

PART I

Professional and Scientific Issues

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CHAPTER 1*Legal and Ethical Issues Affecting Counseling Psychologists*

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Many ethical and legal developments have affected the practice, research, and education of counseling psychologists since Kitchener and Anderson's (2000) chapter was written for the previous edition of the *Handbook*. Most notably, the American Psychological Association (APA, 2002) revised its Ethical Principles of Psychologists and Code of Conduct (Ethics Code). In addition, the implications of laws such as the Health Insurance Portability and Accountability Act (HIPAA) are significant. Further, such professional issues as competence and impairment have received widespread attention in psychology. This chapter provides an overview of a selected set of legal and ethical issues currently affecting counseling psychologists. We focus primarily on developments since the previous edition of the *Handbook*, but for the sake of comprehensiveness, we include reviews of areas that have continuing relevance.

We first discuss fundamental risk management considerations that psychologists or trainees should keep in mind regardless of their specific situation. Next there are two major sections, each with several subcomponents. Because of the significant energy invested in examining and defining professional competence, we highlight the movement to define competencies, issues related to professionals or students with competence problems, and self-care. We then review several potentially challenging ethical situations: (a) dealing with conflicts between professional ethics and the demands of employers, (b) fulfilling the duty to protect, (c) protecting the integrity of the assessment process, and (d) conducting action research and examining socially sensitive topics. However, although it is also important to consider the ethical and legal implications of recent advances in online therapy, assessment, and research, we do not include these activities here because they are discussed by Gore and Leuwerke (Chapter 3, this volume).

Because there are comprehensive sources that detail the revisions to the APA's (2002) new Ethics Code and the rationale for these revisions (e.g., Fisher, 2003; Knapp & VandeCreek, 2003), we do not discuss them here. However, we do want to note that several leading ethicists in counseling psychology contributed material that helped shape the current version of the Ethics Code, especially its aspirational General Principles. For example, although credit is rightfully given to Beauchamp and Childress (1979) for initially articulating the ethical metaprinciples of autonomy, beneficence, nonmaleficence, and justice, it was Karen Kitchener who, in a 1984 article in *The Counseling Psychologist (TCP)*, brought the metaprinciples into psychology. Ideas present in Meara, Schmidt, and Day's (1996) *TCP* article on virtue ethics also are evident in the General Principles. Thus, counseling psychologists have played an important role in the conceptualization of psychology's ethical theory and practice.

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RISK MANAGEMENT

No chapter on ethical and legal issues would be complete without a discussion of informed consent, documentation, consultation, and the use of an ethical decision-making model. Keeping these considerations in mind and following the suggestions in this chapter can help not only to protect the psychologist or trainee but to maximize the likelihood that the client, evaluatee, or research participant receives the best possible treatment. Because most of the discussion has revolved around the relevance of these aspects to providing psychotherapy, we focus on this professional activity in the following discussion, but the points raised are just as relevant in other situations.

Informed Consent

One of the most essential things psychologists and graduate students can do to reduce the possibility of having ethical or legal charges filed against them is to provide thorough informed consent to clients (and their guardian(s) if the client is unable legally to make decisions for her- or himself). The importance of informed consent is underscored throughout the new APA (2002) Ethics Code. What to include in informed consent can be found in the Ethics Code as well as in commentaries on the code (e.g., Fisher, 2003), state regulations, and journal articles (e.g., Pomerantz & Handelsman, 2004; Talbert & Pipes, 1988). Informed consent should be seen as a process, instead of a one-time event at the outset of counseling, research, or assessment. Information should be provided and revisited when the context indicates it may be especially relevant (e.g., when discussing potential harm to self, others, or vulnerable persons). Not only does this approach assist individuals in making choices in the present, it also reduces the likelihood of future problems because people will have received information to help them make decisions about whether to participate or what to disclose during participation.

Although there are options for ways to discuss informed consent and what to include in these discussions, there also may be legal constraints related to managed care, state statutes, and federal laws such as HIPAA. For example, because of the current federal law related to disclosure of sexual orientation in the military ("Don't Ask, Don't Tell") and the fact that commanding officers may have access to mental health records, military psychologists must provide specific, ongoing informed consent with their clients regarding limits to confidentiality, what will be documented in mental health records, and other important information that could potentially affect a client's career (Johnson & Buhrke, 2006). Similarly, informed consent can be complicated when a psychologist is conducting an evaluation for a court. In these situations, informed consent related to the suitability and limitations of a given assessment tool, the implications of using the evaluation in the case, and alternative ways to gain the same data is essential for the defendant and defense counsel to understand, regardless of whether the psychologist was retained by the prosecution or the defense (Cunningham, 2006).

Further, given the proliferation of television and radio shows and Internet websites related to counseling, the public may have misconceptions about what will happen during therapy or assessment situations. In addition, clients may have drawn conclusions about their presenting concerns, have attempted to self-diagnose, or may have been exposed to inaccurate information about specific treatment approaches. It thus behooves psychologists to be proactive in providing information as well as in considering whether to give clients a set of questions they may want to ask, such as was developed by Pomerantz and Handelsman (2004).

Documentation

Several developments have underscored the crucial role of documentation. In particular, the APA (1993) has developed guidelines for record keeping; there is discussion of documentation in regulations and laws; and there is evidence of its role in judicial decision making in cases involving psychologists'

provision of services (e.g., Soisson, VandeCreek, & Knapp, 1987). An illustration of how much more complicated record keeping has become in the past decade is that the APA recently finished revising its official record-keeping guidelines, and the new ones are several times longer than the earlier version. The old saying, “if it isn’t written down, it didn’t happen,” may appear trite, but a complete, contemporaneous record is the psychologist’s or trainee’s best defense if something bad happens. By documenting what they did and why, and what they did not do and why not, professionals or students can demonstrate the thoroughness of their decision making.

A related issue is when notes and other documentation related to counseling can be released to other people. The passage of HIPAA has alleviated some of the concern about access to records. Specifically, a provision in this law allows for process notes to be kept in a separate part of a client’s file and, therefore, to be inaccessible to managed care companies. The law states that companies cannot demand to see psychotherapy notes to authorize or pay for services. Under HIPAA, clients do not have access to these notes; however, state law preempts HIPAA in situations that are more empowering of clients, so in some states, clients may gain access to their entire file. Even though HIPAA states that companies do not have access to psychotherapy notes, companies still may try to obtain them. A provider who allows an insurance company access to psychotherapy notes without the client’s consent is in violation of the law. Thus, therapists need to be familiar with all aspects of the law.

Consultation

Providing informed consent and keeping good records (including documenting the provision of informed consent) help show what one did with a client. A way to demonstrate that these actions were appropriate (met the “standard of care”) is to consult with other professionals and then document the consultants’ recommendations or the conclusions drawn from the consultation. By checking with someone else, providers demonstrate that decisions are based on more than just their own perceptions. This is especially important when values may be affecting clinical decisions, when there is a risk of possible harm to someone, and when the issues in the case are new to the provider. For example, if a practitioner working in a counseling center has a client who wants to address substance abuse issues and the provider has limited experience in this area, the practitioner should consult a colleague who is knowledgeable about substance abuse treatment to ensure that the client receives appropriate care. Consultation can also be helpful because each situation is context-dependent, and there may be few hard-and-fast rules for how to respond in a given situation. For instance, the cultural background of a client may significantly affect treatment planning or the course of counseling. Thus, practitioners should also consider consulting with others who have greater expertise working with clients from particular backgrounds.

Ethical Decision-Making Models

Because what psychologists and trainees have found effective or useful in the past when faced with a dilemma or difficult case may not apply in the present situation, it is imperative to consider the variety of issues that may affect responses to various situations (Barnett, Behnke, Rosenthal, & Koocher, 2007). Ethical decision-making models facilitate a comprehensive review of relevant considerations, and all models emphasize consultation, documentation, and informed consent. There are many such ethical decision-making models in the literature (e.g., Barret, Kitchener, & Burris, 2001; Hansen & Goldberg, 1999; for a review, see Cottone & Claus, 2000), including some that emphasize cultural factors (e.g., Garcia, Cartwright, Winston, & Borzuchowska, 2003).

Although there are several proposed models of ethical decision making, there are no data on how these models are used or how useful they are perceived to be. Cottone and Claus (2000) argued that this lack of empirical research indicates that the utility of these models is unknown. Thus, there is a need for research on how ethical dilemmas are actually resolved and what may interfere with the application of

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the published models (e.g., time pressure, lack of knowledge, fear of appearing incompetent, affective responses, practitioner biases). Until such data are collected, the primary value of the models may be in highlighting issues to take into account (and document, if necessary) when making decisions, especially when various ethical principles appear to be in conflict or when legal and ethical aspects seem incompatible (Knapp, Gottlieb, Berman, & Handelsman, 2007).

An Example of Risk Management

In closing this section, we briefly highlight the application of risk management to the assessment and treatment of suicidal clients as an example of how professionals can attempt to prevent negligence and maximize the likelihood of positive outcomes. Given that all practitioners will have a suicidal client at some point in their careers, psychologists and trainees can benefit from being aware of risk management strategies. However, following these suggestions does not guarantee that a suicide or lawsuit can be averted, but the recommendations should help in the event of a negative outcome.

As mentioned earlier, documentation, informed consent, and consultation are essential. In addition to these aspects, Packman, O'Connor Pennuto, Bongar, and Orthwein (2004) stated that to maximize adherence to risk management suggestions, psychologists should include procedures such as (a) knowing the risk factors for suicide; (b) obtaining risk assessment data throughout treatment (rather than only at an initial screening); (c) providing referrals when one is not competent to provide the care needed; (d) asking about historical information related to past suicide attempts and self-harming incidents, lethality of the attempts, and past suicidal ideation; (e) obtaining treatment records from previous treatment providers; (f) determining the diagnostic impression of the client; and (g) knowing one's legal and ethical responsibilities.

Berman (2006) offered even more specific recommendations, including (a) conducting risk assessments whenever the client's symptoms or circumstances change; (b) not relying on no-suicide contracts as the only means for intervention; (c) talking to family members when appropriate; (d) trying to limit access to the means for suicide; (e) collaborating with other professionals who are working with the client (e.g., psychiatrist, case manager, social worker); (f) asking about suicidal ideation and behaviors on a regular basis; (g) considering what circumstances could provoke suicidal behavior; and (h) conducting mental status exams at each session. Despite the reasonability of such risk management steps, it is notoriously difficult to predict suicide (see Westefeld, Range, Rogers, & Hill, Chapter 31, this volume).

In summary, a variety of issues should be addressed with all clients on an ongoing basis to ensure appropriate, ethical treatment. Although risk management may appear to involve many special strategies that psychologists and trainees should address, being thorough in the assessment and treatment of clients will help prevent professional negligence and increase the likelihood of providing appropriate treatment. Thus, we encourage psychologists and students to be aware of both the general and specific risk management strategies that apply in their specific areas of client care.

COMPETENCE

"Competency is generally understood to mean that a professional is qualified, capable, and able to understand and do certain things in an appropriate and effective manner" (Rodolfa et al., 2005, p. 348). There are several domains of competency, such as assessment and diagnosis. Because of the importance of these issues, we focus on the recent movement to define competencies, identifying and responding to persons with competence problems (both trainees and professionals), and promoting self-care as a way to develop and maintain competence. We envision that there will be continued emphasis on these areas; counseling psychology students and professionals will, therefore, want to remain aware of emerging developments.

Movement to Define Competencies

Concern about developing and defining student competence led the Association of Psychology Post-doctoral and Internship Centers (APPIC) to host a conference where participants broke into 10 work groups to develop state-of-the-art analyses of training in their respective areas of emphasis (Kaslow et al., 2004). Rodolfa et al. (2005) presented a “competency cube” that brings the various areas of emphasis together and shows their relationships. (A draft of benchmarks based on the competency cube can be viewed at <http://www.psychtrainingcouncils.org/pubs/Comptency%20Benchmarks.pdf>.) Three of these work groups appeared most relevant for this chapter: (a) ethical, legal, public policy/advocacy, and professional issues; (b) individual and cultural diversity; and (c) supervision. Consistent with counseling psychology’s core values, we consider multicultural competence to be a part of all the other aspects of competence as well as a competency area of its own.

Ethics Competence

de las Fuentes, Willmuth, and Yarrow (2005) summarized the efforts of the group “charged with addressing the identification, training, and assessment of the development of competence in ethics, legal, public policy, advocacy, and professional issues” (p. 362). The group reached consensus that psychologists and graduate students needed four abilities (p. 362):

1. to appraise and adopt or adapt one’s own ethical decision-making model and apply it with personal integrity and cultural competence in all aspects of professional activities;
2. to recognize ethical and legal dilemmas in the course of their professional activities (including the ability to determine whether a dilemma exists through research and consultation);
3. to recognize and reconcile conflicts among relevant codes and laws and to deal with convergence, divergence, and ambiguity; and
4. to raise and resolve ethical and legal issues appropriately.

The group also stated that trainees and professionals need knowledge and awareness of “the self in community as a moral individual and an ethical professional” (p. 362) and “the various professional ethical principles and codes; practice standards and guidelines; civil and criminal statutes; and regulations and case law relevant to the practice of psychology” (p. 363). The working group also maintained that, to facilitate ethics training, programs need to consider the student application/selection process and provide an environment that fosters ethical reflection and action (see Bashe, Anderson, Handelsman, & Klevansky, 2007, for ideas).

Multicultural Competence

Multicultural competence has received much attention over the past few years (e.g., see Constantine, Miville, & Kindaichi, Chapter 9, this volume). Multiculturalism emphasizes unique issues related to race, ethnicity, gender, sexual orientation, language, age, social class, disability, education, and religious and spiritual orientation that are specific to each individual (APA, 2003). Regarding multicultural competence, Sue, Arredondo, and McDavis (1992) stated that counselors must be aware of their biases, have an understanding of the worldview of their clients, and develop appropriate interventions for each client. As part of the APPIC competencies conference, the Individual and Cultural Differences work group focused on the first two components: (1) the counselors’ awareness of their own assumptions and values, and (2) knowledge of issues experienced by culturally diverse clients (Henderson, Roysircar, Abeles, & Boyd, 2004). These authors focused on diversity based on racial and ethnic background, age, and sexual orientation, and they provided examples of how these variables can affect a therapist’s perceptions and interventions.

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Multiculturalism and multicultural competence has become such an important topic that the APA (2003) developed guidelines for multicultural education, training, research, practice, and organizational change for psychologists. Moreover, counseling psychologists have emphasized the importance of understanding how their own privileges and biases influence their work in practice, research, advocacy, and training (e.g., Goodyear et al., 2000; Neimeyer & Diamond, 2001; Vera & Speight, 2003). Given the emphasis and importance that counseling psychology has placed on multiculturalism, it is essential that counseling psychologists and students become aware of multicultural competencies and their implications for appropriate and ethical practice.

Faculty and Supervisor Competence

Research about the competence of faculty and supervisors is limited. In fact, research is essentially nonexistent about the competent practice of faculty members. The American Association of University Professors (2006), however, has a statement on professional ethics that explicitly addresses the responsibility of university professors to develop and maintain their competence.

Some work has been devoted to discussing ethical practices and issues related to supervision (e.g., J. M. Bernard & Goodyear, 2004). Much of the literature about supervision competence has focused on the supervisee's experiences (e.g., Nelson & Friedlander, 2001). For example, Ladany, Lehrman-Waterman, Molinaro, and Wolgast (1999) examined supervisees' perceptions of their supervisors, focusing on adherence to ethical practices, the working alliance, and the satisfaction of the supervisees. Over half of the respondents reported that their supervisors had violated one or more ethical guidelines. The two most common violations related to (1) performance evaluation and monitoring of supervisee activities and (2) violation of confidentiality related to supervision. Greater nonadherence to ethical principles on the part of the supervisor was related to a weaker supervisory alliance and lower levels of supervisee satisfaction. In interpreting the findings, the authors noted that supervisors may be unaware of the ethical guidelines, as this is still a developing aspect of supervision. Thus, supervisors should consult the literature, agency policies, relevant ethical guidelines, and colleagues when determining how to provide ethical supervision.

Although no specific competencies about supervision have been approved, there was a work group on supervision at the APPIC Competencies Conference. Falender et al. (2004) developed a framework to begin defining supervision competencies. First, they argued that *knowledge* is an important element. This would include knowledge of ethical and legal issues related to supervision; the area in which one is supervising; diversity; the developmental process of supervisees; aspects of evaluation; and theories, models, and research related to supervision. The second competency, *skills*, includes competencies such as balancing multiple roles, being flexible, using science to inform practice, performing self-assessments, and promoting the growth of the supervisee. The third area, *values*, refers to such aspects as the supervisor being respectful and empowering, adhering to ethical principles, engaging in self-education, and remaining aware of one's expertise and limitations. The fourth competency reflects the *social contexts* in which supervision occurs; the authors argued that the supervisor must be aware of the environment and how it may influence the supervision relationship. The fifth competency consists of the *need to train supervisors* through coursework as well as supervision of supervision and other related experiences that allow a supervisor to develop appropriate skills and knowledge. Finally, the authors argued *supervisor competence should be assessed* to determine that a person meets the minimum qualifications to be an effective supervisor.

Persons with Competence Problems

The work on competence development overlaps with concern about assessing and responding to what traditionally has been called student and professional *impairment*, which has been defined as "any physical, emotional, or educational deficiency that interferes with the quality of the professional performance, education, or family life" (Boxley, Drew, & Rangel, 1986, p. 50); an inability or unwillingness

of the person to acquire and maintain professional standards, skills, and handle personal stress; and any clear pattern of behavior from the professional or supervisee that is harmful or deficient (e.g., Boxley et al., 1986; Forrest, Elman, Gizara, & Vacha-Haase, 1999; Gizara & Forrest, 2004). More recently, impairment has been referred to as “problematic students” or “trainees with competence problems” in discussions about training (e.g., Rosenberg, Getzelman, Arcinue, & Oren, 2005; L. Forrest, personal communication, September 2006) and providing “colleague assistance” to professionals. We discuss both student and professional competence problems in the following subsections.

Graduate Students with Competence Problems

Given the increased attention to competence and problems with competence, Johnson and Campbell (2002) argued that graduate programs need to begin to adopt some character (the honesty and integrity with which a person deals with others) and fitness (competence and ability) requirements to minimize the admittance of people who may experience competence problems in graduate school or afterward. They proposed six dimensions that they believe should be essential characteristics of all professional psychologists: (1) personality adjustment (open-mindedness, flexibility, and intellectual curiosity), (2) psychological stability, (3) responsible use of substances, (4) integrity (the person is incorruptible and would not perform actions for the wrong reasons), (5) prudence (being planful and appropriately cautious, exercising good judgment in decision making), and (6) caring (a pattern of respect and sensitivity to welfare and needs of others). There is some overlap between these components of character and fitness with virtue ethics (Meara et al., 1996). No information is available on the degree to which programs have actually used these ideas in admissions decisions.

It is not unusual for some students with problems to be admitted into a graduate program in counseling or clinical psychology. Although the data are limited, most programs deal frequently with at least one student who may have “competence problems” or is “impaired,” with a majority of programs appearing to dismiss at least one student over a 3-year period (Vacha-Haase, Davenport, & Kerewsky, 2004) because of any combination of the following issues: deficient interpersonal skills, supervision difficulties, personality disorders, emotional problems, academic dishonesty, and inadequate clinical skills (Oliver, Bernstein, Anderson, Blashfield, & Roberts, 2004). However, professionals who understand that they have a role as gatekeepers for the profession often report difficulties acknowledging or acting on issues surrounding trainee impairment (J. M. Bernard & Goodyear, 2004; Oliver et al., 2004).

Once a student is determined to be at risk of having competence problems or is unable to perform adequately, the issue becomes how to respond appropriately. Data indicate that students perceive faculty to be unwilling to deal with such situations (Oliver et al., 2004), and faculty indicate that they are concerned about striking a balance between helping the student and fulfilling their gatekeeping responsibilities (Vacha-Haase et al., 2004). If a student is performing inadequately in formal classes, resolution may be relatively easy. But if the problem is more interpersonal and nebulous, then concern about appropriate assessment and documentation and fear of lawsuits may affect the responses of faculty and the university.

In their qualitative study with internship site training directors and supervisors, Gizara and Forrest (2004) highlighted complexities involved in dealing with trainee competence. Their data supported earlier reports that professionals often struggle with these issues because of the perceived incompatibility between identifying as a counseling psychologist and deciding that a trainee is experiencing competence problems. This complexity may be intensified when multiple roles exist among professionals and trainees (Schoener, 1999). To assist programs with developing appropriate responses, the Council of Chairs of Training Councils (2004) developed a consensus statement on competence that programs can adopt in whole or in part and include in the information they provide to new students. This is intended to provide informed consent regarding the extensiveness of the evaluation process to incoming students.

Students and interns also acknowledge both the prevalence and the complexity of the issues associated with trainee competence. For example, Mearns and Allen (1991) found that 91% of the students in their sample had dealt with at least one issue of impairment or ethical impropriety with a peer during graduate

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training. In another investigation, students reported emotional reactions to peer impairment including frustration, ambivalence, helplessness, and resentment toward peers or faculty. In addition to these emotional responses, students noted a sense of confusion, lost opportunities, and extra work stemming from faculty's apparent lack of response to the situation (Oliver et al., 2004). Further, of significant concern is that students believe that faculty members were aware of only some of their peers with problems (Oliver et al., 2004).

It is important to consider how students may respond to their peers who need assistance or are acting inappropriately and even unethically. Several studies have documented that students do not appear willing to confront their peers or go to faculty even when they recognize that there is a problem. Their reasons include guilt associated with reporting a friend, fear of incorrect judgment, and worry about how faculty will interpret their reports (J. L. Bernard & Jara, 1986; Betan & Stanton, 1999; Oliver et al., 2004). This is a significant concern because students may be more likely than faculty to witness or experience competence problems with their peers.

Professional Competence

Professional competence has received significant attention in the literature (e.g., APA, 2006; J. L. Bernard, Murphy, & Little, 1987). However, Herman (1993) argued that discussions of therapist competence have only focused on how much training and experience the person has had and that this is insufficient because research has demonstrated that these considerations have limited influence on treatment outcomes. Therefore, Herman stated that competence must also incorporate the personal characteristics of therapists, as well as their use of research in guiding practice.

Overholser and Fine (1990) also discussed professional competence, focusing on five areas of therapist incompetence. These authors maintained that there is incompetence resulting from lack of knowledge, which must be addressed through lifelong learning and a recognition of one's own limits. Second, incompetence can be because of inadequate clinical skills, such as an inability to provide informed consent and too much emphasis on giving advice and self-disclosure. The third area is incompetence as a result of deficient technical skills (e.g., assessment, specific therapy techniques) that require specific knowledge and expertise before a therapist can use such skills effectively with clients. Fourth, incompetence can stem from poor judgment, which may occur in case conceptualization and treatment planning with particular clients. Finally, incompetence can result from disturbing interpersonal attributes, such as poor social skills and impairment. Given these sources of incompetence, the authors argued that it is the responsibility of psychologists to maintain the integrity of the field by preventing and addressing incompetence as they become aware of it in students, colleagues, or themselves.

Addressing the unethical or incompetent behavior of other professionals deserves more attention. Although this may be uncomfortable and there may be many reasons not to confront such situations (e.g., Good, Thoreson, & Shaughnessy, 1995), psychologists have a responsibility to address such issues to maintain the professionalism of the field, the competency of psychologists in general, and the ethical principles of the profession. However, research indicates that professionals, like students, are unwilling to confront fellow psychologists who are acting inappropriately or unethically (J. L. Bernard et al., 1987; Overholser & Fine, 1990). The problem is so significant that the APA (2006) convened a group to discuss colleague assistance and developed an extensive monograph on the issue, with explicit directions about how to approach and help peers (see also Good et al., 1995).

Self-Care

There has been increasing attention to issues of competence, the inherent stresses involved in the profession, and the empirically documented level of distress among mental health practitioners (e.g., Gilroy, Carroll, & Murra, 2002; Sherman & Thelen, 1998; Thoreson, Miller, & Krauskopf, 1989). Barnett, Johnston, and Hillard (2005) said that devoting ongoing attention to self-care and wellness takes

on ethical importance for mental health practitioners. These authors stated that an individual's distress may naturally progress toward problems with competence if the person does not recognize, attend to, and remedy personal and professional issues. They underscored the explicit connection between self-care and the general principles underlying the APA's (2002) code of ethics (e.g., "Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work," p. 1062). They called for practitioners to monitor and be proactive in dealing with their own distress by practicing self-care.

Additionally, many authors have offered routine preventive and remedial strategies for practitioners and trainees. Barnett et al. (2005) suggested that awareness of one's own level of distress is critical in any effort to prevent or remediate distress. They provided self-assessment questionnaires to help practitioners and trainees engage in self-reflection and identified online resources to assist with preventing and responding to distress and burnout. Similarly, Norcross (2000) offered a compilation of "clinician recommended, research informed, and practitioner-tested" self-care strategies (p. 710). These practical recommendations for trainees and professionals to avoid burnout include embracing multiple strategies that draw from a variety of theoretical orientations, diversifying everyday experiences by finding a balance of personal and professional life, and taking the time to appreciate the rewards associated with one's work.

CHALLENGING ETHICAL SITUATIONS

There are situations and environments that lend themselves to ethical dilemmas and possible legal ramifications. Based on our review of the literature and our own experience, we selected four that have received attention in recent years and that we believe will continue to be the focus of future discussion and scholarship. In particular, we discuss (1) conflicts between professional ethics and the demands of employers, (2) the duty to protect, (3) maintenance of the integrity of the assessment situation, and (4) issues associated with conducting action research and examining socially sensitive topics.

Conflicts between Professional Ethics and the Demands of Employers

One of the topics receiving significant attention in psychology is the tension between a practitioner's ethics and the demands of an employer or supervisor (e.g., ranking officer, university administrator, warden). There has been much controversy over the appropriate role of psychologists in interrogations and other coercive situations (e.g., APA, 2005), the primary responsibilities of a corrections psychologist (e.g., Bonner, 2005), and appropriate ways for colleges and universities to respond to students who may be at risk of harming themselves (e.g., Westefeld et al., 2006).

Perhaps no recent topic has held the attention and galvanized the activism of psychologists and others as the war in Iraq and related issues, such as the detention and interrogation of people held in conjunction with the war or those suspected of being terrorists. The right of psychologists to protest or support policies and actions by the government has not been the source of the debate; rather, the possible involvement of psychologists in interrogations and the proper role, if any, of psychologists in situations where people are being held against their will (particularly by the military) has been controversial. The extent to which psychologists have been involved is a matter of speculation. However, in response to news reports and requests from psychologists involved in activities related to national security, the APA (2005) convened a task force that issued a report reviewing the ethics of involvement in interrogations. The Board of Directors adopted the report as APA policy and the Council of Representatives adopted the report's recommendations and several related items, including a statement that no circumstances ever justify a psychologist engaging in torture (S. Behnke, personal communication, February 19, 2007). Currently there is discussion on a closely related issue: whether the ethical standard in the APA (2002) Ethics Code regarding conflicts between ethics and law needs to be amended.

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The overarching concern involves whether it is ethical for psychologists to be involved in interrogating people when coercive techniques may be involved (APA, 2005). A military psychologist's job may be to assist in gathering information from people being held against their will, but how far that assistance goes, where the line demarcating ethical from unethical behavior lies, and what the consequences are of crossing that line are at the crux of the matter. Some who are against any involvement of psychologists in coercive situations want it to be unethical for psychologists to assist in interrogations; others, regardless of their specific position regarding situations such as Guantanamo Bay, argue that such a position would make it unethical for some military (and possibly police) psychologists to do their jobs.

Those arguing for a change in the Ethics Code maintain that such a revision would allow psychologists who are against some tactics allegedly being used by the military to say that they cannot participate in those interrogations because they violate the Ethics Code. Although few psychologists may be directly involved in assisting the military in these cases, the possible dilemmas faced by psychologists illustrate the larger issues related to situations where a psychologist is being told to do something by a superior that may be contrary to the psychologist's conscience or beliefs about proper professional conduct.

Another environment where there may be conflicts between psychologists' perceptions of their roles and the demands of the employer is within correctional facilities. Given the high percentage of people in the criminal justice system who have mental health problems (James & Glaze, 2006), it is likely that more psychologists will be providing counseling and other services in such facilities. Here, limits to confidentiality and dual roles are often at the forefront of tension between a practitioner's ethics and employer demands. When an inmate discloses information to a psychologist that could potentially affect the security of the institution or the well-being of staff or other inmates, confidentiality may not be possible because the psychologist is often expected to disclose that information to the employer (i.e., institution officials; Bonner, 2005). Furthermore, psychologists are sometimes asked to act as if they were a correctional officer, which places them in dual roles with inmates because of having yet another form of power over their clients. Finally, psychologists may be placed in positions in which they are evaluating or treating individuals who have been sentenced to death and they cannot change the outcome, even though the APA (2001b) has a resolution against the death penalty.

Another relevant situation that may be even more common among counseling psychologists given their traditional work settings relates to how a college or university will respond to a student who may be at risk of self-harm. In some places, institutional policy may mandate notifying parents of students' suicidal ideation or attempts (Baker, 2005) or dismissing students who threaten or attempt suicide (Pavela, 2006). In other instances, an administrator may want information or access to records related to a student about whom there are safety concerns. Although both psychology faculty and counseling center psychologists may encounter students who disclose personal information such as suicidality, the situation for instructors has been discussed less often (Haney, 2004). The extent of confidentiality between a faculty member and a student is, in most situations, more ambiguous because these discussions are less governed by university policies, case law, and state statutes than are the revelations that take place in the context of a staff psychologist-client relationship.

Several recent court cases involving college students who have thought about, attempted, or died by suicide have led administrators to be concerned about their own and the school's liability if a student is harmed or dies (Baker, 2005; Pavela, 2006; Westefeld et al., 2006). Some of the policies that have been drafted in response to these cases have given the administration permission or direction to take fairly strong action; thus, an administrator may want access to as much information as possible to decide what to do. For example, a dean may request to see case files and talk to a student's counselor. In such instances, the provider may feel caught between the demands of the administrator and the confidentiality of the student. Concerns about rupturing the therapeutic alliance are naturally linked to the release of information without the client's permission.

This scenario has parallels with the reporting of child abuse, in that an external force is placing limits on the degree of confidentiality in the counseling relationship—and not following the directive (i.e.,

reporting abuse or giving information to an administrator) can have significant consequences for the therapist (and possibly the client). Supervisees have even less control in such situations in that they are bound not only by the university's policies and demands of administrators but also by the directions of their supervisors. Given these issues, counseling centers would be well served by having policies (and informed consent for clients) in place stating which administrators, if any, have access to records. Such policies also need to clarify how breaches of confidentiality should be managed and documented.

The current state of the world and the litigious nature of U.S. society suggest that these situations will not disappear. In fact, other situations involving therapist loyalties are likely to continue to garner attention. For example, staff in counseling centers that provide disability assessments to students may be pressed to reveal information to other campus representatives about students referred for testing or counseling; they may also be pressured to diagnose a student with a condition to help the student stay in good standing in school or to receive academic accommodations. Thus, counseling psychologists who work in such capacities need to be familiar with the Ethics Code as well as established ethical decision-making models and state-of-the-art analyses of possible resolutions to such difficult situations. We anticipate that the APA and other official bodies will continue to provide information on these dilemmas.

Duty to Protect

Many professionals erroneously discuss the "duty to warn" in relation to the famous *Tarasoff v. Regents of the University of California* (1976) case. The justices in that decision actually said there was a *duty to protect*, which is an even broader mandate. Because there has been so much misinformation about *Tarasoff*, even in ethics articles and books, we urge readers to review the actual case. Suffice it to say that the duty to protect allows professionals many more ways to intervene in potential instances of harm to another than just warning the potential victim or authorities. Each jurisdiction has statutes and case law on this issue, and some of these may have specified that the only way to protect is by breaking confidentiality or attempting hospitalization. Counseling psychologists and students need to check the requirements in their respective locations (Werth, Welfel, & Benjamin, 2007).

The standard discussion of the duty to protect involves reviewing situations involving potential murder or suicide; however, it has been argued that the underlying issue is whether substantial harm may occur to the person or to another individual within a relatively short period and, therefore, a larger number of situations may lead to a duty to protect (Werth & Rogers, 2005; Werth et al., 2007). Using this more expansive view, we decided to focus on other areas where the duty to protect may be an issue with clients: HIV disease, driving, eating disorders, and end-of-life decisions. Of these four, the oldest and most discussed is the possible dilemma about what to do when a client who has HIV is engaging in risky behaviors (e.g., unprotected intercourse, sharing needles used to inject drugs). A book (Anderson & Barret, 2001) that has been written on this topic thoroughly discusses various dilemmas and ways of resolving them (e.g., breaking confidentiality by talking to the police, the health department, or other person(s) who may have been exposed). However, because states may have statutes or cases prescribing or limiting the psychologist's options in such settings, consultation with an attorney may be useful.

On the other hand, clients may present other types of situations where little guidance has been offered. Driving is an area that has been receiving more attention lately. As a result of the aging of the population, newspaper stories about elderly drivers are not uncommon, and data on numbers of accidents reveal that older adults have higher rates than most other age groups (Knapp & VandeCreek, 2005). The larger issue is operating potentially dangerous equipment, which is relevant to many more people and makes concerns about harm to self or others and, therefore, the potential duty to protect, directly relevant to counseling psychologists and trainees.

A person's ability to safely operate equipment, such as an automobile or truck, forklift, or assembly line, can be affected by reduced reflex speed, vision issues, medication side effects, medical conditions, and cognitive impairments. In some of these situations, a physician may have an obligation to inter-

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vene and discuss the potential need to reduce or eliminate the use of dangerous equipment. However, psychologists and trainees may also be considered to have a duty to protect the person and others who may be harmed if the professional or student knew (or should have known) that a person's ability to use equipment safely was impaired. Options may include getting the person voluntarily to stop operating the equipment, discussing the situation with the client's loved one, or reporting the situation to the police or employer.

Another example of a clinical situation that may involve the duty to protect but about which there has been little written is related to clients with disordered eating. There is the possibility that a client's behaviors may be so extreme that the therapist is concerned about the client's safety. To our knowledge, only one article has appeared providing some suggestions for what counseling psychologists may need to do with clients who have anorexia (the mortality data indicate that death from anorexia is a distinct possibility, whereas the data do not indicate a heightened risk related to bulimia) and the therapist has concerns about the client's risk of death (Werth, Wright, Archambault, & Bardash, 2003). In such cases, the counselor can meet the duty to protect in a variety of ways, including breaking confidentiality, trying to get the client to go into inpatient treatment voluntarily, or attempting to hospitalize the client involuntarily. Although the authors concluded that there may be times when the therapist has a duty to protect, they noted that the ethics literature also leaves open the possibility of letting the client's disease take its course and helping the client to die peacefully.

This latter option is related to the emerging literature on psychologists' responsibilities when clients make decisions that may affect the manner and timing of their death (e.g., what is the psychologist's role when a terminally ill client wants to overdose on medication, or when a clinically depressed client wants to discontinue dialysis?). Kitchener and Anderson (2000) discussed the more narrow but related issue of "rational suicide" in the previous edition of the *Handbook*. The American Counseling Association's (2005) new code of ethics has a section on working with terminally ill clients, but psychologists will need to extrapolate from the existing APA (2002) Ethics Code and related literature when faced with this issue. In 2000, the APA Working Group on Assisted Suicide and End-of-Life Decisions issued a comprehensive report, and resolutions on End-of-Life Issues and Care (APA, 2001c), and on Assisted Suicide (APA, 2001a) were subsequently passed by the Council of Representatives.

Werth and Rogers (2005) argued that the set of "Issues to Consider when Exploring End-of-Life Decisions" that was developed by the APA Working Group could be used to help satisfy the duty to protect with clients making decisions that may affect the manner and timing of death. These authors stated that the duty to protect did not mandate prevention of harm in all situations; rather, they indicated that the key issue involves whether the client has impaired judgment when making the decision. They maintained that if, after thoroughly reviewing the client's judgment and decision-making capacity, the therapist concluded that the client did not exhibit impaired judgment, then it could be ethically acceptable not to prevent the client from taking action that would likely lead to the client's death.

As can be seen from these examples, the duty to protect can be applied in a variety of situations and can lead to controversial decisions. We anticipate that the boundaries and nuances of the duty to protect and the options for discharging this duty will be discussed more thoroughly in the coming years.

Maintenance of the Integrity of the Assessment Situation

Changes to the standard on assessment apparently were among the most substantial and controversial of the 2002 revisions of the APA Ethics Code (Fisher, 2003; Knapp & VandeCreek, 2003). We provide a brief overview of issues involved in the release of test data and maintaining test security; we also highlight possible tensions between psychologists and attorneys regarding psychological assessment. Readers with a special interest in psychological testing are encouraged to consult more comprehensive sources.

In the 2002 Ethics Code, there is a distinction between *test data* and *test materials*. According to the code (Standard 9.04a), "The term *test data* refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements

and behavior during an examination” (p. 1071). In addition, any written responses are considered test data. This part of the code goes on to state that if a client signs a release of information, test data can be given to other people (e.g., attorneys), not just other psychologists. The 1992 code prohibited releasing such information to unqualified individuals. There is a provision that psychologists may refuse to grant such release if they think a client may be harmed, but as with the earlier discussion of client access to records, HIPAA and state laws may preempt this part of the code. In Standard 9.11, the code defines *test materials* as “manuals, instruments, protocols, and test questions or stimuli and does not include *test data* as defined in Standard 9.04” (p. 1072). Something containing both test materials and test data (e.g., a Rorschach scoring sheet) is considered data, not materials, and therefore is accessible to clients and others to whom the client releases the information.

There has been extensive discussion of the implications of these definitions and the changes to this standard for psychologists and test publishers (e.g., see the *Journal of Personality Assessment*, 82, 23–47). The APA Committee on Legal Issues (2006) has offered some recommendations for psychologists facing requests to provide assessment-related material to attorneys or courts, but at this point, it does not appear as if psychologists or companies can prevent test data, or test materials that overlap, from being released to clients and others.

The release of test data has caused some concerns for psychologists in general and forensic psychologists in particular because of the different perspectives and roles psychologists and attorneys have in legal situations. Any psychologist may face a subpoena, so not specializing in court-related assessments does not make one immune from these issues. Victor and Abeles (2004) highlighted the tension here by noting that attorneys may consider it appropriate to coach clients how to respond to psychological assessments. Thus, if attorneys have access to test questions, scoring, or interpretation guides (i.e., assuming this information is considered test data), there is the potential that the integrity of assessments may be compromised.

A related issue being debated is whether attorneys (or other observers) have the right to be present when their clients are completing assessments. There has been some discussion of this in the neuropsychological literature (e.g., American Academy of Clinical Neuropsychology, 2001), and the APA has been examining the issue for several years although no policy positions have been endorsed thus far. However, we anticipate that there will continue to be discussion and debate about these issues in the future, even if the APA provides clear guidance.

Action Research and Examination of Socially Sensitive Topics

The detrimental effects of psychology’s history of “misassumptions,” “misadventures,” and “misuses” have been well documented and have contributed to mistrust among community members and potential research participants (Strickland, 2000, p. 331; see also Darou, Hum, & Kurtness, 1993; Harris, Gorelick, Samuels, & Bempong, 1996). Given psychology’s history, as well as the continuously changing demographics of the U.S. population, there has been increased attention to the ethical conduct of research with underrepresented populations in recent years. Specifically, theorists and researchers have focused on the role of ethics in community-based research approaches and socially sensitive research (i.e., research with potential social consequences or implications).

Potential challenges associated with action-oriented research approaches and socially sensitive research may be of particular concern for counseling psychologists and counseling psychology trainees because of the emphasis that the profession places on multiculturalism, science-practice integration, prevention, respect for all individuals, social justice, and a strengths-based, developmental perspective (e.g., Fouad et al., 2004; Neimeyer & Diamond, 2001). Indeed, because there have been numerous recent discussions related to the inclusion of social justice perspectives in training, research, and practice within counseling psychology (e.g., Fouad et al., 2004; Goodman et al., 2004; Toporek, Gerstein, Fouad, Roysircar, & Israel, 2006; Vera & Speight, 2003), it is critical to examine the ethical implications inherent in using these perspectives to inform research.

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Some authors have proposed additional ethical considerations when conducting these types of research. Sieber and Stanley (1988) offered a taxonomy to guide researchers in their analysis of socially sensitive research. They suggested that ethical issues arise at several points in the research process (e.g., formulation of the research question, interpretation of findings) and that psychologists must consider 10 types of potential ethical issues (e.g., privacy, informed consent, risk/benefit ratio). Similarly, Fisher et al. (2002) argued that psychologists need to attend to additional considerations when conducting research with ethnic minority individuals. They encouraged researchers to apply a cultural perspective to the evaluation of research risks and benefits, engage in community consultation, and ensure that they have appropriate awareness and understanding of scientific, social, and political factors related to the groups represented in their research.

Koocher (2002) proposed a model containing six distinct domains (cognitive, affective, biological, legal, economic, and social and cultural risks) that should be examined to assess and minimize risk to research participants. He pointed to the need to consider the potential adverse effects for individuals participating in studies designed for at-risk youth, such as stigmatization and negative self-fulfilling prophecies (e.g., on the part of teachers); the possibility that researchers may collect data that would lead to mandatory reporting (e.g., child abuse or neglect); the possibility that participation in research might lead to litigation as a result of the participant's self-realization (e.g., the participant recalls negative emotions associated with specific experiences); and the potential for monetary compensation to increase the likelihood that low-income individuals would agree to potentially risky research participation or interruption of effective treatment for participation in experimental clinical trials.

Action-oriented research approaches (e.g., Participatory Action Research: Esposito & Murphy, 1999; Emancipatory Communitarian Approach: Prilleltensky, 1997) also lead to the need to reflect on challenging ethical issues as well as potential implications for participants, groups that the participants represent, and the general public. Although there are benefits to conducting such research, including working closely with participants and the possibility that research involvement will lead to participant empowerment, there is also the potential for harm as a result of misunderstanding roles, mistakes related to informed consent and confidentiality, and misinterpretation of results and their policy implications (see Kidd & Kral, 2005). Further, the inclusion of values and attention to issues of social importance in research may lead to a backlash from readers of scholarly journals, clients, policymakers, administrators, or the general public because of the controversial research.

A meta-analysis by Rind, Tromovitch, and Bauserman (1998) on sexual abuse—and the political and social backlash that stemmed from this study (for reviews see Garrison & Kober, 2002; Lilienfeld, 2002)—is an example of the need for researchers to consider the implications of their research when designing studies, gathering data, interpreting results, and disseminating information. Several authors dissected the controversy to raise awareness among researchers of the implications of their findings. These authors (e.g., Garrison & Kober, 2002; Lilienfeld, 2002) suggested ways for psychologists to avoid problems resulting from studying socially relevant and potentially controversial issues, including educating the public about sound research design, being knowledgeable about the policy-making process, emphasizing that one research study is not the final word, and acknowledging the potential misinterpretations of findings.

Psychologists need to carefully attend to multiple sides of issues (particularly controversial ones) when conceptualizing studies and their designs. For research that is socially sensitive to be viewed as credible, psychologists must acknowledge that their values are influencing their work and should actively seek to increase their own awareness of their biases, assumptions, and the potential misinterpretations of findings.

CONCLUSION

This chapter has highlighted significant ethical and legal issues that are relevant to counseling psychologists across their work settings and levels of experience. The APA Ethics Code, professional regulations,

state statutes, and federal laws provide some direction for trainees and professionals, but no set of written guidelines can adequately cover all possible situations. The existing literature may provide assistance, and consultation with more experienced peers will also be helpful, but the beliefs and skills of the psychologist or trainee will influence the process of seeking out and interpreting information. Thus, to practice ethically, counseling psychologists and graduate students must continuously monitor their competence and biases in every professional situation.

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