concern for maintaining client welfare. It is essentia practitioner to embrace a value of client welfare and keep current on the profe and application of ethical principles and the laws governing practice and pra

IMPORTANT TERMS

breach
Buckley Amendment
Child Abuse Prevention and Treatment Act of 1974
client waiver
confidentiality
constitutional right to privacy
court order
duces tecum subpoena
duty to warn
foreseeable d
identifiable v
imminent dar
privilege con
protected rela
subpoena
Tarasoff

SUGGESTED READINGS

Boomer, L.W., Harthsorne, T.S. and Robertshaw, C.S. (1995). Confidentiality and hypothetical case. *Preventing School Failure, 39(3)*, 15–21.

Pope, K.S. (1990). A practitioner's guide to confidentiality and privilege: 20 legal, eth falls. *The Independent Practitioner*, 1, 40–45.

Seppa, N. (1996, August). Supreme court protects patient-therapist privilege. *APA Mo*

Tarasoff v. The Regents of the University of California, 551 P.2d 334 (Cal.Sup.Ct., 19

CHAPTER

8 Boundaries and the E Use of Power

Ms. Wicks: But Maria—I do care about you. I am worried you are placing your.
If it would be easier for you, I would be willing to let you stay with m

Certainly Ms. Wicks is a very caring and concerned counselor. Ms. Wick demonstrated a real care and concern as well as a desire to help. Howev her level of concern and her felt sense of urgency about the situation ma professional judgment. Knowing the boundaries of a professional relati able to operate within those boundaries while expressing professional ca not always an easy process. The power of the helping relationship can b and oftentimes seductive. When such power is not restricted by the boun fessional relationship, it invites misuse and abuse of the client.

Chapter Objectives

The chapter will introduce you to the concept of professional boundaries a under which boundary crossing and violation may occur. After reading should be able to do the following:

1. Describe what is meant by the concept of professional boundaries
2. Describe the difference between boundary violation and boundary
3. Explain how simple identification and transference can interfere nance of professional boundaries
4. Describe what is meant by "dual" or "multiple" relationships
5. List questions for reflection that can guide a practitioner's decisic ethics of dual relationship
6. Explain why sexual intimacy with a client is clearly a boundary vic

Setting and Maintaining Professional Boundaries

A professional relationship is a special entity. The professional relationshi does require unique dynamic and role definition. However, the intensity shared, the isolation provided, and the level of intimacy sometimes expe lenge the boundaries of a professional relationship.

Therapy by definition connects the therapist and client in a mutual jo involves compassion, caring, and empathy—which, according to Greenspa old boundaries of distrust, isolation, suspicion, and despair. Thus, therapy boundless (Coale, 1998). Under these conditions it is possible for ethical pr as the helper blends professional role and relationship with more personal ir concept of boundaries and boundary violations have received increased atte of the increasing litigation and ethic committee hearings related to violatic (Gutheil & Gabbard, 1993). Setting and maintaining professional boundar steps in preventing such personal involvement and the maintenance of an eth

Gutheil and Gabbard (1993) suggest a distinction between boundar boundary violations. In the first situation, boundary crossing, the roles hav Thus, what was once a professional helper–client relationship may now h investment partnership or friendship. The second situation of boundary v when exploitation of the client exists. It is a condition in which there is a r tioner power for personal satisfaction (Lerman & Rigby, 1994).

The position taken here and elsewhere (e.g., Strasburger, Jorgenson 1992) is that all boundary crossings (i.e. departure from commonly accep roles and practices) can become problematic and need to be avoided. Any tion in which the practitioner's needs are given primacy at the client's exp (Peterson, 1992). Whether it is something as subtle as the rearrangemen seating arrangement in order to bring the helper in closer physical proxim tive client or a pause in the conversation that may be inferred as having s decisions by practitioners that are directed to satisfy their professional neec of the client are violations of professional boundaries and need to be avoid (see Case Illustration 8.1).

CASE ILLUSTRATION 8.1
Changing Seats—Moving Closer

Allison, a 32-year-old recent divorcee has been working with Dr. Manel weeks. Their sessions have been focusing on Allison's sense of grief and establishing or reestablishing herself as a single woman.

For each of the past five sessions, Allison sat on the sofa and Dr. Mar from her in a large overstuffed chair. Allison has, in each of the previous s fears that she is not attractive and would often break down in tears when s possibility of being alone. At these times Dr. Manel would allow Allison appropriate would challenge her conclusions that she would forever be alo

Allison entered the current session more upset than she had been in the four. Allison sat and shared with Dr. Manel that she had just received divor she wanted to die. Allison began to sob and stated: "I can't stand this! He do one could ever love me. . . ." At which point, Dr. Manel moved from his chair on the couch next to Allison. As soon as he sat down, Allison flung her arm placing her head on his shoulder. Dr. Manel, wiping her tears, stated: "I think

In reviewing the case of Allison and Dr. Manel (Case Illustration 8 der whether Dr. Manel's change in seating and verbal comment were m port a client in crisis or were in response to his own interest in physical

All professional codes of ethics (see Table 8.1) attend to the issue the need to assure nonexploitation of the client through boundary cross of multiple relationships.

While much attention has been given to sexual misconduct, a poi in much detail later, there are other more subtle boundary crossing/v a practitioner needs to be sensitive. Accepting gifts from clients, participa ities or events provided by the client, engaging in investment activities sional services for goods or client service, all blur the boundaries of a pr The question that needs to be posed when entering these various types o a client is this: "Is this what a therapist does?" (Gutheil & Gappard, 19 placing the personal needs of the helper above that of the client invites Identifying whose needs are being met by the decisions and actions of t helper himself or herself, or the client, will help to identify boundary vi

TABLE 8.1 Boundaries and Mixing of Multiple Relationships

Professional Ethical Standards	Statement on Multiple Relationships
American Counseling Association (1995)	A.6.a.: Counselors are aware of their influential po to clients, and they avoid exploiting the trust and d clients. Counselors make every effort to avoid dual clients that could impair professional judgment or i harm to clients. (Examples of such relationships in limited to, familial, social, financial, business, or c with clients.) When a dual relationship cannot be a take appropriate professional precautions such as ir consultation, supervision, and documentation to en is not impaired and no exploitation occurs.
American Association of Marriage and Family Therapists (1998)	1.2: Marriage and family therapists are aware of th position with respect to clients, and they avoid exp dependency of such persons. Therapists, therefore, to avoid dual relationships with clients that could ir judgment or increase the risk of exploitation. Wher cannot be avoided, therapists take appropriate prof to ensure judgment is not impaired and no exploita
American Psychological Association (1992)	1.17.a: In many communities and situations it may reasonable for psychologists to avoid social or othe contact with persons such as patients, clients, super participants. Psychologists must always be sensitiv harmful effects of other contacts on their work and with whom they deal.

Professional Objectivity: Essential to Professional Boundaries

The effective, ethical helper places the concerns and needs of the client as t ing the client's concerns as a priority (i.e., altruism) rather than the conce (i.e., narcissism) requires the helper to distinguish his or her personal issue needs from those presented by the client. The ability to be empathic, w objective, may be difficult to maintain. However, if the helper's objectivit promised, the professional nature of the relationship may be threatened. T must be aware of the various situations that can compromise professiona know when referral to another helper, who can maintain objectivity, is inc

Professional objectivity can be compromised by a number of situa cise 8.1).

While some, such as simple identification and transference, reflec reality on the part of the helper, a more common form stems from the devel relationship with the client involving both a professional and personal ton conditions is discussed in some detail.

Simple Identification

A subtle form of loss of emotional objectivity is simple identification. Sim occurs when the helper identifies himself or her self with the client. It typic some element or characteristic of the client, or the client's experience and helper to relate to the client's experience as his or her own. Under these helper can begin to view the client as himself or herself (see Case Illustrati

EXERCISE 8.1
Threats to Emotional Objectivity

Directions: After considering each of the following, share your response wit or classmates in order to identify ways of preventing such loss of objectivit

1. Identify one person with whom you have a personal relationship and relationship could block your emotional objectivity and thus interfe an effective helper.
2. How might your own social roles (e.g., son, daughter, mother, fath girlfriend, struggling student etc.) be the source of interference and l when working with some clients or specific types of problems?
3. Identify a number of themes or issues that arouse an emotional resp themes of emotional dependency, victimization, authority and powe might prove too close to your own emotional experience for you to while working with a client presenting similar concerns.

CASE ILLUSTRATION 8.2
Mr. Peepers: A Case of Simple Identification

Mr. Peepers was an elementary school counselor. One student with whon
cern was Jamal. He felt Jamal needed his help because the other fifth
teased Jamal and pushed him and took his things." According to Mr. Pe
were always so mean to Jamal. Mr. Peepers was absolutely sure that Jam
all of this. Well, the reality was that Jamal was fine. In fact, Jamal cam
director of guidance, and asked that Mr. Peepers stop calling him down
felt it was embarrassing and he didn't understand why Mr. Peepers kep
"could protect me from the bullies in school." Apparently, while the bo
Jamal, he teased the other boys as much as they teased him—and the fi
liked Jamal and included him in their activities.

---

fails to discern the important difference between himself or herself exp
the client.

Mr. Peepers' (Case Illustration 8.2) objectivity was certainly con
pursuit of Jamal was a violation of his professional boundaries. The pro
Peepers was not "seeing" Jamal as he was, but rather seeing himself in J
Jamal looked like Mr. Peepers. He was small and somewhat frail looki
glasses and appeared nonathletic. Because Mr. Peepers "identified" with
of physical similarity, his emotional objectivity was destroyed, and he
happened to him as a fifth grader was most likely happening to Jamal.

Clearly, such loss of emotional objectivity needs to be identified
one is to be an effective, ethical helper. Exercise 8.2 provides you with
anticipate the conditions under which you may fall prey to simple ident

Transference

A more complex distortion occurs with transference. In this case, the hel
of the client to fit some aspect of his or her own life. This is a major disto

EXERCISE 8.2
Condition Eliciting Helper Identification

Directions: As noted, simple identification occurs when the helper identi
self with the client. It typically occurs when some element or characteristic
client's experience and story, causes the helper to relate to the client's exp
own. Below you will find a number of descriptors of client characterist
Place a check mark next to those characteristics or elements for which y
sonal experience or history. Next, identify how your identification with
influence your objectivity.

Element or Characteristics	Helper Experience or Characteristics	Impact on Objectivit
(Example): Client is a freshman in college. His father wants him to be an engineer and join his firm. He wants to be a music major but is afraid to upset dad. He is thinking that he could double major, recognizing that he does like engineering and may be able to use the music as a performance option.	Helper was a star athlete in high school. His father has always prepped him to play in college even though did not want to play in college. The helper still resents the fact that he went to the college his dad wanted and played football there even though he truly did not enjoy it	The helper confrontati client. The suggests th promising double maj failure of n assertivene helper keep the client t his father a say NO—i to define n
1. Client experiencing a personal loss (via divorce, or death, or break up)		
2. A client who has been teased for being overweight, underweight, an early developer, or a late developer		
3. A client who is in an unhappy relationship or work situation		
4. A client who is the one in the family to whom every one turn when there is a problem		
5. A person who is currently having sexual difficulties (impotence, premature ejaculation, low libido, limited opportunity, etc.)		
6. A person whose beliefs (religious, political, sexual) have brought a sense of isolation		
7. Identify a significant experience in your life and in the space to the left identify a type of client or client condition with which you may identify		

occurs below the conscious level of the person distorting. It often resu this case the helper, using the context of the helping relationship and p to express feelings, beliefs, or desires that the helper has buried in his and rightfully should address to some other significant person in his or to be sensitive to the possibility of transference is essential to effective

While the loss of objectivity as a result of distorting the client's r with simple identification and transference may be infrequent, all helpe ing emotional objectivity if engaged in direct personal involvement w sibility of engaging with the client in a relationship outside of the bour a topic that has received a lot of attention within the professional liter such dual relationships with clients has and continues to be debated. whichever side of the debate one finds himself or herself on, dual rela as a condition in which one's professional objectivity can be comprom

Dual Relationships: Crossing and/or Mixing Boundaries

A dual relationship is one in which the helper has two (or more) overla client. Table 8.2 highlights a number of professional and nonprofessio which boundary complication may exist. The table is an adaptation of sented by Evans and Hearn (1997).

Loss of professional objectivity and boundary violations are pos fessional is engaged in multiple relationships with his or her client. Th the professional helper is also engaged in personal friendships, famil tionships or shares social activities with their clients (see Case Illustrat

TABLE 8.2 A Matrix of Dual Relationships

Additional Relationships	Primary Professional Relationship		
	Therapist/Counselor	*Instructor*	*Supervisor*
Counselor	———	dual	dual
Instructor	dual	———	potential
Supervisor	dual	potential	———
Researcher	potential	dual	dual
Social/Personal	dual	dual	dual
Sexual	dual	dual	dual
Political	dual	dual	dual
Financial/business	dual	dual	dual

Taken from Evans, D.R. & Hearn, M.T. (1997). Sexual and Non-Sexual Dual Relationships Managing t Evans (ed.), *The Law Standards of Practice, and Ethics in the Practice of Psychology* (pp. 53–84). Toro Montogmery Publications, Ltd. Reprinted with permission.

CASE ILLUSTRATION 8.3
Tom and Elaine: Direct Personal Involvement

Tom is a Master's level counselor working in a college career center. Elain help her with a decision about joining the Peace Corps. Elaine, who is also T explained that she really is unsure if she should move away from their hom four years in the peace corps or to stay at home and continue in graduate sch

Tom suggested that Elaine employ an actuarial technique in which she all of the costs and benefits to be accrued to both Elaine AND the significant p if she stays or goes into the Peace Corps. This was a technique Tom had found other clients. Typically, he would provide an initial example and then ask the cl the process on their own as a "homework." He would then review their matrix sion. With Elaine, however, Tom suggested that they do it together. He felt th identify the possible benefits and costs to both Elaine AND certainly to the o

---

While Tom (Case Illustration 8.3) may truly want to assist Elaine in m decision (for her), he may have difficulty keeping his own strong desire to to him and at home out of the equation. Thus, his suggestions may be aimed ing his needs for a personal relationship than at Elaine's need to make the b choice. Under this situation the dual nature of their relationship (i.e., love re helping relationship) is contaminating the helping process.

It appears that while all professional codes of conduct warn about tl relationships (see Table 8.3), not all within the profession are as clear-cut ab dual relationships or about the sanctions that should be applied.

Those who see dual relationships (sexual and/or nonsexual) as pro Pope & Vasquez, 1991), point to the fact that dual relationships

1. Impair the helper's judgment
2. May present conflict of interests
3. Hold a danger of exploitation of the client, since the helper holds a position
4. Can blur the professional nature of the therapeutic relationship

From this perspective, practitioners are cautioned against engaging multiple relationships with a client. Some sources have even suggested th engaging in dual roles of any kind should be severely sanctioned. In fact, du are the major cause for disciplinary hearings, ethics complaint and financial practice suits against practitioners (Bader, 1994).

However, not all agree with this prohibitive stance. Others suggest tha often unavoidable and, with the exception of sexual or other exploitive rela roles can be a useful resource to the helping process (Biaggio & Greene, 1993; Tomm, 1991). For example, counselor educators may serve not onl but may also act as therapeutic agents for their students' personal develop

TABLE 8.3 Codes Restricting Nonsexual Dual Relationships

Professional Ethical Standards	Statement Regarding Dual Relationship
American Psychological Association (1995)	1.17.a: A psychologist refrains from entering into or prom personal, scientific, professional, financial, or other relatic persons if it appears likely that such a relationship reasona psychologist's objectivity or otherwise interfere with the p effectively performing his or her functions as a psychologi exploit the other party.
National Association of Social Workers (1996)	1.06 Conflicts of Interest (c) Social workers should not engage in dual or multiple r clients or former clients in which there is a risk of exploita harm to the client. In instances when dual or multiple relat unavoidable, social workers should take steps to protect cl responsible for setting clear, appropriate, and culturally se (Dual or multiple relationships occur when social workers more than one relationship, whether professional, social, o multiple relationships can occur simultaneously or consec
American Counseling Association (1995)	A.6.a. Counselors make every effort to avoid dual relation that could impair professional judgment or increase the ris (Examples of such relationships include, but are not limite financial, business, or close personal relationships with cli
American Association of Marriage and Family Therapists (1998)	1.2: Therapists, therefore, make every effort to avoid dual clients that could impair professional judgment or increase exploitation.

al.,1988). As suggested by this example, role blending or dual roles ma within certain contexts such as counselor training and, while possibly dilemmas involving loss of objectivity or conflict of interest, need n unethical (Herlihy & Corey, 1997).

St. Germaine (1993) suggests that while errors in judgment can tionships, that need not be the case. Further, Tomm (1991) argues that that addresses dual relationships may actually create a situation in which maintains interpersonal distance, thus promoting objectification of the r promotion of a vertical hierarchy in the relationship. While caution is adv there is no one directive to which practitioners can turn for guidance in tionships. Exercise 8.3 is provided to assist you in gaining the perspectiv fessional community in regards to the ethics of dual relationships.

The position taken here is that it is not the existence of duality that the possibility that such duality will invite exploitation of the client. A should arouse concern and vigilance on the part of the ethical helper in c exploitation does not occur. Gottlieb (1993) suggests that a practitioner a

EXERCISE 8.3
The Ethics of Dual Relationships

Directions: Using the questions listed below, assess the perception of the your area in regards to the ethics of dual relationships. If possible contact from each of the following professions and share your findings with a collea The professions include school counselor, marriage counselor, clinical social psychologis and psychiatrist.

Questions:

1. Have you ever had a professional helping relationship with a frien close professional associate?
2. What are you feelings about the ethics or ethical challenges confronti helper when working with a friend, relative, or colleague?
3. Would you ever engage in a business venture or investment with an a
4. What are your feelings about professional helpers who engage in sexu a client while still in a helping relationship with that client?
5. What would you do if you were aware that a professional helper, in engaged in a sexual relationship with a client?
6. What length of time, if any, needs to pass between the end of a helping the freedom to date and become emotionally and physically intimate client?

benefits and problems of a dual relationship in light of (1) the power diffe the practitioner and the client; (2) the duration of the professional relations clarity of termination in the therapy. With these as guidelines, any long-t relationship would mitigate a dual relationship whereas a short-term, clearly terminated evaluation such as what might occur in a job interview process, able (Coale, 1998).

St. Germaine (1993) suggests the following as guidelines for reduci risk involved in dual relationships:

1. Set healthy boundaries from the outset of the relationship.
2. Fully inform clients about any potential risks
3. Discuss with clients any potentially problematic relationship and concern.
4. Consult with other professionals periodically if you are engaged in ship.
5. Work under supervision in cases where the potential for harm is hig
6. Document discussions about any dual relationships and relevant ste
7. If necessary, refer the client to another professional.

TABLE 8.4 Factors to Consider When Making Decisions About Dual R

Is it a legal or ethical issue?
Are there changes in the vulnerabilities of the client or another party?
What differences in power are there?
What are the risks for the practitioner?
What are the risks for the client?
What are the benefits for the practitioner?
What are the benefits for the client?
What is the impact on professional boundaries?
What is the potential effect on the goal(s) of the professional relationship?
Are alternative resources or solutions available?
What is your decision?

Adapted from Evans & Hearn's (1997) presentation of the work of Valentich & Gripton (permission.)

Another model for guiding a practitioner in terms of the ethics of has been offered by Evans and Hearn (1997). These authors adapted t presented by Valentich and Gripton (1992). Table 8.4 presents the s offered by Evans and Hearn (1997) as a guide to decision making rega ateness of dual relationships. The table moves the practitioner through tions and considerations that should help him or her to decide on the ap the relationship. Moving from the first question, "Is it a legal or ethical is sideration of power differential and the identification of the potential ri both the client and practitioner, the practitioner is guided to make a dec multiple relationships. These authors further suggest that the practitione the table and place the completed form in the client's file as evidence (went into the decision.

Sexual Intimacy: A Clear Violation of Professional Boundaries

The depth of intimacy and the conditions surrounding the interaction relationship may stimulate feelings of attraction between the helper and acting on this attraction is a serious ethical violation. Sexual relationsh unethical in the helping setting/context. All professional organizations a prohibition of sexual intimacy between a helper and a client (see Table

The inappropriateness of sexual relationship between helper and fact that the helping relationship is unbalanced in power and dependenc reciprocal nature characteristics of a healthy intimate relationship is n sexual contact becomes part of a therapeutic relationship, the expectat fundamental to the process of therapy is violated (Thoreson, Shaughı Cook, 1993).

TABLE 8.5 Intimate Relationships with Clients

Professional Ethical Standards	Statement on Intimate Relationships
American Counseling Association (1995)	A.7.a. Current clients. Counselors do not have any type intimacies with clients and do not counsel persons with have had a sexual relationship.
American Psychological Association (1995)	1.19 Exploitative Relationships. (a) Psychologists do not exploit persons over whom th supervisory, evaluative, or other authority such as stud supervises, employees, research participants, and clien patients.(See also Standards 4.05-4.07 regarding sexua with clients or patients.) (b) Psychologists do not engage in sexual relationships or supervises in training over whom the psychologist h direct authority, because such relationships are so likel judgment or be exploitative. 4.05 Sexual Intimacies With Current Patients or Client Psychologists do not engage in sexual intimacies with or clients. 4.06 Therapy With Former Sexual Partners. Psychologists do not accept as therapy or clients, persc they have engaged in sexual intimacies.
American Association of Marriage and Family Therapists (1998)	1.2: Sexual intimacy with clients is prohibited. Sexual former clients for two years following the termination prohibited.
National Association of Social Workers (1996)	1.09.a: Social workers should, under no circumstances sexual activities or sexual contact with current clients, contact is consensual or forced.

In addition to barring intimate sexual contact within a helping context behavior also speak to the restriction of sexual behavior between a helper the helping relationship has ended. Some—for example, the APA (1992)—period of two years pass before a personal relationship may be entered; othe Gutheil, 1989) suggest that the helping relationship never ends and therefo macies are never appropriate.

Recent Legal Decisions

Arguments for the unethical nature of dual relationships usually highlight helping relationship is one in which there is a power imbalance and one in v

may be extremely vulnerable (DeLozier, 1994; *Norberg v. Wynrib*, 1 nature of dual relationships reflects the courts' view that the helping physician–patient, psychiatrist–patient, and social worker–client) are c (Kutchins, 1991; *McInerney v. MacDonald*, 1992; Simon, 1992a), fidu the professional has a duty to act to the benefit of the other individual in to an undertaking between them (Black, 1991). Since a fiduciary re defined as occurring when an individual places his or her trust in a potential to influence his or her actions (Black, 1991), it could be reasoi professional helping relationships have this fiduciary potential. The co not made de facto rulings to the fiduciary nature of each professional r rulings have suggested that it is the specific nature of each relationship existence of a fiduciary responsibility (*Hodgkinson v. Simms*, 1994; 1992; *McInerney v. MacDonald*, 1992).

If the fiduciary obligation exists, it could be argued that the prac

1. To act with good faith and loyalty toward a client (*McInerney v.*
2. To not abuse the power imbalance by exploiting the client (*Norbe*
3. Act in the best interest of the client (*Hodgkinson v. Simms*, 1994 1992)

Given the conditions of a fiduciary relationship, it is clear that between a helper and a client is in violation of these conditions. In fac Minnesota, California) have enacted statutes that make the therapist–cli a criminal offense. Further, in these states, the power differential and j ity of the client to influence makes consent by the client viewed as no

Beyond Professional Standards: A Personal Moral Response

Sexual misconducts, while being one of the most serious ethical violat patrick, 1995), continue to occur (Olarte, 1997). Thus, while ethical sta that address professional boundaries and ethical use of power, enactmer within the client–helper relationship is less than perfect.

It is clear that more than simply having an awareness of the ethic is needed. Practitioners need to embrace this standard as a personal mora each of the ethical principles, respect and valuing of the client and clier as the preventive base for most ethical abuses. Keeping client needs as tionship can prove invaluable for maintaining appropriate boundaries within the helping relationship.

In addition to understanding codes of ethics governing the creatic of professional boundaries, the ethical practitioner needs to continually own personal needs and to monitor how these may impact the nature o tionships. For example, in addressing sexual misconduct, Stake and Ol mended a multifaceted approach highlighting the importance of sensi

therapists to their own sexuality and the power of the helping relationsl Gutheil, 1989; Holub & Lee, 1990) emphasize the importance of trainin ethical-legal issues surrounding sexual involvement, but also engagem (including personal therapy) aimed at promoting helpers' self-awareness uality, sexual needs, and values.

The need to be aware of self and relationships is essential in order to tain appropriate professional boundaries. Ethical practitioners will be aw sions to depart from what is typical and be able to explain the therapeutic departures. The question that needs to be answered, especially at times o typical or model procedures is "Whose need is being served?"

It is this type of self-questioning, if assimilated into the practitioner' clients, that will help move issues of boundaries and power from ethical gu sonal, moral response.

Case Illustration

At the beginning of the chapter we see Ms. Wicks expressing her concer question one needs to ask is "Is this level of concern and type of behavio boundaries of a professional counseling relationship?"

As you read the continuation of the dialogue continually, ask yoursel are being met?" Further, after reading the presentation, use the reflections ceptualize how you would respond in a situation such as this.

MS. WICKS: But Maria—I do care about you. I am worried you are in harm's way. If it would be easier for you—I would be willin with me for a while.

MARIA: Stay with you?

MS. WICKS: Well, I mean sometimes it is easier to get away from a when you can get out of the area.

MARIA: I don't need to get away from Carlos, I love him.

MS. WICKS: Sometimes, Maria, we romanticize our relationships a is love. It is just our way of justifying having sex with someb almost ruined my life by quitting school and running away wit sweetheart just because I lost my virginity to him. It's real easy t someone when it is only lust.

MARIA: Well—I'm not sure what you are talking about. I love Car me. I don't need to run away from him.

MS. WICKS: I know it seems like love, but trust me, Maria, if you and get away for just a little while, you would see it differently.

MARIA: Ms. Wicks . . . I like you, but . . . you are wrong here. Any we get talking about this? I thought we were talking about you te strong about me having sex or something?

Reflections

1. What is your feeling about Ms. Wicks' invitation to come and
while? Why?
2. Do you feel it is appropriate for Ms. Wicks to share her own hi
romance? Why? Why not?
3. Is Ms. Wicks exhibiting the effects of simple identification or sir
her real personal understanding of Maria's situation?

Cooperative Learning Exercise

As suggested within this chapter, while the need to create and maintain p
aries is essential to an ethical helping relationship, boundary violatio
boundaries are crossed and inappropriate helper behavior is manifeste
helper's loss of emotional objectivity.

Part I: Review each of the following scenarios and along with a class
identify where the loss of emotional objectivity may exist and how b
may be manifested.

Helper 1: A marriage counselor currently going through her
divorce

Helper 2: A young attractive school counselor working with senic
ors students

Helper 3: A drug and alcohol counselor who himself has been an
recently returned to drinking

Part II: Interview three professional helpers, inquiring:

1. During your professional career have you experienced any maj
death of a loved one, loss of a job, divorce?)
2. (For those who have experienced such life crises) During that time
to your professional work did you make, if any?
3. (For those who have not experienced such a crises) If you had e
these life crises, would you adjust your approach to your professio
time of the crisis. If so, how and why? If not, why not?

Share your findings with a colleague and discuss the implications
light of the content of this chapter.

Summary

Setting and Maintaining Professional Boundaries

All professional codes of ethics attend to the issue of boundaries and the
exploitation of the client through boundary crossing and the mixing of mul

All boundary crossings (i.e., departure from commonly accepted pr and practices) can become problematic and need to be avoided. Any bounc which the practitioner's needs are given primacy at the client's expense is

Professional Objectivity: Essential to Professional Boundaries

The effective, ethical helper places the concerns and needs of the client as tc ing the client's concerns as a priority (i.e., altruism) rather than the concer (i.e., narcissism) requires the helper to distinguish his or her personal issue needs from those presented by the client.

Professional objectivity can be compromised by a number of situatio such as simple identification and transferences, reflect a distortion of reali the helper, a more common form stems from the development of a dual r the client, involving both a professional and personal tone.

Dual Relationships: Crossing and/or Mixing Boundaries

A dual relationship is one in which the helper has two (or more) overlappin client. While all professional codes of conduct warn about the risk of dual r all within the profession are as clear-cut about the evils of dual relationsh sanctions that should be applied.

It is not the existence of duality that is the problem, but the possibilit ity will invite exploitation of the client. As such, each case should arouse c ilance on the part of the ethical helper in order to ensure that exploitation

Sexual Intimacy: A Clear Violation of Professional Boundaries

Sexual relationships of any kind are unethical in the helping setting/cont sional organizations are very clear about prohibition of sexual intimacy b and a client.

The inappropriateness of a sexual relationship between helper and cl fact that the helping relationship is unbalanced in power and dependency i the reciprocal nature of a healthy intimate relationship is not possible. Whe becomes part of a therapeutic relationship, the expectation of trust that is fur process of therapy is violated.

Recent Legal Decisions

The unethical nature of dual relationships reflects the courts' view that t tionships (i.e., physician–patient, psychiatrist–patient, and social worker fiduciary nature (Kutchins, 1991; *McInerney v. MacDonald*, 1992; Simo ciary meaning that the professional has a duty to act to the benefit of the ot any matters related to an undertaking between them.

If the fiduciary obligation exists, it could be argued that the practitio

1. To act with good faith and loyalty toward a client (*McInerney v. Ma*
2. To not abuse the power imbalance by exploiting the client (*Norberg v*
3. Act in the best interest of the client (*Hodgkinson v. Simms*, 1994; *M* 1992)

The courts, however, have not made de facto rulings to the fiduci professional relationship. Rather, rulings have suggested that it is the spe relationship that determines the existence of a fiduciary responsibilit *Simms*, 1994; *M.(K.) v.M. (H.)*, 1992; *McInerney v. MacDonald*, 1992).

Beyond Professional Standards: A Personal Moral Response

Keeping client needs as primary in the relationship can prove invaluab appropriate boundaries and use of power within the helping relationship

The need to be aware of self and relationships is essential in order t tain appropriate professional boundaries. Ethical practitioners will be a sions to depart from what is typical and be able to explain the therapeuti departure. The question that needs to be answered, especially at times typical or model procedures is "Whose need is being served?"

IMPORTANT TERMS

altruism
boundaries
boundary crossing
boundary violations
dual relationships
exploitation
fiduciary obligation
fiduciary relationship
multiple rela
narcissism
professional
professional
sexual intim
simple ident
transference

SUGGESTED READINGS

Coale, H.W. (1998). *The vulnerable therapist*. New York: The Haworth Press.

Kottler, J.A., Sexton, T.L., & Whiston, S.C. (1994). *The heart of healing: Relations* Francisco: Jossey Bass.

Noel, B.W., & Watterson, K. (1992). *You must be dreaming*. New York: Poseidon.

Pope, K.S., Sonne, J.L., & Holroyd, J. (1993). *Sexual feelings in psychotherapy*. Wash can Psychological Association.

PART FOUR

The Process of Helping

CHAPTER

9 Efficacy of Treatment

Michelle: Hi, Lynn. Do you have a minute?

Lynn: Sure, Michelle. What's up?

Michelle: I've been working with this girl, Maria, and we have a real good work but I just don't feel like I have a true grasp of what is going on or that ing this situation the best way. I explained this to Maria, and she has g permission to speak with you about the case. I know you are really bu hoping that you could provide some supervision around this case to se I'm on the right track and using the best approach.

While our counselor, Ms. Wicks (Michelle), is certainly skilled and trai ally, her real interest and concern for her client and her own self-awareness her expertise have led her to seek consultation from a colleague. Approachi the essential training and experience is an ethical must. However, beyond t ing, ongoing professional development, consultation, and supervision are t the ethical professional.

The ethical responsibility to be competent extends beyond the basic a helper and includes the helper's ability to employ treatment strategies that It is these issues of treatment efficacy and helper competency that serve as t current chapter.

Chapter Objectives

The chapter will review the ethics and legality surrounding the issue of cor and efficacy of treatment. The value of professional training, action researc elements of competent practice will be highlighted.

After reading this chapter you should be able to understand the follo

1. Describe what is meant by the term competence
2. Discuss the role of continuing education, ongoing supervision, and co ongoing development of professional competence
3. Describe the value of approaching practice from a reflective, action tation
4. Discuss the conditions under which referral would appear to be the r treatment decision

5. Describe legal considerations and concerns in relation to the issue tence, standard of care, and treatment efficacy

Practicing Within the Realm of Competence

The ethical professional is called upon to accept responsibilities and e basis of competence and professional qualification. Table 9.1 provides th a select group of professional associations on the issue of professional petency. What should be evident by reviewing Table 9.1 is that each of t supports the notion that one should not engage in practices that require s possessed. To be ethical, as a helper, requires that competency be dev tained and that the helper's competence level be represented accurately t ers, and the general public.

Competence

Being competent means that the helper has the knowledge, skills, and perform those tasks relevant to that profession. To suggest one is compete individual is capable of performing a minimum quality of service that i of his or her training, experience, and practice, as defined in professiona ulatory statues.

Competence is defined in relative terms; that is, rather than havin tive standard against which to judge a professional's level of performanc incompetent, competence is most often defined using the conduct of oth fession as the comparative standard. Often the "reasonable man" standard uate the competence of the professional's behavior. This reasonable ma the question, "What would a reasonable person do in a similar situation'

Professional Development: Knowing the State of the Profession

Competence can be developed from formal training as might be found in or training for certification and licensure. Further, one's own ongoing con professional reflective practice, and supervision may serve as additic developing and maintaining competence.

Formal Training

Formal training occurs both at the undergraduate and graduate levels of s of general knowledge of helping theory and skills along with research su tion strategies may be acquired through undergraduate and graduate cours in addition to these cognates, the competent practitioner must have guid application of this knowledge. In many disciplines (e.g., psychology) th

TABLE 9.1 Ethical Codes Addressing Helper Competence

Professional Organization	Ethical Principle/Standards
American Counseling Association (1995)	C.2.a: Boundaries of Competence. Counselors practice onl boundaries of their competence based on their education, t supervised experience, state and national professional cred appropriate professional experience. Counselors will demc commitment to gain knowledge, personal awareness, sensi pertinent to working with a diverse client population.
American Psychological Association (1995)	Principle A: Competence Psychologists strive to maintain high standards of compete work. They recognize the boundaries of their particular co the limitations of their expertise. They provide only those only those techniques for which they are qualified by educ or experience. Psychologists are cognizant of the fact that required in serving, teaching, and/or studying groups of pe the distinctive characteristics of those groups. In those area recognized professional standards do not yet exist, psychol careful judgment and take appropriate precautions to prote those with whom they work.
American Association of Marriage and Family Therapists (1998)	3.6: Family therapists do not diagnose, treat, or advise on p the recognized boundaries of their competence.
National Association of Social Workers (1996)	O-1: Social workers should base their practice "upon recog knowledge relevant to social work" and they should "critic and keep current with, emerging knowledge relevant to soc (NASW O-1). Ethical Principle: Social workers continually strive to incre professional knowledge and skills and to apply them in pra workers should aspire to contribute to the knowledge base profession. 1.04 Competence (a) Social workers should provide services and represent th competent only within the boundaries of their education, tr certification, consultation received, supervised experience, relevant professional experience. (b) Social workers should provide services in substantive a intervention techniques or approaches that are new to them engaging in appropriate study, training, consultation, and s people who are competent in those interventions or technic

with supervised field and intern experiences are considered essential pendent practice.

For most of the helping professions, professional organizations a licensing bodies have identified both aspirational levels and mandatory a way of defining competence. Each of these levels of governance moni and application of professional practice. Colleges and universities ofte training that have been shaped by the professional standards under th sional accrediting organizations. Professional accrediting bodies (e.g., logical Association, Council for the Accreditation of Counseling and I Programs (CACREP)) qualify educational programs as meeting stan demanded for colleges or universities to offer degrees and certify that tl high professional standards, thus establishing the foundation for ethic these school-based programs, professional organizations (e.g., Americ ing Association, American Rehabilitation Counseling Association, Ac Social Workers) often develop aspirational codes of ethics, which wl internal mandatory enforcement mechanism, call their members to pe level of professional practice.

Beyond the professional organization level, the professional regu state and national level promulgate and enforce standards of practice lishment of certification and licensure standards. Often these requirer demanded for entrance into the profession, requiring additional post de supervision. The definition of minimum professional training for entry l as the mandate to remain up-to-date on the state of the profession throu cation varies from state to state. It is essential for the ethical helper to about the these standards (see Exercise 9.1).

Being an ethical, competent practitioner requires not only a b training, but also the maintenance and development of this knowledge continuous professional growth. The ethical helper continually strives

EXERCISE 9.1
Licensing and Certification Requirements

Directions: Since the requirements defining minimum requirements for vary from profession to profession and in many instances from state to s you to be aware of the specific requirements for entrance into your partic

Step 1: Identify two arenas for professional practice (e.g., school cour marriage counselor, clinical social worker, etc.).
Step 2: Identify two states, one in which you intend to practice and a ne
Step 3: Contact each state's department or bureau of professional license these can be found by simply calling the main number of your st
Step 4: Complete the following grid.

	Profession—Area of Practice		Profession—Ar
State	*Home State*	*Neighboring State*	*Home State*
Minimum Education (Bachelor's, Master's, Master's+, Doctorate)			
Supervised Experience (internship, practice, etc.)			
Post Degree Requirements (course work, field experience etc.)			
Other requirements			

petence. The ethical helper strives to increase his or her competence by develop his or her skills and understanding of the helping process.

Continuing Education

All the codes of conduct call for practitioners to be current with emerging kı vant to their profession (see Table 9.2). It is incumbent upon the ethical upgrade knowledge and skill by participating in continuing education experi uing education may be in the form of additional course work at the loca courses taught through qualified associations and organizations.

While the call for ongoing education and professional developmer specifics are still lacking. Does this suggest a certain number of courses? Cre supervision? Many organizations and state licensing and certifying bodies number of continuing education hours be completed within a number of ye ple, the American Association for Marriage and Family Therapists (AAMF members to complete 150 hours of continuing education every three years

TABLE 9.2 Maintaining Professional Development

Professional Ethical Standards	Statement on Professional Development
American Association for Marriage and Family Therapy (1998)	3.4: Family therapists remain "abreast of new dev
American Counseling Association (1995)	C.2.f.: Counselors recognize the need for continu maintain a reasonable level of awareness of curre professional information in their fields of activity maintain competence in the skills they use, are op procedures, and keep current with the diverse and populations with whom they work.
American Psychological Association (1995)	General Principle A (Competence) that psycholo knowledge of relevant scientific and professional to the services they render and they recognize the education."
National Association of Social Workers (1996)	4.01.b: Social workers, should strive to become a in professional practice and the performance of pr functions. Social workers should critically examir with, emerging knowledge relevant to social worl should routinely review professional literature an continuing education relevant to social work prac ethics.

Board of Licensing for Psychologists in Pennsylvania requires psychc 30 hours of approved continuing education every two years in order renew their licenses. However, the specific requirements vary across prc riage counselor, school psychologists, clinical social worker) and fron important for each practitioner to be aware of the standards set by his sional organization or those required for relicensing or recertification wi they intend to practice.

Supervision and Consultation

Practicing within the realm of competence starts with a practitioner o scope of practice. Practitioners are ethically bound to restrict their profe the profession and specialties for which they have been trained and required, they must possess the appropriate certification and licensure. P realm of competence also means knowing when it is essential to con another professional who has more experience and training with this client and or problem.

The use of peer consultation, in which specific concerns can be sh perienced colleague, is a valuable means for maintaining competence. For Tabachnick, and Keith-Spiegel reported in 1987 that psychologists rat changes among colleagues as the most effective resource for promotin ethical practice.

Peer consultation can provide mutual support for problematic cases. consulting with colleagues regarding a client, the ethical practitioner neec need for his or her own continued support with the client's right to maint ity. The American Psychological Association's ethical standards, for exan

> When consulting with colleagues, (1) psychologists do not share confide that reasonably could lead to the identification of a patient or client with v confidential relationship unless they have obtained the prior consent of th nization or the disclosure cannot be avoided, and (2) they share inform extent necessary to achieve the purposes of consultation. (1992, 5.06)

Even with this sensitivity to the requirements of confidentiality, the e employ a peer consult to formulate the problem, review the decisions mad ferent point of view on the process. Often a colleague with more experie some clarity about the helping process and may even assist the practiti additional insights or adjustments in the treatment process.

Consulting with a professional peer not only provides the helper a v for expanding his or her knowledge and skill, but can also serve as a valu balance for the helper when the boundaries of competence may be exceed cially true when the helper's own objectivity may be blurred (see Chapter conditions the peer consultation can provide a mechanism for examining professional issues involved in any one particular case (Lewis, Greenburg,

For those working within certain clinical settings, formal peer revie porated as a way of maintaining professional competence and standards of serving in an independent practice, it would be valuable to develop a netwo who can continue to serve as peer consultants.

The Standard of Care: Appropriate Treatment

Most malpractice cases turn on the question of negligence (Bennett et al gence implies that the practitioner failed to meet the relevant standard of to Bennett and colleagues (1990), the question of negligence will be det debate over the clinical correctness and efficacy of the treatment that was gi the practitioner's judgment in choosing it (p. 33).

While there is no single prescribed way to conduct "helping," ethical g lish some standards of care that must be followed. For example, sexual clients are prohibited. Further, innovative therapy involving physical contact be the basis for malpractice suites, particularly when the contact is extren

choking). While these are extreme examples that most mental health encounter, failure to properly administer and interpret tests and invento to take appropriate steps in the face of homicide and suicide, and failur priate methods and forms of treatment may be areas in which helpers ar short of recognized standards of care, failing to provide appropriate tre

Defining an Appropriate Treatment

Standards of practice have not specifically been identified. There are nc tives for what must be done under each condition of helping. The stanc definition of appropriate treatment are typically determined by comparir performance with that of other professionals in the same community wit ing and experience.

There is an evolving sense of what should prevail, and it is the star sonable and prudent practitioner may do in situations like this that sets t (see Exercise 9.2)

EXERCISE 9.2
Standard of Care: A Reasonable, Prudent Response

Directions: Below you will find two clinical scenarios. Read each sit mental health provider in your local community and ask him or her what situation.

Situation 1: You are treating an individual diagnosed with AIDS. informed you that he is in and has been in a long-term relationship. informed you of the name of his partner, with whom he lives. In your mos client informs you that not only is he engaging in unprotective sex with has not informed his lover that he has AIDS. What do you do? Do you i

Situation 2: You have been seeing a couple for marriage counseling. Yo for your records on the case from one partner's lawyer. What do you do the subpoena? How?

Reflections:

1. Did the two practitioners essentially agree on the steps to be taker
2. Did their responses seem to be in line with what you have read a duty to warn, informed consent, etc.?
3. Share your findings with a classmate/colleague who may have exercise. Does these seem to be consistency in practitioner respons as a definition of standard of care?

Share your findings with your classmates or colleagues.

Employing Effective Treatments

But beyond a generic standard of what a reasonable and prudent practitioner
tion has been drawn to the importance of employing tried and true technique
of intervention. A number of professionals have called for use of effectiv
have consumer groups. Klerman (1990), for example, noted: "The psy
responsibility to use effective treatment. The patient has a right to the pr
Proper treatment involves those treatments for which there is substantial evid
Further, the International Association for the Right to Effective Treatment (
cational and advocacy group, was established to ensure that all clients " b
progressive, effective interventions available" (p. 3). Finally, a number of st
duced bills that would require each psychological treatment procedure
standards of scientific validity before it can be offered to a client (Cavalier
the ethical helper needs to be aware of the current research on treatment eff
employ these strategies when and where appropriate.

Defining Efficacious

Providing the most effective treatment available requires professionals to k
the research on treatment effectiveness for their particular client population
In line with this need to identify and employ effective treatment strategies,
on Promotion and Dissemination of Psychological Procedures (1995) from
clinical psychology within the American Psychological Association, has dev
for determining whether a treatment should be considered empirically valid.
also established a list of interventions that have been "well established" an
"probably efficacious," citing the literature that supports this claim. Others
ated interventions that possess substantial amounts of empirical evidence and
efficacy (e.g., Ammerman, Last, & Hersen, 1993; Fischer, 1993; Gorey, 199
Sheldon, & Gillespie, 1992; Thyer, 1996). These include interpersonal ther
sion, exposure treatment of agoraphobia and social phobia, stress inoculati
stress reduction, behavior therapy for female orgasmic dysfunction and ma
function, to name a few (Chambless, Sanderson, Shoham, Johnson, Pope, e

As the professions and the research identify specific strategies with
effectiveness, these interventions become the standard of care. As such, it
the ethical practitioner to not only be aware of this research and these tec
develop the competency required for the ethical application of these strateg
of this, the Task Force on Psychological Interventions developed, in additi
effective interventions, references for training manuals that describe the trea
and additional training resources when they were available (see Sanderson &
pp. 8–11). This task force will update this list annually.

Managed Care: Compounding the Standard of Care Issue

The issue of treatment efficacy is of special consideration when a practition
with a managed care situation. With managed care pushing for brief, more

forms of treatment, the ethical practitioner must be able to identify for w
are appropriate and which form of service is required. Discerning for v
is appropriate and advocating for those clients for whom such an ap
appropriate becomes an essential role of the ethical, competent practitior
a managed care environment. Further, competence to perform short-te
ment, when appropriate, requires that the practitioner be prepared an
achievable, specific treatment goals and to be active and more directiv
treatment. Short-term models are not simply long-term therapy models
Utilization of these short-term models requires the ethical practitione
understanding and skills. Thus, the ethical practitioner will not only kn
treatment is appropriate but will also have been trained in this approacl

Employing an Action Research Approach to Practice

In areas for which there is not solid research to direct best practice or in
of the profession is not clearly articulated (e.g., when individual counse
groups), service needs to be predicated on theoretical and technical idea
substantial portion of the profession (Woody, 1997). Thus, knowing th
els, theories, and schools of thought is as essential as having the ability
ity and reliability of a particular strategy for one's own practice. In speak
for example, Chambless and colleagues (1996) noted: "Psychology is a
help those in need, clinical psychology draws its strength and uniquene
scientific validation. Whatever interventions that mysticism, authorit
politics, custom, convenience, or carelessness might dictate, clinical psy
what works. They bear a fundamental ethical responsibility to use, wh
ventions that work *and to subject any intervention they use to scienti*
emphasis added). This last point suggests subjecting any interventi
scrutiny is a directive to all ethical practitioners and not just those intere
large empirical research. The ethical helper will approach his or her pra
professional, integrating research and practice.

In order to be effective in their practice, human service provid
method and findings of research with the realities of their professional
tioner–researchers, they will need not only to interact in the moment
inquire, and critique their own interactions. Further, for their observatior
ingful data and useful guidance, they must be systematic and valic
methodology provides practitioners with the means of acquiring these va
results in the development of effective strategies of professional practic

Action Research Defined

Action research has been broadly defined (e.g., Peters & Robinson, 198
described by Banister, Burman, Parker, Taylor, and Tindall (1994), acti

ply "a way of trying out changes and seeing what happens (p. 108). As action research is applied research in which the researcher–investigator i tioner (e.g., a counselor, teacher, social worker) attempting to use researc ogy for identifying the "what" they do and for making decisions on doing research provides practitioners with the method for viewing their profes systematically and deciding on them rationally. It is the opportunity to b practice, becoming true practitioners–researchers.

Action Research: An Ethical Consideration

Viewed as a frame of mind, action research calls us to a continued intere constituencies better and providing increased accountability for our service research is not simply a good idea, rather it becomes an ethical responsibi ing the effectiveness of our practice and increasing the competency of our professional can guarantee success in each and every encounter or situatio ical practitioners need to assess the degree to which their practices are both tive. Action research provides a mechanism for monitoring the efficacy practice decisions and methods.

Table 9.3 provides a brief review of one model of action research tha to the mental health professional. While presented as a linear set of step practice it is a recurring, recycling process that continually takes and giv and to practice.

TABLE 9.3 Steps in the Action Research Process

Step	Description
1. Identification of the research question	Three types of questions seem to emerge. First, what are our pra Second, what specifically about our practice is effective? And fi we do to enhance our effectiveness as practitioners?
2. Problem relevance, problem significance	The goal is to be able to answer questions such as "Why study it expect will happen as a result of this investigation?" "How is th study significant to my practice?"
3. Definitions	The practitioner–action researcher needs to begin to more concr define the concepts, the constructs, the variables involved. Whe possible the action research needs to define these by their action performed (i.e. operational definitions).
4. Review of related literature	Reviewing the professional literature for evidence of similar inv prove a valuable step to intervention planning.
5. Developing hypotheses	With action research, it should be remembered that these are tru hypotheses." As data is collected and decisions are made, the hy reshaped. In fact true, to the qualitative nature of the action rese hypotheses can emerge from the data as the study progresses.

TABLE 9.3 (*Continued*)

Step	Description
6. Outcome measures	If the action researcher seeks to increase his or her understand operations of his or her professional practice or the impact of decisions, then measurement of those decisions and their impa place. One should employ outcome assessment that measures multiple perspectives (i.e., the subject/client, the practitioner– others) and through multiple approaches.
7. Methods: Creating a design	As with any study, for our conclusions to be valid we must co approach or a design that provides validity of data collection a
8. Data collection	The types of data collected and the method of collection will c researcher-and problem specific. But the information gathered detailed and as informative as possible so that as an action res know what is happening in ways that you previously did not k researcher needs to remember that he or she is a practitioner a researcher and that he or she has a professional responsibility There are ethical considerations, especially those regarding in that need to be considered.
9. Data analysis	At a minimum the data needs to be organized and grouped wit trends and characteristics noted. When appropriate, visual pres descriptive and inferential statistics should also be employed.
10. Interpretation	In reviewing the data, the action researcher needs to balance re significance with practical relevance. Having answered the qu happens if . . . , the researcher now needs to answer questions knowing what happens if mean for my clients, my students, an To me? To my professional decision making? To my current p

The Use of Referral

The ethical helper provides only those services for which he or she is trai and credentialed (e.g., certified or licensed). Competence refers not onl which the professional possesses the knowledge, skills, and abilities requi various tasks and procedures relevant to that profession, but also to the when it is appropriate to provide the services and when it is desirable to

In the private confines of a helper's office, however, where a practi direct supervision or teacher scrutiny, it may be all too easy to be seduce problem solving in areas for which one is ill prepared. Consider the follo Robinson (see Case Illustration 9.1).

Even if we assume the best intent on the part of Dr. Hansen, the tru that he lacks the training and appropriate experience to work with Mrs. R depression. Further, his lack of experience and training is more evidence ness to serve both in the role of Mrs. Robinson's therapist and marital co

CASE ILLUSTRATION 9.1
Moving from Individual to Couple Counseling

Dr. Hansen received a call from Mrs. Alice Robinson who described herself and unclear about the direction she wanted to go with her career. Dr. Hansen tional counselor, scheduled to meet with Mrs. Robinson to begin vocational/career assessment.

Following the initial intake, Dr. Hansen concluded that Mrs. Robinso in vocational and career counseling, was doing this in reaction to what she failing marriage." Dr. Hansen saw Mrs. Robinson three more times with clearly identifying Mrs. Robinson's goals for counseling. Through these Hansen came to realize that Mrs. Robinson was seriously depressed. She standing history of depression and self-medicating alcohol consumption. S considering committing suicide on more than three occasions in the past mo Robinson noted that she is unable to eat, has lost approximately 20 pound period, and is having difficulty sleeping. The root of this depression, accordi son, is the fact that "she cannot communicate" with her husband, and she kn thing is done they will get a divorce. And according to Mrs. Robinson, she s could not live without him!"

Mrs. Robinson described how long she has been wanting to seek cou (her depression) and for she and her husband. But, according to Mrs. Robi n't feel comfortable seeking help since there are so many "wacko doctor Robinson expressed her comfort and trust with Dr. Hansen and asked if he v her marriage.

Dr. Hansen, while being trained and supervised in career/vocational c to work both individually with Mrs. Robinson in order to assist her with h also to set up an arrangement to see her and her husband as a couple to start training."

If one were to assume that Dr. Hansen was qualified to work with a it might be easy to believe the transition from working with the distraugh to couple-marriage counseling was a logical extension of the helping con is that marriage and family counseling is grounded in its one unique theore which is distinct from that of individual counseling (Cottone, 1992). S expertise and competence with a couple, even when competent working invites unethical behavior and a failure to provide appropriate standard o Hansen needs to reflect not only on his own training (formal and informal experience working with clinically depressed individuals, but also on t preparation in systemic-relational treatment before proceeding to treat if would be essential for ethical, competent practice.

Helpers, regardless of their knowledge and skill, cannot provide ever by every client. Ethically, therefore, a helper needs to know not just the v applying helping skills, but also when the situation is beyond his or her cap the boundaries of his or her competence have been exceeded.

Knowing When to Refer

Knowing when to refer is not always easy. At a minimum, the ethical hel time it is determined that she or he is unable to provide the professional, c required. The ethical, competent helper needs to be aware of his or her a the kinds of support and supervision available, and an accurate sense of hi energy, and availability to take on a particular case. When any of these tion, referral should be considered.

If Dr. Hansen (see Case Illustration 9.1) reflected on his own dec might have concluded that a trained, experienced marriage relational cour competently provide the services that Mrs. Robinson and her husban As such, he would have made a referral rather than attempting to provi himself.

Each practitioner can provide competent service, but no one prac master of all the knowledge and skills required to competently address th ations and clients presented. As each profession develops its knowledge the skills required, it will become increasingly incumbent on the practiti the limits of his or her own competency and the richness of resources ava use of referral.

Knowing Where to Refer

In making a competent referral the practitioner needs to understand the cific support and services requested. As such, the ethical, competent h cadre of available referral sources whose character and capacities are knov 1990). Building a referral system branching through the surrounding g essential. This referral network should include a variety of professiona helpers including psychologists, psychiatrists, social workers, ministers, pl social service agencies, hospitals, and so on.

Being fully versed on the resources available not only enables t to select the service(s) that most effectively meet the client's needs, bu helper to explain the reason and the process of referral to the client. Be the services available allows the helper the opportunity to highlight the tions of the person or program to whom the client is being referred, alo formation needed to make for a smooth and comfortable referral and client.

While a listing of various human services agencies and providers ma contacting the local county government or mental health/mental retardatic in your phone book, more personalized knowledge is required for adequa cise 9.3 is offered as a guide for developing this personalized, referral ne

Making the Referral

Recognizing the need or value of referral is only the first step. In addition t need and having available resources to whom to refer, the competent help

EXERCISE 9.3
Developing a Referral Network

Directions: You can begin developing a referral network by contacting lc human service providers by phone or by letter and gathering the following i

Name:_____
Address:_____
Phone:_____

1. What is the purpose or mission of your professional service or practi
2. What type of people (age, gender, socioeconomic position, ethnici served by your service?
3. What type of difficulty, problem or concern is most often addressed by
4. What resources are available (e.g., 24-hour hotlines, medical facil materials, housing, job placement, etc.?)
5. What is the procedure or process for gaining access, making an appo ing assistance?
6. What is the general therapeutic theory or model employed?
7. What is (are) the training levels of the helpers who provide these ser
8. Are there fees? How much? Payment plans? Sliding scales? Insuranc
9. Who is the contact person?
10. Is there a waiting list?
11. Other Information: (e.g., special services, general impressions, etc.)

the skill to assist the client to accept and embrace this referral. It is not unu to interpret the suggestion of a referral as a sign of rejection or as evidence nature of his or her condition.

The competent, ethical helper will present the idea of referral in a w as a continuing, productive step in the helping process—that, far from be rejection, it is evidence of the helper's concern. And rather than evidence ness of the situation it is evidence of the clarity of the nature of the problen of the existence of a resource with a record of success in these situations. C logue presented in Case Illustration 9.2.

As evident in the exchange (see Case Illustration 9.2), presenting t referral needs to be done as a hopeful, positive step in the helping process. T to convey to the client that this is not an abandonment, but an extension ar the helping process. In making a referral the helper should

- Be clear and direct about the goal and expectation for seeking referr
- Confront what referral is NOT, that is, it is not a rejection or a sta lessness

CASE ILLUSTRATION 9.2
Preparing Margaret for Referral

Linda is a Master's level mental health counselor working for an Emplo gram (EAP). Her training is in counseling psychology, and she has expe individual, solution-focused approaches to counseling. As a counselor in tracted to provide a maximum of six sessions of direct service, while managing all clients whom she refers for ongoing assistance. Margaret, to her because her husband "kicked her out" of their house and is filing fo in addition to being depressed about the situation with her marriage, is in rent living conditions. The exchange occurs near the end of the first sessi

LINDA: Margaret, you have certainly been open and honest with speaking about the marriage and your relationship with Tom ha upsetting.

MARGARET: It has been easier than I thought. You are a very kin listener.

LINDA: Thank you. But as we've talked it has become clear to n you are concerned about , the one thing that seems to need im helping you with your housing problem.

MARGARET: Yeah, I don't have any money to go and get a new a and last night I slept in the car. I know I have enough money to night or two but I don't know what I can do . . . (starts to cry).

LINDA: You are correct in saying that you can't continue to sleep ing and answer to your question of,"where can you go" should cern. Do you agree?

MARGARET: Yes (crying).

LINDA: Housing or social service support for displaced women is we provide here at the EAP or that I am very experienced with.

MARGARET: (Interrupting) Oh, NO! You have to help me . . .

LINDA: It going to be all right. I am going to help. Even though these type of situations, I know someone who can really help us experience in these situations. So what I would like to do is call at the Women's Center and see if she has the time to talk with us The Women's çenter is right around the corner from here and i counseling for women who are in situations just like yours resources for temporary housing and even help women find low- once they help you get settled they can help you with some of started discussing.

MARGARET: But how about you. . . . I like you . . .

LINDA: And I like you. In fact, I really want you to get the best he I think the Women's Center is the answer. But I can still help, b Anderson and telling her some of things you have shared with me about your current concerns and some of your goals. I could also Ms. Anderson, if that makes sense after talking with her. And, if

back to talk with me, or if we want to look into another referral sou that, as well. So how do you feel about me calling and seeing if v appointment for you?

MARGARET: Okay . . . but I can still call you if I need to?

LINDA: Absolutely . . .and I will call you to see how things are goin had a hance to work with the Women's Center.

- Share information about the referral source, nature of service, costs,
- Discuss the client's feelings and concerns
- Answer all client questions regarding the referral
- Reassure the client about the value of the referral
- Assist the client in making the initial contact.
- Establish a mechanism for follow-up with each other. Encourage the helper know how the initial visit went

If you are requesting special services for a client from a colleague, i provide the colleague with the information about the case that is necessar goals of the referral. Needless to say, it is essential to gain the client's cons laboration prior to speaking with professional to whom you are referring. C contract has been established, it is important for the referring helper to bac involvement unless specifically requested by the attending professional.

Recent Legal Decisions

Malpractice or professional liability lawsuits are based on negligence t 1997). That is, a client, who in legal proceedings is the plaintiff, would asse has breached the standard of care. Malpractice requires a demonstrating of i even when there is no proof of injury complaints to professional ethics cor latory agencies (e.g., licensing boards) can result in sanctions.

The legal concept of negligence is based on the premise that all mer owe to one another the duty to exercise a certain inherent standard of care. I courts will look to the profession itself to define which standard should be on the standard of care question varies around the country. Some courts wil sis on "accepted" practice, others on what is "customary." In this latter case develop evidence to define the customary standard applied by others ir "field" defined in the most specific sense possible (Bennett et al., 1990, p ple, when a clinical psychologist who has been trained in cognitive techn this orientation explicitly to his or her clients, comes to the courtroom, the or her performance is predefined. The cognitive school is recognized by th psychologists as a distinct and viable orientation, with well-defined stand and clinical guidelines. Should this psychologist be operating without the a ing or outside the customary procedures for a cognitive therapist, he or she able to negligence and malpractice. Therefore, not only do helpers need to

within their scope of training, but must perform in ways that are typica associated with that form of service. Helpers who develop or subscribe apies might find themselves having to prove that a "respectable minorit sion concurs in their techniques or treatment strategies.

An alternative approach to negligence, malpractice, and the issue is that derived not from one's own training but from the clinical imperat condition. In *Hammer v. Rosen*, 165N.E. 2d 756 (1960) the court rulec (psychiatrist) decision to beat his patient as part of therapy was a prima practice. The court noted that some acts are so obviously unacceptable tha is not needed to justify the conclusion of malpractice. If a nontrad employed, documentation of the reasons for its choice rather than a approach, along with expert testimony showing the efficacy of the thera uation and/or its theoretical and scientific bases, may be needed should a be filed (Dickson, 1998). It could be assumed that the same logic may be uation in which a practitioner used a traditional, but less than effective vention. The theoretical and empirical base for that decision may be malpractice action be filed.

Beyond Professional Standards: A Personal Moral Response

While the threat of malpractice can certainly motivate one to perform witl of his or her training, it is not an insurance in and of itself that such ethic formance of duty will occur. As with all of the ethical standards and pr directives to provide competently within the standard of care is or can be of expectation rather than an operative schema guiding practice decision

As ethical practitioners, we need to move the concepts and pri within this chapter from levels of comprehension to incorporation as pe moral imperatives. Once assimilated as a personal value and moral resp petently will be a simple consequence of being competent— in the bro term. The final exercise (Exercise 9.4) is provided to assist you in adding sonal component to this theoretical, conceptual discussion.

Case Illustration

The scenario that opened this chapter not only revealed Ms. Wicks' (Micl cern for her client, Maria, but her personal awareness of the possible limit competence and ability to assist Maria. With these two conditions in place out a peer for consultation and possible referral.

MICHELLE: Hi, Lynn. Do you have a minute?

LYNN: Sure, Michelle, what's up?

EXERCISE 9.4
Personalizing the Importance of Competence

Part 1: Below you will find a list of "presenting concerns." As you read the li
mark under the column indicating whether you would work with the person
vice or refer the person to another helper. If you are currently in a formal deg
gram, answer the question as if you had just completed that training.

Presenting Concerns	Provide Service
A person with anxiety about making a career decision	
A person grieving the recent death of her parent	
A person thinking about leaving his wife	
A person concerned about the possibility of having a drinking problem	
A person who has questions about her sexual orientation	
A person having academic difficulties in college	
A person who feels extremely depressed	
A person who is experiencing headaches and muscle tensions as a result of job-related stress	
A person who is concerned about his explosive temper	
A person who is having conflict with her adolescent, which at times has exploded into physical confrontations	

Part 2: Now for each of the above, reconsider your decision. This time assur
was viewed by you with the same level of care and concern as you would h
very close to you (e.g., family member, spouse, best friend, etc.). Once you
level of concern for the client, did you adjust your original decisions? Wh
about your customary standard of care? Consider steps you can take to app
with the same depth of concern and provision of quality, competent service.

Part 3: For those situations in which the decision was to refer, begin to
resources that you would feel comfortable referring all clients to, including a
personally very close to you.

MICHELLE: I've been working with this girl, Maria, and we hav ing relationship, but I just don't feel like I have a true grasp of that I am approaching this situation the best way that I might. Maria, and she has given me written permission to speak with I know you are really busy, but I was hoping that you could p vision around this case to see if you feel like I'm on track approach.

Following a discussion of case details, their conversation continued:

LYNN: It really does appear that you have gained Maria's trust a experience and background, that was not an easy task.

MICHELLE: Oh, thanks . . you are right, it wasn't the easiest want to do the best for her.

LYNN: Well, your specific solution-focused approach really doe tive, especially in helping her with the "life crisis" of finding port herself, and essentially stay safe. So I would sugge strategize with her the way you have been and identify additi she can use. . . .

MICHELLE: I will—but as I said I feel there is much more here crisis.

LYNN: I agree . . . It is very clear that Maria has some real issue especially her father—and I think one of the goals you could t be to get her to feel safe and crisis-free so that she might be w her family in some family therapy.

MICHELLE: We touched on that a couple of times but she was r were speaking, I remembered that her resistance did seem to appears the more she feels comfortable with me and what w more she may be willing to risk some family sessions! But I a in family work—I mean I've had a course, but that's not some if she agrees, I would like to refer her. I really respect you ar with families, and I have heard great things about Dr. Hemin with families. Would it be okay if when we get to that point, I along with Dr. Hemingway's?

Reflections

1. In reviewing the case, can you see evidence of the helper (Ms. client's welfare above her own image and ego?
2. Identify two specific things done by Ms. Wicks that reflect her aw to provide competent and efficacious service.
3. In addition to having a course in family-systems therapy, what w minimally required before one engage in such an intervention?
4. What might you suggest Ms.Wicks do prior to including Dr. Her ral list?

5. What might you suggest Ms. Wicks do to prepare Maria for referral? ' Ms. Wicks continue to play?

Cooperative Learning Exercise

As with all of the previous cooperative learning exercises, the current exer to help you personalize the material and begin to move your understanding practice. Therefore, before proceeding to the next chapter, read and respon following. Working with colleagues, classmates, or supervisors, share yc develop the comprehensive plan for developing increased levels of compet

Goal identification: Briefly share your vision or goal in terms of the ty would like to do as a practitioner, that is, the type of client you envision w nature/scope of problems, and the setting in which you wish to work.

Legal Requirements: Identify the professional standards and minimal re essary to perform the tasks described in the question above. What are the sp and certification requirements in your state that apply to the practice yo forming?

Contact: Contact one professional currently practicing in an area simila you have identified as your professional goal. Identify the level of training, model this practitioner employs. Identify clients or presenting complaints sionals feels are outside the boundaries of his or her competence and gathe to whom he or she refers.

Contract: Finally, in discussion with your colleague, classmate, or supe your current level of training and experience to the standards established w and the level of expertise identified by the professional you contacted. Wh exist and what is your plan to fill those gaps in competency?.

Summary

Practicing Within the Realm of Competence

Being competent means that the helper has the knowledge, skills, and abilitie form those tasks relevant to that profession. Competence is defined in rela typically using the conduct of others within the profession as the comparati

Professional Development: Knowing the State of the Profession

Competence can be developed from formal training as might be found in g or training for certification and licensure. Further, all the codes of conduc tioners to be current with emerging knowledge relevant to their profession. upon the ethical practitioner to upgrade his or her knowledge and skill thr ing in continuing education experiences and peer consultation.

The Standard of Care: Appropriate Treatment

Most malpractice cases turn on the question of negligence, which sug tioner failed to meet the relevant standard of care. The question of negli mined by the debate over the clinical correctness and efficacy of the given, along with the practitioner's judgment in choosing it. The stan definition of appropriate treatment are typically determined by compari performance with that of other professionals in the same community wi ing and experience. However, as the professions and the research identi with demonstrated effectiveness, these interventions become the stand

Employing an Action Research Approach to Practice

Practitioners bear a fundamental ethical responsibility to use, when po that work and to subject any intervention they use to scientific scrutin

In order to be effective in their practice, human service provi method and findings of research with the realities of their professional tioner–researchers, they will need not only to interact in the moment b and critique their own interactions. *Action research* methodology pr with the means of acquiring these valid, useful data and results in effective strategies of professional practice.

The Use of Referral

Knowing when to refer is not always easy and there are no simple or c

At a minimum, the ethical helper will refer any time it is determi unable to provide the professional, competent services required. In add the need and having available resources to whom to refer, the compet have the skill to assist the client to accept and embrace this referral.

Recent Legal Decisions

Malpractice or professional liability lawsuits are based on negligenc client would assert that the helper has breached the standard of care. court decisions could lead to the assumption that where a practitioner us less than effective strategy of intervention, the theoretical and empirica sion may be essential should a malpractice action be filed.

IMPORTANT TERMS

action research
best practice
brief therapy
certification
competence
continuing education
customary
efficacy of the treatment
formal training
licensing
malpractic
managed c
negligence
peer consul
professiona
reasonable
referral
referral net
regulatory l
standard of

SUGGESTED READINGS

Bass, L.J., DeMers, S.T., Oglof, J.R., Peterson, C., Pettifor, J.L., Reaves, R.P., Retfal Sinclair, C., & Tipton, R.M. (1996). *Professional conduct and discipline in ps* ton, DC: American Psychological Association.

Bennett, B.E., Bryant, B.K., VandenBos, G.R., & Greenwood, A. (1990). *Profession management*. Washington, DC: American Psychological Association.

Parsons, R.D. (1995). *The skills of helping*. Boston: Allyn and Bacon.

Parsons, R.D., & Brown, K.S. (In press). *Action research*. New York: Addison-Wesle

CHAPTER

10 Evaluation and Accountability

Dr. Flournoy: Hello, Ms. Wicks?

Ms. Wicks: Yes.

Dr. Flournoy: I am Dr. Flournoy from Children and Youth Services.

Ms. Wicks: Hello.

Dr. Flournoy: The Ramerez family has been referred to our service, and I un
have been working with Maria, here at school. I have requeste
seling records be subpoenaed, and I simply wanted to let you k
so that you could begin to get them in order.

Counseling records? Subpoenas? For some mental health practitioner
taining records may be an anathema to the nature of the helping process
tation to disclose these records as a result of a simple request, subpoena,
arouse debilitating anxiety.

The need and ethical responsibility of keeping and maintaining rec
inherent conflict that may exist when disclosure of these records is requ
focus for the current chapter.

Chapter Objectives

The chapter will introduce you to the importance of maintaining records
of professional accountability and an essential step toward demonstratin

After reading this chapter you should be able to do the following:

1. Describe the benefits of utilizing a system of evaluation within on
2. Define the terms *formative* and *summative* evaluation
3. Describe one approach to measuring outcome and goal achieveme
4. Identify the minimal records necessary for demonstrating competer

While it is true that no one professional can guarantee success i
encounter, the ethical practitioner will monitor services and adjust as requ
itoring, or evaluation, be it through the informal collection of data or more
offer direction and serve to demonstrate accountability. However, for som
cept of "evaluation" may be viewed as superfluous or tangential to the pr

helping. In fact, Hackney and Cormier (1991) suggest that one of the primary ing is the failure to monitor and evaluate the effects of the intervention strat

Parsons (1995) noted that use of a properly implemented and maint evaluation can

1. Serve as an ongoing reminder that the helping relationship is not one client can remain dependent; it is terminal
2. Be used as a tool to foster an awareness of the movement of the hel well as to anticipate that the helping relationship is coming close to a
3. Provide the feedback and criteria needed to decide on an adjustme approach, a referral or a termination.

The value to the overall planning and decision making of the helpe good evaluation system makes it a practical and worthwhile idea for all h when viewed through the lens of accountability—to the client and the profe uation system becomes an essential ethical practice (see Table 10.1).

TABLE 10.1 Ethical Positions on Record Keeping

American Counseling Association (1995)	B.4 Records (a) Requirements of Records. Counselors maintain records nec rendering professional services to their clients and as required l regulations, or agency or institution procedures. (b) Confidentiality of Records. Counselors are responsible for safety and confidentiality of any counseling records they create transfer, or destroy whether the records are written, taped, com stored in any other medium.
American Psychological Association (1995)	5.04 Maintenance of Records. Psychologists maintain appropriate confidentiality in creating, accessing, transferring, and disposing of records under their co these are written, automated, or in any other medium. Psychol and dispose of records in accordance with law and in a manner compliance with the requirements of this Ethics Code.
American Association of Marriage and Family Therapy (1998)	2.3: Marriage and family therapists store and dispose of client that maintain confidentiality.
National Association of Social Workers (1996)	3.04: The National Association of Social Workers (1996) state (a) Social workers should take reasonable steps to ensure that in records are accurate and reflective of services provided. (b) Social workers should include sufficient and timely docum records to facilitate the delivery of services and to ensure conti provided to clients in the future.

Monitoring and Evaluating Intervention Effects

Evaluation is often thought of as something that is done at the end of a
scriptive, evaluation of the helping process needs to be both ongoing a
well as "summative" in form.

Formative Evaluation

Formative evaluation is evaluation that occurs as an ongoing process th
ing encounter. It is the gathering of feedback and data used to expedi
about the current process and the upcoming steps and procedures to be
vides data that give form to the ongoing process. The means of collec
can range in degree of formality. For example, a practitioner may choose
survey or questionnaire at various points in the helping encounter. Or, n
practitioner may simply set time aside to solicit feedback from the clie
experience in the relationship with the helper and the procedures emplo
ticular point (see Case Illustration 10.1).

CASE ILLUSTRATION 10.1
Formative Evaluation

DR. BROWN: First let me tell you how much I appreciate your o
ness to share with me some of your concerns about your soc
your desire to become more assertive in these. I feel very comf
you and feel that the things we have talked about in this firs
helped us to clarify your goal and even begin developing a
there. I think it may be helpful if we took a moment to share ou
session as a way of making future sessions more productive. I
ested in receiving your feedback about our session today.

JIM: To be honest, I was very nervous when I made the appointi
really surprised how much I shared. I really feel like I can trust
fortable speaking with you, and that is not my style, usually.

DR. BROWN: Well, that is very nice to hear, and I know from w
you tend to be a private person. Jim, as you are aware, we will p
more about your family background and previous relationship
on. How do you feel about that? (Dr. Brown checks Jim's under
ing process).

JIM: I know that probably needs to be done—it makes me a litt
said, I do feel comfortable with you and trust you, especially hc
idea of confidentiality. I just may need to go slow.

DR. BROWN: That's good feedback for me. The pace of the sessi
one that feels right for you. So if we need to go slow . . . we wil
into something, and it seems right to me . . . we will. I think as

to "process" how we are doing—we can make sure we stay on trac
is both productive and comfortable. (Dr. Brown checks Jim's c
takes direction.)

JIM: Yeah, me too.

DR. BROWN: So, while overall you are hoping to get some help
assertiveness skills, our immediate goal is for you to take notes or
one in which you felt you were assertive and one in which you felt
Are these the goals we agreed on? (Dr. Brown checks agreement

JIM: Yes—that's exactly what I want to do . . . get more assertive! A
of doing some "research work" for our next session.

For this evaluation to truly form and give shape to the decision-mak
should begin with the first session. As evident in Illustration 10.1, the helpe
mative evaluation within the first session. The approach taken by this
insight into the client's level of comfort with the interaction and his abilit
laboratively in the helping process. This evaluation also served as a check
of the helper's understanding regarding the desired goals and outcome
process. The use of such a formative evaluation not only provides for hel
ity but provides the data for monitoring and increasing efficacy of treatme

Summative Evaluation

Summative evaluation is the type of evaluation most typically thought of w
goal or outcome assessment. The specific purpose of summative evaluati
strate that the action plan has reached its original objective. Summative eva
the helper and the client data to determine (1) if the original goals were a
factors that contributed to this goal attainment, and (3) maybe even the va
egy versus some alternative. The articulation of clear treatment goals, and
of summative evaluation strategies, serve as invaluable sources for demons
efficacy and helper accountability.

The presence of clearly articulated goals or outcome, is essential fo
and summative forms of evaluation. Without a clear, shared vision of wl
process is going, it will be hard to know if it is on track or even if it has a
establishment of treatment goals and objectives, the identification of out
and the maintenance of appropriate responsible records serve as keystone
efficient practice.

Setting Treatment Goals and Objectives

The setting of the goals and objectives for a helping relationship is highly i
values and beliefs of the therapists (Brace, 1997). Research has demonstr
tend to adopt counselor values that, without some forethought, could undu

client to embrace not only the counselor's values but goals and vision fo tionship (e.g., Beutler, 1983; Owen, 1982). Because of the potential to i and the client's ability to formulate his or her own goals and objectiv for the practitioner to be sure to engage the client in terminal goal formu opment of treatment goals and objectives should be shaped by an over the client's welfare and with a desire to facilitate the client's own self- autonomy.

Brace (1997) suggests a set of rules that could guide the develop helping relationship. These rules reflect a consideration of the ethical c welfare and best interest, as well as a respect for the client's right to self- autonomy. Table 10.2 reflects a number of these guidelines.

TABLE 10.2 Guidelines for Developing Helping Goals

Guidelines Reflecting Concern from Client Welfare	Guidelines Reflecting Respect Autonomy
1. Examine goals to be sure they are in the client's best interest.	1. Helpers should explicate the they affect goal developmer
2. Goals should be mutually consistent.	2. Changes in the client's valu the course of the helping sh the client's conscious volitic
3. There should be adequate reasons for pursuing a chosen end goal (i.e., what the client wishes to accomplish as a result of the helping process) rather than an alternative.	3. Any action taken with the ir client, but without the client involuntary hospitalization) justifiable.
4. The choice of instrumental goals (i.e., the selection of means to accomplish end goals) should be based on adequate reasons; if the ones chosen are found to be ineffective, they should be replaced with others that are effective.	4. The helper should avoid dec the development of goals sir client's right to informed co
5. Factors that are causal or contributory and pertain to the goal should be assessed.	5. An explicit agreement on th their pursuit should be estab helper and the client.
6. The helper should avoid and/or correct errors in clinical judgment that could adversely affect goal attainment.	
7. Treatment should not harm the client—if harm may result it should be outweighed by the treatment's potential benefit and should have the client's informed consent.	
8. The helper should keep implicit and explicit promises to the client.	

TABLE 10.2 (*Continued*)

Guidelines Reflecting Concern from Client Welfare	Guidelines Reflecting Respect fo Autonomy
9. When helping involves more than one person, equal importance should be given to the welfare of each.	
10. Should consider the possible effects of the client's instrumental and end goals on others so as to minimize harm.	

Measuring Outcome and Goal Achievement

The selection of appropriate outcome measures is far from easy. It is, how helping where the old adage "the more, the better" has application (S Bleuer, & Walz, 1997). Using more than one outcome and outcome meas probability of accurately depicting the experience. At the most fundament titioner can assume that one outcome reflects the nature of the present example, if a clinician is interested in ameliorating a presenting complaint, complaint (e.g., test anxiety, marital dissatisfaction, depression, etc.) pro the outcomes desired. After targeting the general area in which the h demonstrate impact (i.e., reduce test anxiety, increase achievement level ular area needs to be clearly and concretely defined. It is important to r there will be a primary focus for the assessing outcome (e.g., reduce the depression, or increase student attention etc.), these targets may be manife of different ways and occur within a unique context. The more perspectiv outcome and the more measures we employ, the greater the chance w standing the nature and depth of impact our practice may have produc approach taken by the helper illustrated in the following case (Case Illust

CASE ILLUSTRATION 10.2

Assessing Outcomes of Treatment with Depressed C

Alicia came to therapy because of a "constant" feeling of sadness and an in vated about anything in her life. At the initial meeting with Alicia, Dr. W identify the various ways in which her feelings of sadness were experience ing her life.

DR. WARRICK: Alicia, you have mentioned that you are not "dc you can't get motivated. Could you tell me more about that?

ALICIA: Well, I have a lot of school work that should be done a down to do it I think—why bother, nothing is going to come ou away from the computer and get something to eat or go to bed.

DR. WARRICK: So it seems that you not only feel sad, at times, bu belief that "nothing is going to work"?

ALICIA: That's right! And it is not just with school stuff. If I get a I typically go, why bother going out, it is not going to help. And

DR. WARRICK: So one of the things that we may watch as we worl your feelings of sadness, but also the frequency of this "why bo thinking?

ALICIA: I don't want to feel sad anymore, but I also understar about the thinking.

DR. WARRICK: You also seem to suggest that when you are fee avoid your friends and avoid engaging in activities (like school

ALICIA: Yeah, I have not seen my friends in weeks. I'm sure they I don't even do housework anymore—my place is a mess.

DR. WARRICK: Well, Alicia, I appreciate how open you have b and I truly feel we have taken a good step toward helping you to f way you want to. As we continue working together, we will not on your feelings of sadness with the intent of gaining some relief there is an increase in the frequency with which you go out with house chores and school work. Further, we will hopefully as se thinking. Rather than thinking "why bother" thoughts we will se thoughts. How does that sound?

ALICIA: It sounds like a lot and I'm not sure that we can do this. why bother thought again! But if I would start feeling and think ferently, then I would not need to be here.

DR. WARRICK: That's good—and I like the way you already attac yours!

While most individuals recognize depression to be a mood, an af depression also manifests itself in a person's behavior, thought processes, interactions. A helper, like Dr. Warrick (see Illustration 10.2), who may assess the effectiveness of a particular medication or treatment approac should assess changes not only in the client's mood but also in the client doing school work), thought processes (e.g., had less frequent thoug thoughts of "why bother"), and interpersonal interactions (e.g., began to re ily and friends), along with gathering information about how the client changes.

Table 10.3 provides one useful way for conceptualizing the various c interventions may impact the client. It is useful to consider gathering dat all, of these domains in an attempt to accurately evaluate the impact of p The listing presented is an adaptation of the work of Arnold Lazarus (19 of this model is the belief that a person's functioning or dysfunctioning is

TABLE 10.3 Classification Scheme for Outcome Measures: Using an Example of a Clie Experiencing Anxiety in Social Settings

Modality	Manifestation	Sample Methods of
Behavior	Withdraws from social contact	Observation
Affect	Anxious	Survey (anxiety check
Sensation	Muscle tension	Self-Report (journal)
Imagery	Dreams about being abandoned	Self-Report (journal)
Cognition	Believes he has no right to say no	Assertiveness question
Interpersonal	Withdraws and fails to maintain eye contact	Observation, interview
Drugs/Biology	Stomach upset/Blood pressure high	Self-report and blood p recordings

seven modalities: behavior, affect, sensation, images, cognition, interpe ships, and biology/physiology. Lazarus represented these seven domains w BASIC ID. Using each of these components as a reference point, the helpe alize the impacts of his or her practice more broadly.

Table 10.3 presents three dimensions for consideration when identify action research. First, *modality* refers to the specific arena in which this c manifested (i.e.,BASIC ID). The second dimension, *manifestation*, is the practitioner identifies the manner or form in which this particular target of t appears. The final column, *data collection techniques*, identifies the types o can be useful when assessing that domain. It should be noted that while a sp data collection has been identified in Table 10.3, other methods may work a 10.1 provides an opportunity to employ to this approach with a problem o

EXERCISE 10.1
Identifying Personal Outcomes

Directions: Below are a number of general statements about personal i growth. Select one that may be of interest to you and, using the table below ious manifestations of this goal achievement along with techniques for asse

1. Become a better student
2. Become more social
3. Become more spiritual
4. Improve general health

Modality	Definition
Behavior	
Affect	
Sensations	
Imagery	
Cognition	
Interpersonal	
Drugs	

Record Keeping

Record keeping is important not just to document service, but also to g practitioner in his or her practice decisions. Accurate, complete record allow a practitioner to review the therapeutic process and thus foster self part of the practitioner. Thus, implicit within the discussion of evalu measurement is the understanding that data will be collected and recor sis. These data can be of various forms including test scores, clinician notations. In whatever form they are, these data constitute a client's r handled with sensitivity.

Maintaining thorough records and clinical notes is essential to the itoring of services as well as to providing data should the interaction ev in the case of a lawsuit. In fact, Schaffer (1997) suggests failure to records places a practitioner in great ethical and legal jeopardy. Thus, about possible requirements to disclose, experiences of inconvenience, belief in the power of his or her memory, the ethical practitioner will c useful professional records. In fact, all of the professional organizatio call for the ethical collection, maintenance, and dissemination of client

Nature and Extent of Records

Records should document the nature, delivery, and progress of servic tional information may be required by state statute and/or contract as wh vided as part of a managed care organization. While the specifics of wh as part of a client's record varies from state to state, generally it is impo legible record that includes at a minimum: identifying data; dates of ser vices; fees; any assessment, plan for intervention, consultation, and/or s may be appropriate; and any release of information obtained. One exam records one should maintain was developed by the Committee on Profes Standards of the APA. This committee adopted a set of guidelines (se Jones, & Nagy, 1994), which suggests that a minimum records should c

- Intake sheet, including client identifying information
- Documentation of a mental status assessment
- Signed informed consent
- Treatment plans
- Psychological tests
- Documentation of referrals
- Types of services provided
- Appointment dates and times
- Release of information
- Discharge summary

While the above provides some minimal guidelines for identifyin type of records to be collected and maintained, the specific form of each the nature and content and style of clinical notes and records, will be deter cific regulations of the setting in which the services are provided, state law erences (see Exercise 10.2).

Regardless of the types of data collected, clarity and utility should g The notes are meant to assist in the treatment (utility), and since records be and copies could be requested, they should be clearly written in a manner nondemeaning.

EXERCISE 10.2
Nature of Records to Be Kept

Directions: Using the questions listed below, interview two professional he following professions.

- Private practitioner
- School counselor
- Criminal justice worker/counselor
- Drug and alcohol counselor
- Marriage therapist

Then ask each helper if he or she keeps client files and if not, why not. her:

- What type of information do you keep in your files?
- How long do you maintain your files?
- Does your client have access to these files?
- Have you had your records subpoenaed? If so, what was your

Compare and contrast the helpers' responses. Was there commonality helping profession? What similarities or differences existed across profes

Storage and Access

The collection and maintenance of such sensitive information can confl right to personal privacy if not handled professionally and ethically. Vic priate record keeping has been one of the top five areas of legal liabili (Snider, 1987). For example, the American Psychological Association's] of Psychologists and Code of Conduct (1995), principle 5.04 states:

> Psychologists maintain appropriate confidentiality in creating, storing, a ring and disposing of records under their control, whether these are wri in any other medium. Psychologists maintain and dispose of records in a law and in a manner that permits compliance with the requirements of th

There is, however, no one set of standards that concretely and ur across professions and settings. It is incumbent for each professional to ur ical principles articulated within his or her profession. In addition to the practitioner needs to be aware of the legal statutes and practice princip acquisition, storage, and maintenance of records in their own particular s ple, practitioners working within a school setting that receives federal fun erned by the Family Educational Rights and Privacy Act (FERPA). This a of access to educational records to students and their parents and defines e as any record kept by employees of the educational institution. Since records is not required of practitioners working within a nonfederally fu clear that the decisions regarding the nature of records collected and the can vary setting to setting.

In what is now a significant event in the history of educational rec Russell Sage Foundation, convened a conference in 1969 of representat tional and legal institutions, as well as experts in related fields, to addres lecting, maintaining, and disseminating records within the schools concluded that "current practices of schools and school personnel relating maintenance, use and dissemination of information about pupils threater ance between the individual's right to privacy and the schools stated nee sell Sage Foundation, 1970). The outcome of this conference was the proposed set of guidelines that, while targeted to pupil records, has value ers, regardless of the setting, and the population with whom they work. A gleaned from the historic conference are presented in Table 10.4 and ser point for Exercise 10.3.

Database and Computer Storage

The issue of storage and access takes on special significance when consi advances of this technological era and the use of computers for database st ple, the American Psychological Association's Ethical Principles describ

> If confidential information concerning recipients of psychological servic into databases or systems of records available to persons whose access

TABLE 10.4. Summary of Russell Sage Conference

Collection of Data	Consent	No information should be collected without prio consent.
		The client should be informed as fully as possibl with the practitioner's professional responsibility capacity of the client to understand.
		Even when data is collected under conditions of obligation to obtain consent remains.
Maintenance of Data	Levels: Category A	Data included here reflect the minimum persona (e.g., name, address, date of birth, academic bacl
		For schools, these data should be maintained in
	Category B	Data of clear importance but not absolutely nece helping the client or protecting others over time standardized testing, family background data, ob rating scales).
		These data (in regard to school settings) should l unnecessary at periodic intervals (e.g., transition moving from elementary to junior high)
	Category C	Useful information needed for the immediate pr or clinical findings).
		Data should be reviewed at least once a year (in and destroyed as soon as their usefulness is ende continues and validity of information has been v may be transferred to Category B.
	Confidential, personal files	Any and all data that are considered personal pr professional should be guarded by the rules give dictated by professional ethics, terms of employ special agreements made between the profession client.
Dissemination	Releasing without consent	In school setting, category A and B data may be other school officials including teachers who ha educational interest in pupil records.
	With consent/ judicial order	School may not divulge any information to anyc legitimate school personnel without written conse with judicial order.
	Nonrelease	Under no conditions, except court order, should information in Category C.

Adapted from *Guidelines for the collection, maintaining & dissemination of pupil records.* Russell Sage Fo

EXERCISE 10.3
Assessing School Record Keeping

Directions:
Step 1: Contact your high school or a local high school. Inquire what thei
the gathering, maintenance, access, and disposal of the following types c

1. Student attendance
2. Student course grades
3. Student discipline record
4. Student health records
5. Student standardized test scores
6. Student counseling records (if any)
7. Student IEPs or specialized academic program plans
8. Teacher, counselor, administrator anecdotal notes on students

Step 2: Using the category breakdown listed in Table 10.4 (Russell Sag
evaluate the degree to which this school is following the Russell Sage gu

---

sented to by the recipient, then psychologist use coding or other tech
inclusion of personal identifiers. (APA, 1996, 5.07)

Recent Legal Decisions

One area of professional practice that has recently been impacted by co
regard to a client's right to access psychiatric records. The federal Freed
Act of 1966 and various state patients' rights laws often specify client r
tain personal records. While mental health records have previously been
policy, the trend appears to be reversing in favor of client access.

For example, it was initially successfully argued that such free acc
harm to a client—that sharing technical information with clients who a
understand or deal with this information may prove counterproductive an
argument found support in the case of *Godkin v. Miller* (1974). Janet C
voluntary patient at three different New York hospitals. Later, she and he
to write about the experience and requested access to her records. Her req
In her lawsuit against the New York State Commissioner of Mental Hyg
tors of the hospital, the court ruled that the refusal was warranted in light
hospitals stated a preference to release the information to another profes
number of points in the process of record acquisition, storage, maintenanc
position in which a practitioner may be confronted with ethical and c
However, the courts have not provided a clear directive covering all of
such, it is in the general ethical principles and usual customary practice

needs to find direction. Arthur and Swanson (1993) provide a summary c legally relevant points. These authors note:

1. Security of files must be maintained such that unauthorized access is

2. Notes should be written in nontechnical, clear, and objective statements descriptions. Subjective or evaluative statements involving professional judgr designated as such and written in a separate section clearly set aside from fac

3. All client records should be written with the understanding that they m the client, a court, or some other authorized person.

4. Only information that is necessary and appropriate for the provision o client should be documented.

Case Illustration

The scenario that opened this chapter highlighted the importance of record k potential that such records may be requested. As we continue the scene, ho see that it also raises a number of issues regarding (1) the types of informatic (2) the way that records are maintained, and (3) the questions of access to r

DR. FLOURNOY: Hello, Ms. Wicks?

MS. WICKS: Yes?

DR. FLOURNOY: I am Dr. Flournoy from Children and Youth Servi

MS. WICKS: Hello.

DR. FLOURNOY: The Ramerez family has been referred to our servi stand that you have been working with Maria, here at school. I hav your counseling records be subpoenaed, and I simply wanted tc ahead of time, so that you could begin to get them in order.

MS. WICKS: I appreciate your notification. Even though we utiliz intake forms, inventories, and counseling notes, it is always nice to time to get them together. As I am sure you are aware, I will nee Release of Information and I would like one from Maria, in additio

DR. FLOURNOY: I understand that you would like a release and act copies of both a parent release and the client's signed release. You for your records. You mentioned that you have intake forms, i client notes with computer access.

MS. WICKS: Yes.

DR. FLOURNOY: Well, I'm going to ask for all the notes includir sional observations and anecdotal notes.

MS. WICKS: Well, Dr. Flournoy, the school's policy is that co include:

- Intake sheet, including client identifying information
- Signed informed consent
- Documentation of referrals
- Types of services provided
- Standardized test scores and/or inventories employed
- Appointment record
- Release of information
- Summary of contact

So I will be happy to provide these to you.

DR. FLOURNOY: Thank you. But I know as a counselor you prob notes. I would like to see those as well.

MS. WICKS: The notes that we have are those identified by s already listed those and I will be glad to provide them. But first, with Maria, and even though she signed the release, I would exactly what we will be releasing.

Reflections:

1. What do you think about Ms. Wicks' request for a release of info the parents and Maria? Was it legally required? Ethically required
2. Ms. Wicks outlined the type of information that the school di to maintain. How adequate do these records appear to be? Is there is missing?
3. What concerns would you have with having this data in computer
4. What is your reaction to Ms. Wicks' response in regards to persona
5. Ms. Wicks noted that she wanted to explain to Maria the typ be released. Was that necessary? Required? What are your feeli decision?

Cooperative Learning Exercise

As with all of the previous cooperative learning exercises, the current ex to help you personalize the material and begin to move your understandi practice. Working with a colleague and/or classmate, identify the types tion that you feel are needed in the course of your professional practic retained within a client record. Next,

1. Design samples of the specific forms or data collection tools you v
2. Contact three individuals currently working in the area of professi you envision doing and request copies of their data collection tools
3. Finally, contact your state association and inquire about the length be responsible for maintaining these records.

Summary

Monitoring and Evaluating Intervention Effects

Evaluation of the helping process needs to be both ongoing and formativ
mative in form. Formative evaluation is evaluation that occurs as an
throughout the helping encounter. Summative evaluation is the type of eva
ically thought of when considering goal or outcome assessment.

Setting Treatment Goals

Because of the potential to influence the client and the client's ability to fo
own goals and objectives, it is important for the practitioner to be sure to
in terminal goal formulation. When articulating treatment goals, the more
take on the outcome and the more measures we employ, the greater the cl
understanding the nature and depth of impact our practice may have prod

Record Keeping

Record keeping is important not just as a documentation of service but a
direct the practitioner in his or her practice decisions. Maintaining thorc
clinical notes is essential to the planning and monitoring of services as we
data should the interaction ever be questioned as in the case of a lawsuit
document the nature, delivery, and progress of services provided. The coll
tenance of such sensitive information can conflict with a client's right to
if not handled professionally and ethically.

IMPORTANT TERMS

accountability
data collection techniques
evaluation
Family Educational Rights and Privacy Act (FERPA)
formative
modality
outcome mea
record keepin
Russell Sage
terminal goal
summative

SUGGESTED READINGS

Coale, H.W. (1998). *The vulnerable therapist.* New York: The Haworth Press.

Crawford, R.L. (1994). *Avoiding counselor malpractice.* Alexandria, VA: American C
tion.

Russell Sage Foundation (1970). *Guidelines for the collection, maintenance, and dis
records.* Hartford, CT: Russell Sage Foundation.

Schaffer, S.J. (1997). Don't be aloof about record-keeping; it may be your best liat
National Psychologist, 6(1), 21.

Snider, P.D. (1987). Client records: Inexpensive liability protection for mental health
of Mental Health Counseling, 9, 134–141.

EPILOGUE

While the text has provided an extensive review of the various professions duct and ethical standards, the truth is that relying solely on the ethical cod practice decision making is insufficient (Treppa, 1998). Throughout this t theme was for the ethical helper to keep the focus of all decisions on the well-being of the client. But beyond that focus, it is useful for the helper reflect on the question of "How does who I am impact this process and th Asking this question both emotionally and analytically throughout the course assist helpers in making ethical choices. Ethical codes provide guidelines o sion making, however, ethical decisions are at times largely influenced by p biases, cultural mores, and contextual considerations. Thus, it is important cal helper develops a model for ethical decision making that is consistent fession's standards of practice while at the same time reflecting their own p

The following decision model is provided as both a conclusion to our t ning of your own long career in ethical decision making. The model, which h from the work of Hill, Glaser, and Harden (1995), combines the rational-ev work presented in the literature, the emotional and intuitive aspects of the he to the situation. While presented in a linear, stepwise fashion, it needs to b practice, decision making is less than linear and will weave back and forth a

1. *Identifying the problem.* A helper becomes aware of a problem either a of his or her own knowledge of the helping process or ethical codes or via f supervisor, colleague, or even a client. It is important that the helper identif reactions to the situation and the role they may play in the continuation of t his or her failure to move in a ethical path.

2. *Defining the problem.* The helper needs to identify what ethical principl dards of practice and treatment may be at odds. Further, the ethical practi consider the specific needs of those people and systems involved. Beyond ic elements, the ethical helper needs to also identify the way his or her cultura ing gender, race, class, etc.) may affect the situation, as well as the way his ings and values come to play within the situation.

3. *Identifying a solution.* At this stage the helper needs to generate practic considering the practicality of each solution (i.e., cost-benefit), the guiding p development of a solution is the principle of nonmaleficence ("do not har cence ("do the greatest good").

4. *Choosing a solution.* According to Hill, Glaser, and Harden (1995), t be considered when selecting a solution are: "Is this solution the best fit b and rationally? Does this meet everyones needs, including mine? Can I imp with this?"

5. *Reviewing the process.* Once a solution has been chosen, it is import consider how his or her own values and personal characteristics may h choice. Questions to consider include: (1) Would another helper have m ferent choice? (2) Is this how I would want to be treated? (3) Is the decis (Haas & Malouf, 1989)? (4) Does this feel right and would I be comfort scrutiny of my decision?

6. *Implementing and evaluating the decision.* With implementation cor reassessment of both the dilemma and the choice of response. These ne the decision or require the helper to return and redefine the problem.

7. *Continuing a reflection.* Finally, for this process to become more o response rather than a simple rote procedure, the helper needs to reflect process and the impact. It is important to grow through and with ea Understanding what is learned about one's practice decisions, clients, himself or herself, is an important step in the process of becoming an et

REFERENCES

Adleman, J., & Barrett, S.E. (1990). Overlapping relationships: Importance of the perspective. In H. Lerman & N. Porter (Eds.), *Feminist ethics in psychotherapy* (York: Springer.

Ahia, C.E., & Martin, D. (1993). *The danger-to-self-or-others exception to confide* dria, VA: American Counseling Association.

Alperin, R. (1994). Managed care versus psychoanalytic psychotherapy: Conflicting *ical Social Work Journal*, 22, 137–148.

American Association for Marriage and Family Therapy. (1995). *AAMFT code of* ton, DC: Author.

American Association for Marriage and Family Therapy. (1998). *AAMFT code of* ton, DC: Author.

American Counseling Association. (1995). *Codes of ethics and standards of pra Counseling Association.* Alexandria, VA: Author.

American Counseling Association. (1996). *ACA code of ethics and standards of prac* VA: Author.

American Psychological Association (1995). *Ethical principles of psychologists and* Washington, DC: Author.

American Psychological Association (1992). Ethical principles of psychologists and *American Psychologist, 47*, 1597–1611.

Ammerman, R.T., Last, C.G., & Hersen, M. (Eds.). (1993). *Handbook of prescripti children and adolescents*. Boston: Allyn and Bacon.

Anderson, B.S. (1996). *The counselor and the law* (4th ed.). Alexander, VA: Amer Association.

Arbuckle, D.S. (1977). Consumers make mistakes too: An invited response. *Personn Journal, 56*, 226–228.

Arthur, G.L., & Swanson, C.D. (1993). *The ACA legal series: Confidentiality and munication.* Alexandria, VA: American Counseling Association

Atkinson, D.R. (1983). Ethnic similarity in counseling psychology: A review of t *Counseling Psychologist, 11(3)*, 73–92.

Bader, E. (1994). Dual relationships: Legal and ethical trends. *Transactional Anal* 64–66.

Banister, P. Burman, E., Parker, I. Taylor, M., & Tindall, C. (1994). *Qualitative chology: A research guide.* Philadelphia, PA: Open University Press.

Beauchamp, T.L., & Childress, J.F. (1989). *Principles of biomedical ethics.* Oxford sity Press.

Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). *Cognitive therapy of depre* Guilford Press.

Bednar, R.L., Bednar, S.C., Lambert, M.J., & Waite, D.R. (1991). *Psychothera clients: Legal and professional standards.* Pacific Grove, CA: Brooks/Cole.

Bennett, B.E., Bryant, B.K., VandenBos, G.R., & Greenwood, A. (1990). *Professi risk management.* Washington, DC: American Psychological Association.

Benningfield, A.B. (1994). The impaired therapist. In G.W. Brock (Ed.), *America Marriage and Family Therapy ethics casebook* (pp. 131–139). Washingtor Association for Marriage and Family Therapy.

Bergantino, L. (1996). For the defense: Psychotherapy and the law. *Voices* (Fall),
Berenson, B.G., & Carkhuff, R.R. (1967) *Source of gain in counseling and ps*
York: Holt, Rinehart & Winston.
Bergin, A.E. (1991). Values and religious issues in psychotherapy and mental hea
chology, 46(4), 393–403.
Bersoff, D.N., & Koeppl, P.M. (1993). The relation between ethical codes and
Ethics and Behavior, 3, 345–357.
Bertram, B., & Wheeler, A.M. (1994). Legal aspects of counseling: Avoiding lawsı
lems. Workshop materials. Alexandria, VA: American Counseling Associati
Beutler, L.E. (1983). *Eclectic psychotherapy: A systematic approach.* New York:
Biaggio, M., & Greene, B. (1995). Overlapping/dual relationships. In E.J. Rave &
Ethical decision making in therapy: Feminist perspectives (pp. 88–123) New Y
Black, H.C. (1991). *Black's law dictionary* (abridged, 6th ed.). St. Paul, MN: We
Blum, S.R. (1992). Ethical issues in managed mental health. In S. Feldman (Ed.)
health services (pp. 245–265). Springfield, IL: Charles C. Thomas.
Bogust v. Iverson, 102 N.W.2d 288 (Wis. 1960).
Brace, K. (1997). Ethical considerations in the development of counseling goals. I
guide to ethics in therapy (pp. 17–35). New York: Hatherleigh Press. Boston
Bricklin, P.M. (1993, May). When ethics are law. *The Pennsylvania Psychologists*
May, 8– 9.
Brown, L.S. (1994). *Subversive dialogues: Theory in feminist therapy.* New Yor
Basic Books.
Canter, M.B., Bennett, B.E., Jones, S.E., & Nagy, T.F. (1994). *Ethics for psychol*
tary on the APA ethics code. Washington, DC: American Psychological Ass
Canterbury v. Spence, 464F.2d 772 (1972).
Carkhuff, R. R., & Berenson, B.G. (1977) *Beyond counseling and therapy.* New Y
and Winston.
Cavaliere, F. (1995, July). Grassroots efforts stall unfavorable legislation. *APA M*
Chalk, R., Frankel, M.D., & Chafer, S.B. (1980). *AAAS professional ethics project.*
American Association for the Advancement of Science.
Chambless, D.L., Sanderson, W.C., Shoham, V., Johnson, S.B., Pope, K.S., C
Baker, M., Johnson, B., Woody, S.R., Sue, S., Beutler, L., Williams, D.A
(1996). An update on empirically validated therapies. *Clinical Psychologist,*
Coale, H.W. (1998). *The vulnerable therapist.* New York: The Haworth Press.
Cohen, E.D. (1997). Ethical standards in counseling sexually active clients with H
leigh guide to ethics in therapy (pp. 211–233). New York: Hatherleigh Press.
Corey, G., Corey, M.S., & Callanan, P. (1988). *Issues and ethics in the helping pro*
Pacific Grove, CA: Brooks/Cole.
Corey, G., Corey, M.S., & Callanan, P. (1993). *Issues and ethics in the helping pro*
Pacific Grove, CA: Brooks/Cole.
Cottone, R.R. (1992). *Theories and paradigms of counseling and psychotherapy.*
Bacon.
Crawford, R.L. (1994). *Avoiding counselor malpractice.* Alexandria, VA: Ame
Association.
Cummings, N.A. (1990). The credentialing of professional psychologists and its i
other mental health disciplines. *Journal of Counseling and Development, 68(*
DeLozier, P.P. (1994). Therapist sexual misconduct. *Women & Therapy, 15,* 55–6
Denkers, G., & Clifford, R. (1994). *A survey of psychologists' experiences with manag*
issues. San Mateo, CA: San Francisco Bay Area Psychologists Task Force on M

Deutsch, C.J. (1984). Self-reported sources of stress among psychotherapists. *Proj*
ogy: Research and Practice, 15(6), 833–845.
Dickson, D. (1998). Confidentiality and privacy in social work: *A guide to the lav*
and students. New York: The Free Press.
Doherty, W.J.(1995). *Soul searching: Why psychotherapy must promote moral re*
York: Basic Books.
Edwards, H.B. (1995, November/December). Managed care and confidentiality. *I*
Management, 15, 3.
Eisel v. Board of Education of Montgomery County, 324 Md. 376, 597 a, 2d 447 (M
Elkin, I., Shea, M.T. Watkins, J.T. Imbers, S.D., Sotsky, S.M. Collins, J.F. Glass, I
Leber, W.R., Docherty, J.P., Feister, S.F., & Paroloff, M.D. (1989). National
tal Health treatment of depression collaborative research program: Genera
treatment. *Archives of General Psychiatry, 46,* 971-983.
Emerich v. Philadelphia Center for Human Development, Slip Opinion #J-253-9
11, 1996).
Emerson, S., & Markos, P.A. (1996). Signs and symptoms of the impaired cou
Humanistic Education and Development, 34, 108–117.
Engels, D., Willborn, B.L., & Schneider, L.J. (190). Ethics curricula for counselc
grams. In B. Herlihy & L.B. Golden (Eds.), *Ethical standards casebook* (pp. 1
dria, VA: American Association for Counseling and Development.
Erickson, S.H.. Ethics and confidentiality in AIDS counseling. A professional dil
Mental Health Counseling, 15(2), 118–31.
Evans, D.R., & Hearn, M.T. (1997). Sexual and non-sexual dual relationships: Ma
aries. In D. R. Evans (Ed.), *The law, standards of practice, and ethics in th*
chology (pp. 53–84). Toronto, Canada: Emond Montgomery Publications, Lt
Everstein, L., Everstine, D.S., Heymann, G.M., True, R.H., Frey, D.H., Johnson
R.H. (1995). Privacy and confidentiality in psychotherapy. In D.N. Bersoff (
flicts in psychology (pp. 151–155). Washington, DC: American Psychologica
Falicov, C.J. (1982). Mexican families. In M. McGoldrick, J.K.Pearce, & J. Gio
nicity and family therapy (pp. 134–163). New York: Guilford Press.
Family Educational Rights and Privacy Act of 1974, 20 U.S.C., sec. 1232(g), (Buc
Farber, B.A. (1983). *Stress and burnout in the human service professions.* New Yorl
Finney, M., & Mitroff, I. (1986). Strategic planning failures: The organization as its
In H.S. Sims (Ed.), *The thinking organization* (pp. 317–335). San Francisco:
Fischer, J. (1993). Empirically based practice: The end of ideology? *Journal*
Research, 18(1/2), 19–64.
Forester-Miller, H., & Davis, T.E. (1995). *A practitioner's guide to ethical decisio*
dria, VA: American Counseling Association.
Freudenberger, H., & Richelson, G. (1980). *Burn-out: How to beat the high co*
York: Doubleday.
Godkin v. Miller, 379 F. Supp. 859 (ED N.Y. 1974), aff'd, 514 F 2d 123 (2d Cir.1
Gorey, K. (1996). Effectiveness of social work intervention research: Internal ver
ations. *Social Work Research,* 20, 119–128.
Goss v. Lopez, 419 U.S. 565 (1975).
Gottlieb, A. (1993). Avoiding exploitive dual relations: A decision-making mod
40, 41–47.
Greenspan, M. (1995, July-August). Out of bounds. *Common Boundary,* 51–56.
Grimm, D.W., (1994). Therapist, spiritual and religious values in psychotherap
Values, 38(3), 154–164.

Gutheil, T. G. (1989, Nov./Dec.). Patient-therapist sexual relations. *The Californi*

Gutheil, T.G., & Gabbard, G.O. (1993). The concept of boundaries in clinical p and risk-management dimensions. *American Journal of Psychiatry, 150*(2),

Guy, J.D. (1987). *The personal life of the psychotherapists.* New York: Wiley.

Haas, L.J., & Cummings, N.A. (1991). Managed outpatient mental health plans: practical guidelines for participation. *Professional Psychology: Research c* 45–51.

Haas, L.J., & Cummings, N.A. (1995). Managed outpatient mental health plans: practical guidelines for participation. In D.N. Bersoff (Ed.), *Ethical conf* Washington, DC: American Psychological Association.

Haas, L.J., & Malouf, J.L. (1989). *Keeping up the good work: A practitioner's gu ethics*. Sarasota, FL: Professional Resource Exchange.

Hackney, H. & Cormier, L.S. (1991). *Counseling strategies and intervention.* Allyn and Bacon.

Hammer v. Rosen, 165 N.E. 2d 756 (1960).

Handelsman, M.M., & Galvin, M.D. (1995) Facilitating informed consent for ou apy: A suggest written format. In D.N. Bersoff (Ed.), *Ethical conflicts in ps* ton, DC: American Psychological Association.

Handelsman, M.M., Kemper, M.B., Kesson-Craig, P., McLain, J., & Johnsrud, C tent and readability of written informed consent forms of treatment. *Profes Research and Practice, 17*, 514–518.

Hare-Mustin, R.T., Marecek, J., Kaplan, A.G. & Liss-Levinson, N. (1995). Right sibilities of therapists. In D.N. Bersoff (Ed.), *Ethical conflicts in psychol* Washington, DC: American Psychological Association.

Hedges, L.E. (1993 May-June). In praise of dual relationship, part I. *The Californi*

Hedlund v. Superior Court of Orange County, 669, P.2d41, 191 Cal.Rptr. 805 (1

Hendrix, D. H. (1991). Ethics and intrafamily confidentiality in counseling with *Mental Health Counseling*, 13, 323–333.

Herlihy, B., & Corey, G. (1996). *ACA ethical standards casebook* (5th ed.). Alex ican Counseling Association.

Herlihy, B., & Corey, G. (1997). *Boundary issues in counseling: Multiple roles a* Alexandria, VA: American Counseling Association.

Herlihy, B. & Sheeley, V.L. (1988). Counselor liability and the duty to warn: Sele trends and implication for practice. *Counselor Education and Supervision, 2*

Hill, M., Glaser, K., & Harden, J. (1995) *A feminist model for ethical decision m* Guilford Press.

Hipp, M.L., Atkinson, C., & Pelc, R. (1994). *Colorado Psychological Association* Denver, CO: Colorado Psychological Association.

Hodgkinson v. Simms (1994). 117 DLR (4th) 161.

Holub, E.A. & Lee, S.S. (1990). *The counselor and the law* (3rd ed.). Alexand Counseling Association Press.

Hopkins, B.H., & Anderson, B.S. (1990). *The counselor and the law* (3rd ed.) American Counseling Association Press.

Horack v. Bris, 474 N.E. 2d13 (1985).

International Association for the Right to Effective Treatment. (1996). The IARE losophy. *IARET Newsletter, 7*(1), 3.

Ivey, A.E., Bradford-Ivey, M., & Simek-Morgan, L. (1993). *Counseling and psyc ticultural perspective* (3rd ed.). Boston: Allyn and Bacon.

Jablonski v. United States, 712 F.2d 391 (9th Cir., 1983).

Jacob-Timm, S & Hartshorne, T.S. (1998). *Ethics and law for school psychologi* York: John Wiley and Sons.

Jaffe v. Redmond et al., WL 315841 (U.S. June 13, 1996).

Jeffrey, T.B., Rankin, R.J., & Jeffrey, L.K. (1992). In service of two masters: dilemma faced by military psychologists. *Professional Psychology: Researc* 91–95.

Kalischman, S.C., & Brosig, C.L. (1993). The effects of statutory requirements ment reporting: A comparison of two states. *American Journal of Ortho* 284-297.

Kalischman, S.C., & Craig, M.E. (1991). Professional psychologists' decision t child abuse: Clinician and situation influences. *Professional Psychology: Re tice*, 22(1), 84-89.

Keith-Spiegel, P., & Koocher, G. (1985). *Ethics in psychology: Professional sta* New York: Random House

Kitchener, K.S. (1984). Intuition, critical evaluation and ethical principles: The f cal decisions in counseling psychology. *Counseling Psychologist*, 12, 43–55.

Kitchener, K.S. (1986). Teaching applied ethics in counselor education: An inte logical processes and philosophical analysis. *Journal of Counseling and* 306–310.

Klerman, G.L. (1990). The psychiatric patient's right to effective treatment: Implic *v. Chestnut Lodge. American Journal of Psychiatry, 147*, 409–418.

Knapp, S. (1998). Cultural awareness and competence. *The Pennsylvania Psy* April 7.

Knapp, S., & VandeCreek, L. (1983). Privileged communications and the counse *Guidance Journal, 62*, 83–85.

Kuh, G.D., & Whitt, E.J. (1988). The invisible tapestry: Culture in American coll ties. *AAHE-ERIC/ Higher Education Report, No. 1.* Washington, DC: Americ Higher Education.

Kurpius, D.J. (1985). Consultation interventions: Successes, failures and proposal *Psychologists, 13*, 368–389.

Kurpius, D.J. (1997). *Current ethical issues in the practice of psychology.* The series, Vol. 10. (pp. 1-16). New York: Hatherleigh Press.

Kutchins, H. (1991). The fiduciary relationship: The legal basis for social workers' clients. *Social Work, 36*, 106–113.

Lazarus, A. (1989). *The practice of multimodal therapy* (2). Baltimore: John Hopkin

Langwell, K.M. (1992). The effects of managed care on use and costs of health ser orandum). Washington, DC: Congressional Budget Office.

Lerman, H. & Rigby, B. (1994). Boundary violations: Misuse of the power of the t man & N. Porter (Eds.), *Feminist ethics in psychotherapy* (pp. 51–59). New

Lowenberg, F., & Dolgoff R. (1988). *Ethical decisions for social work practice* (3 F.E. Peacock Publishers.

Lewis, G.J., Greenburg, S.L., & Hatch, D.B. (1988). Peer consultation groups for p vate practice: A national survey. *Professional Psychology: Research and Prac*

Lipari v. Sears, Roebuck & Co., 497 F.Supp. 185 (D.Neb. 1980).

MacDonald, G., Sheldon, B., & Gillespie, J. (1992). Contemporary studies of t social work. British Journal of Social Work, 2, 615–643.

M.(K.) v. M.(H.), (1992), 96 DLR (4th) 289.

Mazza v. Huffaker, 300 S.E. 2d 833, (1983).

McGuire, J., Nieri, D., Abbott, D., Sheridan, K., & Fisher, R. (1995). Do *Taraso* AIDS-related psychotherapy? Ethical decision making and the role of ther and perceived client dangerousness. *Professional Psychology: Research* 608–611.

McInerney v. MacDonald (1992), 93 DLR (4th) 415.

Merluzzi, T., & Brischetto, C. (1983). Breach of confidentiality and perceive counselors. *Journal of Counseling Psychology, 30*, 245–251.

Miller, D., & Thelen, M. (1986). Knowledge and beliefs about confidentialit *Professional Psychology: Research and Practice, 17*, 15–19.

Miller, I. (1996). Ethical and liability issues concerning invisible rationing. *Profe Research and Practice, 27* (6), 583–587.

Nally v. Grace Community Church, 47 Cal.3d 378 (1988).

National Association of Social Workers. (1996). *Code of ethics*. Washington, D

Newman, J.L. (1993). Ethical issues in consultation. *Journal of Counseling a* 148–156.

Newman, R., & Bricklin, P.M. (1991). Parameters of managed mental health car professional guidelines. *Professional Psychology: Research and Practice,*

Norberg v. Wynrib (1992), 92 DLR (4th) 449.

Olarte, S.W. (1997). Sexual boundary violations. In *The Hatherleigh guide* (pp. 195–209). New York: Hatherleigh Press.

Owebm G. (1982). Ethics of intervention for change. *Australian Psychologist, 2*

Parsons, R.D. (1996). *The skilled consultant*. Boston: Allyn and Bacon.

Parsons, R.D. (1995). *The skills of helping*. Boston: Allyn and Bacon

Parsons, R. (1985). The counseling relationship. In R. Wicks, R. Parsons, D. C *handbook of pastoral counseling*. Mahwah, NJ: Paulist.

Peck v. Counseling Services of Addison County, 499 A.2d422(VT 1985).

Pepper-Smith, R. Harvey, W.R., Silberfeld, M., Stein, E. & Rutman, D. (1992) tency assessment. *International Journal of Law and Psychiatry, 15*, 13-23.

Peters, M., & Robinson, V. (1984). The origins and status of Action Research. *Th Behavioral Science, 20*(2), 113-124.

Peterson, M.R. (1992). *At personal risk: Boundary violations in professional-* New York: W.W. Norton

Pryzwansky, W.B. (1993). Ethical consultation practice. In J.E. Zins, T.R. I Elliot (Eds.), *Handbook of consultation services for children* (pp. 329–3 Jossey-Bass.

Pope, K.S., Tabachnick, B.G., & Keith-Spiegel, P. (1987). Ethics of practice: Th iors of psychologists as therapists. *American Psychologist*, 42(11), 993–10

Pope, K., & Vasquez, M.J.T. (1991). *Ethics in psychotherapy and counseling*. S Bass.

Reamer, F.G. (1997). Managing ethics under managed care. *Families in Society*

Reamer, F.G. (1990). *Ethical dilemmas in social service* (2nd ed). Columbia Un

Reaves, R.P., & Ogloff, J.R.P. (1996). Liability for professional misconduct DeMers, J.R.P. Ogloff, C. Peterson, J.L. Pettifor, R.P.Reaves, T.Retfalvi, clair, & R.M.Tipton (Eds.), *Professional conduct and discipline in psyc* Washington, DC: American Psychological Association.

Remley, T.P., Jr. (1996). The relationship between law and ethics. In B. Herlihy *ACA ethical standards casebook* (5th ed.; pp. 285–292). Alexandria, VA: A Association.

Richardson, B.I. (1992). Utilizing the resources of the African American Church: S seling professionals. In C.C. Lee & B.L. Richardson (Eds.). *Multicultural is new approaches to diversity.* Alexandria, VA: American Counseling Associ

Russell Sage Foundation. (1970). *Guidelines for the collection maintenance an pupil records.* Hartford, CN: Russell Sage Foundation.

Salgo v. Leland Stanford Jr. Board of Trustees, 317P.2nd 170 (1957).

Salo, M. & Schumate, S. (1993). *Counseling minor clients.* Alexandria, VA: Amer selor Association.

Sanderson, W.C., & Woody, S. (1995). Manuals for empirically validated treatme Task Force on Psychological Interventions, Division of Clinical Psycholo chological Association. *Clinical Psychologist, 48(4)*, 7–11.

Schaffer, S.J. (1997). Don't be aloof about record-keeping; it may be your best liab *National Psychologist,* 6(1), 21.

Schein, E. H. (1990). Organizational culture. *American Psychologist, 45*, 109–11

Schein, E. H. (1991). Process consultation. *Consulting Psychology Bulletin, 45*, 1

Schlesinger, M. (1995). Ethical issues in policy advocacy. *Health Affairs, 14*, 23-

Schmidt, J.J. (1991). *A survival guide for the elementary/middle school counselor* The Center for Applied Research in Education.

Schutz, B.M. (1982). *Legal liability in psychotherapy: A practitioner's guide to* San Francisco, CA: Jossey-Bass.

Schwitzebel, R.L., & Schwitzgebel, R.K. (1980). *Law and psychological practic* Wiley and Sons.

Seppa, N. (1996, August). Supreme court protects patient-therapist privile *27*(8), 39.

Sexton, T.L., Whisten, S.C., Bleuer, J.C., & Walz, G.R. (1997). *Integrating outc counseling practice and training.* Alexandria, VA: American Counseling As

Shani, A.B. (1990). Solving problems bureaucracies cannot handle. In G. Busl (Eds.), *Parallel learning structures.* Reading, MA: Addison-Wesley.

Shore, M. (1996, January). Impact of managed care. *New England Journal of Me*

Simon, R.I. (1992a). *Clinical psychiatry and the law* (2nd ed.). Washington, DC: atric Press.

Simon, R.I. (1992b). *Concise guide to psychiatry and the law for clinicians.* Wash ican Psychiatry Press.

Skorupa, J., & Agresti, A.A. (1993). Ethical beliefs about burnout and continued tice. *Professional Psychology: Research and Practice, 24*(3), 281–285.

Smith, D., & Fitzpatrick, M. (1995). Patient-therapist boundary issues: An integra ory and research. *Professional Psychology: Research and Practice, 26*(5), 4

Smith v. Seilby, 72 Wash.2nd 16 (1967).

Snider, P.D. (1987). Client records: Inexpensive liability protection for mental *Journal of Mental Health Counseling*, 9, 134–141.

Speight, S.L., Myers, L.J., Cox, C.I., & Highlen, P.S. (1991). A redefinition of r seling. *Journal of Counseling & Development, 70*, 29–36.

St. Germaine, J. (1993). Dual relationships: What's wrong with them? *American C*

Stadler, H.A. (1990). Counselor impairment. In B. Herlihy & L.B. Golden (Eds.), *dards casebook* (4th ed.; pp. 102–110). Alexandria, VA: American Associat and Development.

Stake, J.E. & Oliver, J. (1991). Sexual contact and touching between therapist a of psychologists' attitudes and behaviors. *Professional Psychology: Resec* 22(4), 297-307.

Stanley, B. (1987). Informed consent in treatment and research. In I.B. Weiner *Handbook of forensic psychology* (pp. 63–85). New York: Wiley.

Strasburger, L.H., Jorgenson, L., & Sutherland, P. (1992). The prevention of ps misconduct: Avoiding the slippery slope. *American Journal of Psychother*

Stromberg, D., Stone, G., & Claiborn, C. (1993). Informed consent: Therapists' k Professional Psychology: Research and Practice, 24, 153–159.

Stromberg, C., and his colleagues in the Law Firm of Hogan & Hartson of Was April). Privacy, confidentiality and privilege. *The psychologist's legal upda* National Register of Health Service Providers in Psychology.

Sue, D.W., Arrendondo, P., & McDavis, R. (1992). Multicultural counseling cor dards: A call to the profession. *Journal of Counseling & Development, 70,*

Sue, D.W., Ivey, A.E., & Pedersen, P.B. (1996). *A theory of multicultural cour* Pacific Grove, CA: Brooks/Cole

Sue, S., & Morishma, J.K.(1982). *The mental health of Asian-Americans.* San Fra

Sue, D.W. & Sue, D. (1990). *Counseling the culturally different* (2nd ed.). New Y Sons.

Sullivan, T., Martin, W., & Handelsman, M. (1993). Practical benefits of an inf cedure: An empirical investigation. *Professional Psychology: Research* 160–163.

Tarasof v. The Regents of the University of California, 551 P.2d 334 (Cal.Sup.C

Task Force on Promotion and Dissemination of Psychological Procedures. (19 dissemination of empirically-validated psychological treatments: Report an *Clinical Psychologist, 48*(1), 3–23.

Tepper, A.M. & Knapp, S.(1999, February). Pennsylvania recognizes an affirm third party victims. *The Pennsylvania Psychologists Quarterly.*

Thomason, T.C. (1993). Counseling Native Americans: An introduction for non In D.R. Atkinson, G. Morten, & D.W. Sue (Eds.). *Counseling American min tural perspective* (pp. 171–187). Dubuque, IA: Wm. C. Brown.

Thomson, A. (1990). *Guide to ethical practice in psychotherapy.* New York: Jol

Thoreson, R.W., Shaughnessy, P., Heppner, P.P., & Cook, S.W. (1993). Sexual after professional relationship: Attitudes and practices of male counselors. *ing and Development, 71,* 429–434.

Thyer, B.A. (1996). Forty years of progress toward empirical clinical prac *Research, 20,* 77–81.

Tomm, K. (1991, winter). The ethics of dual relationships. *The Calgary Particip*

Totten, G., Lamb, D.H., & Reeder, G.D. (1990). *Tarasoff* and confidentiality in chotherapy. *Professional Psychology: Research and Practice, 21*(3), 155–1

Treppa, J.A. (1998). A practitioner's guide to ethical decision-making. In R.I Needels, & H.V. Hall (Eds.), *Avoiding ethical misconduct in psychology s* 26–41.), Springfield, IL: Charles C. Thomas.

Truax, C.B., & Carkhuff, R.R. (1965). The experimental manipulation of ther *Journal of Consulting Psychology, 29,* 119–224.

Tutty, L. (1990). The response of community mental health professionals to clien and suggestions. *Canadian Journal of Community Mental Health, 9*(1), 1–2

Valentich, M., & Gripton, J. (1992). Dual relationships: Dilemmas and doubts. *C Human Sexuality, 1,* 155–166.

Van Maanen, J., & Barley, S.R. (1985). Cultural organization: Fragments of a the Moore, M. Louis, C. Lundberg, & J. Martin (Eds.), *Organizational culture* (p Hills, CA: Sage.

Vesper, J.H., & Brock, G. (1991). *Ethics, legalities and professional practice issue family therapy.* Boston: Allyn and Bacon.

Viederman, M. (1991). The real person of the analyst and his role in the process cure. *Journal of the American Psychoanalysis Association, 39*, 451–489.

Wigmore, J.H. (1961) Evidence in trials at common law. In J.T. McNaughton (Ed.), (Vol 8, rev.ed.). Boston: Little, Brown.

Wilson v. Corbin, 41 N.W., d.702 (1985).

Winick, B.J. (1991). Competence to consent to treatment: The distinction between tion. In D. B. Wexler & B.J. Winick (Eds.), *Essays in therapeutic jurisprud* Durham, NC: Carolina Academic Press.

Woody, R.H. (1997). *Legally safe mental health practice: Psycholegal questions an* son, CT: Psychosocial Press.

Younggren, J.N. (1993). Ethical issues in religious psychotherapy. *Register Repor*

APPENDIX A

Professional Organizations

American Counseling Association (ACA), 5999 Stevenson Avenue, Al 22304-3300.

National Board of Certified Counselors (NBCC), 3-D Terrace Way, Gr 27403.

American Psychological Association (APA), 750 First Street, N.E., Wa 20002-4242

American Board of Professional Psychology (ABPP), 2100 East Broadwa Columbia, MD 65201

American Association for Marriage and Family Therapy (AAMFT), 110 Washington, DC 20036-4601.

National Association for Social Work (NASW), 750 First Street N.E., Sui ington, DC 20002-4241.

APPENDIX B

Codes of Ethics and Standards of Professional Practice

Within the body of this text, specific sections of the most recent versions
Ethics for (1) the American Counseling Association, (2) the American Psyc
ciation, (3) the American Association of Marriage and Family Therapis
National Association of Social Workers have been identified. However, as
out the text, professional codes of ethics evolve in response to contempora
that profession. Thus, Appendix B includes the Introduction/Preambles for
professional associations discussed throughout the text along with web sit
the full codes and standards. The reader is directed to the listed web sites f
professional groups to receive the current Standards of Practice and Codes

American Counseling Association Code of Ethics and Standards of Practice

Preamble

The American Counseling Association is an educational, scientific, and p
nization whose members are dedicated to the enhancement of human deve
out the life-span. Association members recognize diversity in our socie
crosscultural approach in support of the worth, dignity, potential, and u
individual.

The specification of a code of ethics enables the association to clar
future members, and to those served by members, the nature of the ethic
held in common by its members. As the code of ethics of the associati
establishes principles that define the ethical behavior of association meml
of the American Counseling Association are required to adhere to the C
Standards of Practice. The Code of Ethics will serve as the basis for proce
plaints initiated against members of the association.

Online: http://www.counseling.org/resources/codeofethics.htm

American Psychological Association Ethical Principles of Psychologists and Code of Conduct

Preamble

Psychologists work to develop a valid and reliable body of scientific knov research. They may apply that knowledge to human behavior in a variety doing so, they perform many roles, such as researcher, educator, diagnost supervisor, consultant, administrator, social interventionist, and expert wit is to broaden knowledge of behavior and, where appropriate, to apply it p improve the condition of both the individual and society. Psychologists res importance of freedom of inquiry and expression in research, teaching, a They also strive to help the public in developing informed judgments ar cerning human behavior. This Ethics Code provides a common set of val psychologists build their professional and scientific work.

This Code is intended to provide both the general principles and the c cover most situations encountered by psychologists. It has as its primary g and protection of the individuals and groups with whom psychologists wo vidual responsibility of each psychologist to aspire to the highest possible st duct. Psychologists respect and protect human and civil rights, and do participate in or condone unfair discriminatory practices.

The development of a dynamic set of ethical standards for a psych related conduct requires a personal commitment to a lifelong effort to a encourage ethical behavior by students, supervisees, employees, and colle priate; and to consult with others, as needed, concerning ethical problems. gist supplements, but does not violate, the Ethics Code's values and rules guidance drawn from personal values, culture, and experience.

Online: http://www.apa.org/ethics/code.htm

American Association for Marriage and Family Therapy Code of Ethics

The Board of Directors of the American Association for Marriage anc (AAMFT) hereby promulgates, pursuant to Article 2, Section 2.013 for Bylaws, the Revised AAMFT Code of Ethics, effective July 1, 1998. T of Ethics is binding on Members of AAMFT in all membership cat Approved Supervisors, and applicants for membership and the Approve ignation (hereafter AAMFT Member). If an AAMFT Member resigns in during the course of an ethics investigation, the Ethics Committee will c tigation. Any publication of action taken by the Association will includ Member attempted to resign during the investigation. Marriage and fan strongly encouraged to report alleged unethical behavior of colleagues t fessional associations and state regulatory bodies.

Online: http://www.aamft.org/about/ethics.htm

National Association of Social Workers Code of Ethics

Preamble

The primary mission of social work profession is the enhance human we meet the basic human needs of all people, with particular attention to the ne erment of people who are vulnerable, oppressed, and living in poverty defining feature of social work is the profession's focus on individual well context and the well-being of society. Fundamental to social work is atte ronmental force that create, contribute to, and address problems in living.

Social workers promote social justice and social change with and on "Clients" is used inclusively to refer to individuals, families, groups, o communities. Social workers are sensitive to cultural and ethnic diversity discrimination, oppression, poverty, and other forms of social injustice. may be in the form of direct practice, community organizing, supervisi administration, advocacy, social and political action, policy development tion, education, and research and evaluation. Social workers seek to enh of people to address their own needs. Social workers also seek to promot ness of organizations, communities, and other social institutions to indivi social problems.

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

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

This constellation of core values reflects what is unique to the social Core values, and the principles that flow from them, must be balanced w and complexity of the human experience.

National Association of Social Workers
Purpose of the Code of Ethics

Professional ethics are at the core of social work. The profession has an c
ulate its basic values, ethical principles, and ethical standards. The *NAS*
sets forth these values, principles, and standards to guide the social worl

The *Code* is relevant to all social workers and social worker stud
their functions, the settings in which they work, or the populations they

The *NASW Code of Ethics* serve six purposes:

The *Code* identifies core values on which social work's mission is

The *Code* summarizes broad ethical principles that reflect the pro
ues and establish a set of specific ethical standards that should be u
work practice.

The *Code* is designed to help social workers identify relevant co
professional obligations conflict or ethical uncertainties arise.

The *Code* provides ethical standards to which the general public c
work profession accountable.

The *Code* socializes practitioners new to the field to social work'
ethical principles, and ethical standards.

The *Code* articulates standards that the social work profession itsel
whether social workers have engaged in unethical conduct. NASW
cedures to adjudicate ethics complaints filed against its members.[1]
this *Code*, social workers are required to cooperate in its implemen
in NASW adjudication proceedings, and abide by any NASW disc
sanctions based on it.

The *Code* offers a set of values, principles, and standards to guide
and conduct when ethical issues arise. It does not provide a set of rules t
social workers should act in all situations. Specific applications of the *Co*
account the context that is being considered and the possibility of co
Code's values, principles, and standards. Ethical responsibilities flow fro
tionships, from the personal and familial to the social and professional.

Further, the *NASW Code of Ethics* does not specify which value
standards are most important and ought to outweigh others in instances w
Reasonable differences of opinion can and do exist among social worke
the ways in which values, ethical principles, and ethical standards sho
when they conflict. Ethical decision making is a process. There are n
social work where simple answers are not available to resolve compl
Social workers should take into consideration all the values, principles,

[1]For information on NASW adjudication procedures, see *NASW Procedures for Grievances.*

this *Code* that are relevant to any situation in which ethical judgment is w
workers' decisions and actions should be consistent with the spirit as wel
this *Code*.

In addition to this *Code*, there are many other sources of informati
thinking that may be useful. Social workers should consider ethical theor
generally, social work theory and research, laws, regulations, agency polici
evant codes of ethics, recognizing that among codes of ethics social worl
sider the *NASW Code Ethics* as their primary source. Social workers also
of the impact on ethical decision making of their clients' and their own per
cultural and religious beliefs and practices. They should be aware of any c
personal and professional values and deal with them responsibly. For add
social workers should consult the relevant literature on professional ethics
sion making and seek appropriate consultation when faced with ethical dile
involve consultation with an agency-based or social work organization's e
a regulatory body, knowledgeable colleagues, supervisors, or legal counse

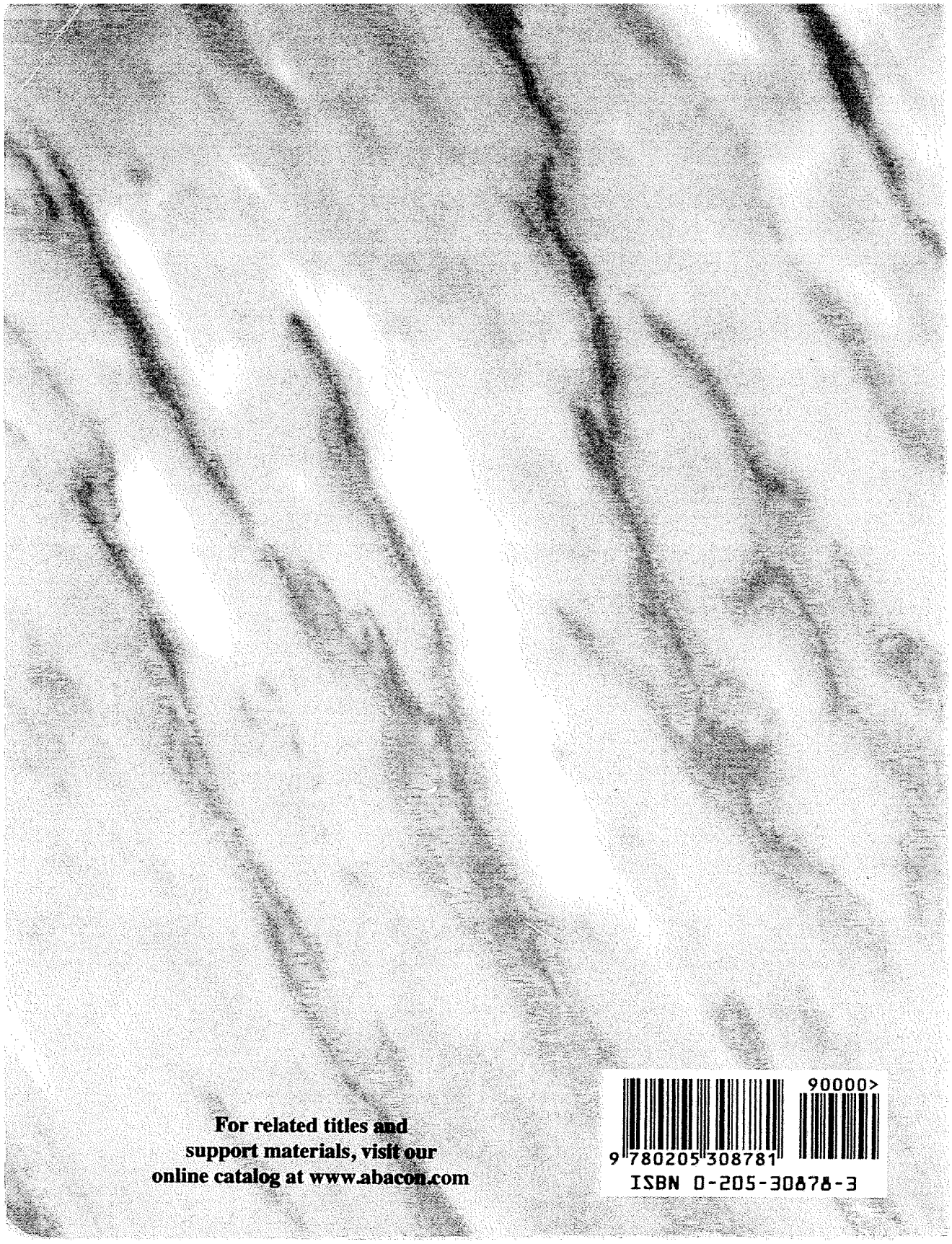
Instances may arise when social workers' ethical obligations conf
policies or relevant laws or regulations. When such conflicts occur, soci
make a responsible effort to resolve the conflict in a manner that is cor
values, principles, and standards expressed in this *Code*. If a reasonable
conflict does not appear possible, social workers should seek proper cor
making a decision.

The *NASW Code of Ethics* is to be used by NASW and by individuals
nizations, and bodies (such as licensing and regulatory boards, profession
ance providers, courts of law, agency boards or directors, government ag
professional groups) that choose to adopt it or use it as a frame of refere
standards in this Code does not automatically imply legal liability or viol
Such determination can only be made in the context of legal and judic
Alleged violations of the *Code* would be subject to a peer review process
are generally separate from legal or administrative procedures and insu
review or administrative procedures and insulated from legal review o
allow the profession to counsel and discipline its own members.

A code of ethics cannot guarantee ethical behavior. Moreover, a co
not resolve all ethical issues or disputes or capture the richness and compl
striving to make responsible choices within a moral community. Rather,
sets forth values, ethical principles, and ethical standards to which profess
by which their actions can be judged. Social workers' ethical behavior sh
their personal commitment to engage in ethical practice. The *NASW Code*
the commitment of all social workers to uphold the profession's values an
Principles and standards must be applied by individuals of good chara
moral questions and, in good faith, seek to make reliable ethical judgmen

Online: http//www.naswdc.org/code.htm

INDEX



For related titles and support materials, visit our online catalog at www.abacon.com

9 780205 308781 90000>
ISBN 0-205-30878-3