

# PREFACE

Clinical mental health counseling is a relatively new profession that is evolving to meet the needs of today's society. Clinical mental health counselors provide services to a broad array of clients presenting with various issues and diagnoses. In the past, counselors were generally relegated to working in community agencies, but with the passage of state counseling laws and the development of national certifications, clinical mental health counselors now work in private practice, hospital settings, the Department of Veterans Affairs, community agencies, and other related facilities. The outlook is bright for the future of clinical mental health counseling.

In this text, we offer a broad-based introduction to the theories and practices related to clinical mental health counseling. Our goal is to provide you the fundamental information required to begin the journey toward becoming a licensed or certified clinical mental health counselor. Of course, this text will be only one part of your journey, but it is designed to continue to be a resource for you throughout your professional development.

The materials in *Clinical Mental Health Counseling: Fundamentals of Applied Practice* are organized in order to match your developmental understanding of the profession. The text is divided into three parts: Introduction to the Profession of Clinical Mental Health Counseling, The Practice of Clinical Mental Health Counseling, and Contemporary Trends in Clinical Mental Health Counseling. Each chapter is designed to meet learning outcomes associated with the 2009 accreditation standards established by the Council for Accreditation of Counseling and Related Educational Programs (CACREP). The learning outcomes are based on general core areas of the CACREP standards and those related to the specialization of clinical mental health counseling.

In Part 1 of the text, we provide an introduction to clinical mental health counseling. This part focuses on the history of mental health counseling and professional development. The chapters in the first part cover

- The development of clinical mental health counseling as a profession
- Ethical and legal issues in clinical mental health counseling
- Education and credentialing
- Employment settings

Part 2 of the text is dedicated to the practice aspects of the profession. The general focus is on developing both an understanding of client issues and approaches for addressing those issues. The chapters in this part cover

- Advocacy
- Assessment and diagnosis
- Case conceptualization and treatment planning
- Managed care
- Consultation
- Prevention and crisis intervention

Part 3 of the text is designed to address the major trends and changes occurring in the clinical mental health counseling profession. We review many of the emerging

practice areas and provide an overview of essential knowledge related to the following areas:

- Psychopharmacology
- Forensic mental health
- Addictions
- Clinical supervision
- Internet-based counseling

The underlying emphasis of this text is that clinical mental health counseling is a specialized helping profession. Further, the consistent theme is that mental health counselors are well prepared to provide quality services in a variety of settings. Although many different professions provide mental health services, clinical mental health counselors have the training, knowledge, and expertise necessary to treat a broad range of mental health issues.

Our text is a collaborative effort based on our experiences as clinical mental health counselors and counselor educators. As editors, we have more than 40 years of combined experience in the mental health field and have seen thousands of clients. We have also had the privilege of training hundreds of students. Our colleagues who have contributed to this effort have vast experience as well, and we have learned from their contributions. The pages of this text are a result of all our combined efforts.



### **Video Icon**

A series of online videos, developed specifically for this book, are available in the e-text edition of this text. If you are viewing the e-text edition, please click the Video Icon in each chapter. Icons appear throughout the text.

## **ACKNOWLEDGMENTS**

A text of this scope could not have been possible without the help of our wonderful colleagues in the field of clinical mental health counseling. We are indebted to both the chapter authors and the practitioners who contributed their Voices from the Field. It is because of the work of these professionals that we are able to assure readers they are getting the most current and relevant information available.

We are also grateful for the input of our editor, Meredith Fossel, who has been a steadfast supporter of this project since its inception. Her tireless enthusiasm and willingness to mentor this project will not be forgotten. We are fortunate to have been one of her last book projects in counseling before moving upward and onward in her profession.

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Finally, we are forever grateful to our friends and family who not only supported this project but also supported us along the way. Our children Ellis, Jake, Joe Lee, Emily, and Laura Beth are a constant source of inspiration and motivation. Our friends around the world and closer to home, including Mississippi, Jacksonville, and Beaumont, provide us with the foundation we need to serve others in this profession and beyond.

# Introduction to the Profession of Clinical Mental Health Counseling

**CHAPTER 1** What Is Clinical Mental Health Counseling?

**CHAPTER 2** Ethical and Legal Issues

**CHAPTER 3** Education, Credentialing, and Professional Development

**CHAPTER 4** Employment Settings for Clinical Mental Health Counselors

# What Is Clinical Mental Health Counseling?

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## CHAPTER OVERVIEW

This chapter covers the differentiation between clinical mental health counseling and other forms of professional counseling. We first discuss the history of clinical mental health counseling and its relationship to the medical model of treatment. Then, we address the unique professional identity of clinical mental health counselors. In addition, we discuss the complexities of the professional licensure process. This chapter concludes with the various additional certifications available to clinical mental health counselors.

## LEARNING OBJECTIVES

The learning objectives for this chapter are designed to be consistent with the 2009 Council for Accreditation of Counseling and Related Educational Programs Standards (CACREP, 2009). As such, upon completion of this chapter, the student will have knowledge of the following clinical mental health counseling standards:

1. Understands the history, philosophy, and trends in clinical mental health counseling. (A.1)
2. Is aware of professional issues that affect clinical mental health counselors (e.g., core provider status, expert witness status, access to and practice privileges within managed care systems). (A.7)
3. Understands professional issues relevant to the practice of clinical mental health counseling. (C.9)

Additionally, students will have knowledge of the following core entry-level standard:

1. History and philosophy of the counseling profession. (G.1.a)

## INTRODUCTION

Welcome to your introduction to clinical mental health counseling. As a student, you are poised to enter the profession of counseling. You may have heard others saying the “field of counseling” but you are truly entering a profession. What you will learn as you pursue your studies is that counseling is a distinct profession because it is

governed by a code of ethics and each state has enacted laws that define a scope of practice. Clinical mental health counseling is a specialized area of the counseling profession that involves unique training, education, and clinical work. Among the various counseling areas, clinical mental health counseling is the primary specialization for the prevention, assessment, and intervention of issues associated with mental health (AMHCA, 2012).

The profession of counseling is relatively young within the field of helping professions. Emerging formally on the scene in the late 1800s, the counseling profession has transformed from mere vocational guidance to myriad counseling specialties and occupations.



## **HISTORICAL OVERVIEW OF CLINICAL MENTAL HEALTH COUNSELING**

One way to fully appreciate the profession is to explore the history of counseling and, more specifically, the history of clinical mental health counseling (CMHC). In the seminal article by Aubrey (1977), counseling is described as a profession that arose in response to societal changes of the late 19th century. Movement from a primarily farm-based society to a society dependent on manufacturing and transportation created opportunities for vocational guidance in industrial and education settings. This movement was spearheaded by Frank Parsons, commonly referred to as the “father of vocational guidance” (Aubrey, 1977). His posthumous book, *Choosing a Vocation*, became a manual for counselors working in vocational settings (Briddick, 2008). The strength of Parsons’s approach lay in finding the best way to place the best people in the work environments that would make them, and the companies they worked for, successful. As commonplace as that seems today, it was absolutely revolutionary at the time!

By the mid-20th century, counseling had begun to shift from the assessment of skills for employment to a focus on the client’s needs and well-being. This shift was a direct result of the impact of Carl Rogers and his person-centered approach on the provision of counseling services (Aubrey, 1977). Of course with this focus on the client, the issues and concerns of the client began to come to the forefront. By the 1970s, it was clear that counselors were providing services that we would now call clinical mental health counseling. However, at that time, mental health counselors were not organized and had no professional identity distinct from that of guidance counselors (Colangelo, 2009).

CMHC developed within the larger profession of counseling when master’s-level practitioners working in agencies, hospitals, and private practice found they lacked a professional home because psychologists practiced at the doctoral level whereas social workers practiced at the bachelor’s level. These disenfranchised counselors found that, because they were not eligible for licensure in other helping fields such as psychology, they needed to band together to form an identity unique to clinical mental health counseling. These efforts helped to distinguish CMHC from the larger profession of counseling and other disciplines such as social work and psychology. With the formation of the American Mental Health Counselors Association (AMHCA) and the advent of professional licensure, clinical mental health counselors finally had a professional voice. But what is their professional identity?

A critical concept to be discussed in relation to the history of mental health counseling, as well as ongoing professional challenges, is that of professional identity. In other words, what sets clinical mental health counselors apart from other helping professionals? There are many similarities to the various helping professions, which results in significant confusion to the public that the profession serves. Psychologists, with their traditional role

as assessors and diagnosticians, are qualified and licensed at the doctoral level. Psychiatrists, who hold prescribing privileges (as do some psychologists but that is beyond the scope of this distinction), are qualified and licensed as medical doctors. Social workers, with their emphasis on case management, are qualified and licensed at the bachelor's level (although some do pursue master's clinical degrees). Clinical mental health counselors, however, are the only helping professionals qualified and licensed at the master's level. In addition, their primary role is to counsel. Although other helping professions may employ some aspects of counseling, just as clinical mental health counseling employs diagnostic, assessment, and case management practices, CMHC is the only profession whose primary purpose is counseling.

What does this mean? When clients decide to see a counselor, they may or may not seek a clinical mental health counselor. They often see those in the disciplines of psychology, psychiatry, and social work as equivalent. The rich history of clinical mental health counselors as providers of counseling services sets the profession apart philosophically, if not practically, in the public eye. One such distinction is in the profession's use of the wellness model as opposed to the medical model. Additionally, counselor preparation programs, which are master's-level graduate programs, separate CMHC from the other helping professions.

## The Medical Model and the Wellness Model

The term *medical model* is often used in the discussion of the helping professions, but what does it mean? The medical model is an approach to how clients are best helped and begins with the identification of a problem from a pathology perspective. The medical model is grounded in the belief that mental illness is like any other illness and treatment practices borrowed from medicine will be effective in addressing mental health concerns (Wampold, 2001).

It is not unreasonable to make such assertions. Clinical mental health counseling's history of helping is grounded in experimental approaches to the treatment of mental health concerns. Early societies viewed mental illness as requiring treatment by the tribal elders. Individuals with psychiatric problems were often sidelined from society, subjected to what are now considered to be inhumane treatments, such as the use of hallucinogens, bloodletting, starvation, and beatings. Any "success" with such methods resulted in their increased use. Of course, it is now known that such methods are not the most desirable forms of treatment.

Psychologists and behaviorists of the time scientifically approached mental illness and adopted the early medical principles that continue to influence the helping professions. Mental illness was treated primarily in hospitals, if at all, requiring a medical approach. Emil Kraepelin (1856–1926) is credited with developing the first system of organizing mental health concerns when he published a compendium of psychiatry asserting that psychiatry was a branch of medical science worthy of scientific investigation (Hippius & Müller, 2008). Kraepelin's work served as the foundation for both the *International Statistical Classification of Diseases and Related Health Problems* (commonly known as the ICD), which classifies physical illnesses, and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), which classifies mental illnesses.

The medical model serves as one lens through which to view the development and treatment of client problems. However, counseling differs from psychology and

psychiatry in that it takes a wellness and strength-based approach to the treatment of mental health concerns. The profession of counseling is unique in the mental health field in its use of the *wellness model* as opposed to the medical model. Whereas other mental health professionals such as psychologists and psychiatrists view mental or emotional concerns as illnesses from the diagnostic perspective, mental health counselors view these concerns as a part of normal development. Clinical mental health counselors operate from this wellness perspective and receive additional training in the medical model and pathology. In addition, mental health concerns are viewed through a developmental lens, and mental health counselors take into account life stages. In other words, one's mental health is assessed based on a developmental continuum, because some forms of mental illness are not exclusive to one stage of development. The mental health counselor works with all clients to improve their quality of life. However, as emerging clinical mental health counselors, you need to be well versed in the responsibilities of using the medical model, particularly in a managed care atmosphere, as discussed in Chapter 8 of this text.

Because much of the treatment of mental illness came from a medical model perspective, this work occurred in hospitals and institutions where medical doctors could work. Generally known as lunatic asylums, institutions were built to contain and restrain the mentally ill, who were often viewed as demon possessed and treated as inmates. In the mid-1800s, Dorothea Dix championed for an increase in the number of asylums from 8 to 32 in the United States. The US census began counting and categorizing those with mental illness and mental retardation through the inclusion of the category "Insane and Idiotic." Although the number of asylums grew, the treatment was not improving from earlier barbaric times. In the early 1900s, American treatment of mental illness included rampant physical abuse, which was highlighted by Clifford Beers in his 1908 book *A Mind That Found Itself*.

Beers, a Yale graduate and intelligent businessman, suffered from mental illness including an intense depression following the death of his brother. Following a suicide attempt, Beers was hospitalized for treatment in a private institution where he was confined, beaten, and subjected to unhygienic and unsafe conditions. He endured multiple institutionalizations prior to writing his book, in which he exposed the living and treatment conditions of the helpless mentally ill and thereby changed the face of hospitalization for mental illness.

Beers's work became the foundation of the Connecticut Society for Mental Hygiene, which then became a national organization and is still in existence under the title Mental Health America (MHA). For decades MHA has been at the forefront of educational and legislative initiatives to advocate for the right to fair treatment of mental illness (2011). The development of this national awareness caused hospital conditions to become more humane and the treatment of mental illness to receive national focus. While hospital conditions improved, the number of those in need began to increase beyond the institutions' ability to serve them. A congressional Joint Commission on Mental Illness and Mental Health was formed in the 1950s to educate the public and promote mental health awareness. Although this was a laudable goal, it did not address the increase in inpatient needs and the limitations of our nation's hospital systems. This disparity was addressed when President John F. Kennedy introduced the Community Mental Health Act of 1963, also known as the Mental Retardation and Community Mental Health Centers Construction Act.

## **Community Mental Health Act of 1963**

Early mental health treatment was provided using the best resources and research available. Although they were not ideal, treatment options certainly improved throughout the early 20th century. Prior to the mid-1960s, virtually all mental health treatment was provided on an inpatient basis in hospitals and institutions. Many hospitals were state run, and typically in the larger population centers of each state. Few could afford private care, and state-funded care would be considered substandard, at best.

Using the medical model previously discussed, psychologists, psychiatrists, and physicians worked diligently to keep patients safe and provide treatment for their mental health needs. Upon discharge from the hospitals, patients were returned to their home communities where they often did not receive appropriate follow-up care. This resulted in a return of symptoms and, ultimately, a return to the hospital. However, the institutions in which these patients were placed were becoming increasingly overcrowded.

During this time research being conducted suggested that patients who improve while institutionalized would remain stable longer if they received ongoing care in their communities. Yet community-based mental health care was unheard of during this time. President John F. Kennedy endorsed a proposal that mental health patients would benefit from staying in their home communities with familial support and community-based treatment. This proposal resulted in the Community Mental Health Act of 1963.

The Community Mental Health Act of 1963 proved to be the first time that the US government became involved in mental health care. The act's primary focus was deinstitutionalization, with community mental health centers taking on treatment of the previously hospitalized patients. President Kennedy hoped for a reduction in hospitalizations of 50%, and the National Institute of Mental Health (NIMH) was created to serve as an oversight for community centers (Feldman, 2003). Federal grants were provided and community centers sprang up all over the United States. Some states used this as an opportunity to close state-run hospitals, which did not ultimately help with overcrowding. However, the creation of the community-based treatment facilities increased the jobs available to counselors, and the profession of clinical mental health counseling grew out of this act.

The placement of care in communities, rather than in centralized hospitals and institutions, truly embodied the community mental health model. Many of the existing counselors had been trained in colleges of education and did not have the strength of a professional identity. These new professionals, functioning as clinical mental health counselors, banded together to form the American Mental Health Counselors Association (AMHCA) in the late 1970s to increase the professional identity. With this increase in CMHC positions for counselors came a need for standardized training programs. Licensure and certification for counselors also came under scrutiny in order to improve opportunities for counselors wishing to work in CMHC positions. See Chapter 3, Education, Credentialing, and Professional Development, for more information about advances in education, licensure, and certification for clinical mental health counselors. A brief exploration follows.

## **DEVELOPING A PROFESSIONAL IDENTITY**

We have just learned how clinical mental health counselors came to exist. However, what is the professional identity of counselors? The answer may seem obvious. They are, after all, counselors, right? As you have been reading, however, the identity of counselors is

not always clear. Let's consider what it means to be a professional clinical mental health counselor.

As already mentioned, counseling is a profession, not a field. Professional counseling is built on a strong foundation rooted in a code of ethics, established through defined theories, and maintained through licensure, credentialing, and professional organizations. Professional mental health counseling was defined in the late 1970s as “an interdisciplinary multifaceted, holistic process of (1) the promotion of healthy life-styles, (2) identification of individual stressors and personal levels of functioning, and (3) preservation or restoration of mental health” (Seiler & Messina, 1979, p. 6). In other words, mental health counselors have always identified with the wellness and prevention-based approach. They assess stressors and strengths, develop an understanding of the etiology or cause of the concern, and generate interventions and preventions to fit the needs of the individual client.

As clear as this may seem, being a professional counselor is not without controversy. Relationships with the sister disciplines of psychology, psychiatry, social work, and marriage and family therapy have not always been harmonious, which brings us to a discussion of scope of practice.

### **Scope of Practice**

*Scope of practice* is a term commonly used by national and state licensure boards to describe the rights and limitations of the practice of any particular profession. Usually, scope of practice embodies the procedures, processes, and clientele served by a particular profession. Within the counseling profession, scope of practice is determined by state licensure boards and written into state law. As such, scope of practice for professional counselors varies from state to state.

In most states, clinical mental health counselors are granted, through their scope of practice, the ability to provide intake assessment, diagnostic evaluation, and treatment of individuals, families, and groups. The terms *psychotherapy* and *psychoanalysis* are examples of terms that might be protected due to scope of practice limitations. In many states, clinical mental health counselors can provide psychotherapy but rarely, if ever, are they allowed to call themselves psychoanalysts. That title is typically reserved for professionals with an MD (doctor of medicine), PhD (doctor of philosophy), or PsyD (doctor of psychology) degree and additional training in psychoanalysis.

Because the profession of counseling is regulated on a state-by-state basis, these distinctions can become very complicated for counseling students. It is essential to research your state law and understand the title designated to professional counselors in your state, scope of practice limitations, and licensure requirements. This is further explored in Chapter 3.

### **Professional Training**

As already mentioned, when professional counselors emerged on the scene, there was a need to standardize their professional training. Because a strong professional identity was missing in the field of counseling, initiatives began to ensure that those who call themselves professional counselors have received adequate training to provide clinical mental health counseling services. To meet this need, a division of the American Counseling Association (ACA) became involved in the standardization of training. The Association for

Counselor Education and Supervision (ACES) developed some initial standards that would allow counselor preparation programs to seek voluntary accreditation. From this initiative, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) was born.

Beginning in the early 1980s, CACREP offered voluntary accreditation to counselor preparation programs. The purpose of accreditation is to create a unified set of training standards that, in turn, strengthen the professional practice of counseling (CACREP, 2013a). CACREP accredits close to 600 programs at universities across the United States in the following specialty areas:

- Addiction Counseling
- Career Counseling
- Clinical Mental Health Counseling
- Marriage, Couple, and Family Counseling
- School Counseling
- Student Affairs and College Counseling
- Counselor Education and Supervision

Of specific interest to this text is the clinical mental health counseling specialty. This program's accreditation is one of the newest offered by CACREP and represents a movement away from the separate programs of community counseling and mental health counseling. The clinical mental health counseling specialty was introduced in 2009 and is defined in the following section.

## **Clinical Mental Health Counseling**

Clinical mental health counseling programs prepare graduates to work with clients across a spectrum of mental and emotional disorders, as well as to promote mental health and wellness. Clients may be seen individually, as couples, in families, or in group settings. Clinical mental health counselors are knowledgeable in the principles and practices of diagnosis, treatment, referral, and prevention and often work in interdisciplinary teams with other health professionals (e.g., psychiatrists, social workers, MDs). Employment opportunities may include private practice, community-based mental health centers, hospitals, and other treatment settings (CACREP, 2013b).

Students who pursue a master's degree in a CACREP-accredited clinical mental health counseling program take courses that meet a multitude of requirements in these areas:

- Foundations of Counseling
- Counseling, Prevention, and Intervention
- Diversity and Advocacy
- Assessment
- Research and Evaluation
- Diagnosis

Central to the CACREP philosophy is that students are assessed on both knowledge and skills in relation to these topic areas. Because of this, CACREP graduates are afforded a number of additional opportunities in employment, certification, and licensure. Let's hear from one such graduate and how she has found her place in the profession of counseling.

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## VOICE FROM THE FIELD 1.1

I have a passion for counseling and helping others reach their full potential. Helping clients and students discover coping mechanisms they did not know they possessed and identifying alternative ways of approaching everyday problems is what I enjoy the most. I like the fact that counseling serves as a stronger, more realistic link between education and work. This is one of the main reasons the profession is growing so fast. Some factors that have influenced me the most would be the opportunity to teach counselors in training, embrace diversity and community, and foster change within my clients and in my community. I received my master's from a CACREP program at Delta State University and now am a PhD student in the Counselor Education and Supervision program at Walden University. My educational experiences have afforded me the opportunity to act as a social change agent and contribute not just to my profession but to my community as well.

The flexibility, objectivity, and the nonjudgmental approach of counselors is what, I think, separates counseling from other disciplines. This is not to say that any of the other human service professions (social work or psychology) do not provide this same opportunity, but only that, for me, the counseling profession seemed to go beyond the basics and provided insight that is more beneficial in order to help clients be able to help themselves. In many ways it has to do with who I am and where I believe my strengths and skills will have the greatest impact.

As director of student support services for the Robert E. Smith School of Nursing at Delta State University, I have been able to apply concepts and counseling approaches that I learned from my master's counseling program, in order to benefit and support a population of at-risk students, many of whom had not been exposed to counseling before. Currently I serve as president of the Mississippi Counseling Association, and this experience has only served as verification that I am pursuing the correct profession. The ideas, standards, activities, and functions within the association fit my beliefs of the importance of counseling as well as provide me with an opportunity to advocate for my profession. Having the opportunity to serve as president of a state association has given me a great sense of pride and accomplishment, not just for my profession but for who I have become as a result of being a counselor and a person.

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## LICENSURE AND CERTIFICATION

In the field of clinical mental health counseling, certification is offered by a host of providers whereas licensure is offered by states only. Both topics are briefly covered here. For a deeper discussion, please see Chapter 3.

### Licensure

As already mentioned, CACREP is an accrediting body that sanctions the training process of counselors. Accreditation is one way that the profession shows accountability to standards. However, CACREP addresses graduate training only, and although it provides an excellent foundation for the licensure process, simply graduating from a CACREP program does not guarantee licensure. Licensure is government-sanctioned regulation of the practice of counseling that occurs at the state level.

Licensure as a professional counselor is defined by the regulatory power of each state. In other words, every state is charged with both the right and the requirement to pass licensure laws, develop state regulatory agencies, and engage in all necessary activities

deemed appropriate to protect the public (ACA, 2012). In most states, it is illegal to practice counseling without a license. However, because state laws differ, it is possible that your state does not require a license for all types of employment as a counselor. As counselors in training, it is imperative that you become extremely familiar with your state's licensure law and state regulations for acquiring and maintaining your license. You will also want to investigate the type of license: will you be licensed as a Licensed Professional Counselor (LPC), or a Licensed Mental Health Counselor (LMHC), or does your state use another title?

From state to state, these licenses do not have automatic reciprocity; that is, simply because you hold a license in one state does not mean you will automatically receive a license in another state. Each state holds the responsibility to establish standards toward licensure and moderate its practice in the state. There are substantial differences in training requirements, supervision requirements, and state-specific continuing education requirements between states. For example, most states recognize CACREP as the minimum standard for training. For students graduating from non-CACREP-accredited programs, states may require copies of syllabi or course descriptions to determine CACREP equivalency. In addition, the state may require added coursework that your graduate program did not require. In Florida, the license is LMHC (Licensed Mental Health Counselor). Students who graduate from a CACREP Clinical Mental Health program have their training automatically counted toward licensure. As someone who graduated from a CACREP Community Counseling program, I had to provide evidence that I had taken courses in substance abuse and sexuality counseling to qualify for consideration for licensure. In addition, I am required to take continuing education courses in the prevention of medical errors, Florida laws and rules, HIV/AIDS, and domestic violence in order to complete requirements for licensure. Of course, ongoing specified continuing education is required to maintain the license once it is granted.

In recent years, all 50 states have established laws to regulate the profession of counseling. Although an in-depth discussion of all of the states is beyond the scope of this chapter, there are some basic commonalities and areas of difference for counselors in training to be aware of. In all 50 states, a master's degree is required for a license as a professional counselor or a professional mental health counselor. Most states require that the degree be in counseling, although some states allow for related degrees. Counseling psychology is also accepted in many states. Master's degrees in psychology or social work are rarely accepted for initial licenses in counseling, but they may be accepted in situations of reciprocity or endorsement of a license from another state. In other words, someone who was licensed decades ago based on his or her master's in social work might be eligible for a license in another state that would not currently accept a master's in social work candidate. The endorsement of the previous license is based on the fact that at the time the person was initially licensed, he or she met all qualifications required by that state. Because state laws change so often, it is important to keep up with licensure regulations of your current state as well as any states you may consider moving to.

Aside from the type of graduate program required, the number of supervised clinical hours post-master's is also a subject of discrepancy among states. Some states require 1,000 hours post-master's, whereas others may require up to 3,500 hours but allow the hours you accrued during your degree program to count toward that total. Certain states require that the supervisor be another licensed helping professional from any discipline, whereas others require that the supervised hours be provided by a board-qualified supervisor in the same profession. When investigating the number of supervised clinical

hours needed for your state, be sure to inquire about the type of supervisor needed, the number of hours needed, and whether or not any hours from your master's program will count toward the total.

Once you are licensed, you will be required to maintain your license by completing a specified number of continuing education units on a regular basis. Some states have annual renewals, whereas others renew every two years. Many states require that your continuing education be in specified topic areas such as ethics or medical errors. Again, this is information you will need to verify as you begin your career as a licensed counselor in your state.

The role of the state licensure board is to protect the public. One of the ways the board does this is through adjudication of complaints. Serving as the ultimate authority over a counselor's license, state boards can grant, suspend, or revoke licensure for cause. Although this is a rarity, it does happen. If a complaint is made to the board, an investigation occurs. The counselor is not charged with proving innocence, but in some cases the complainant is able to prove guilt.

The idea of an ethical complaint is frightening to most counseling students—with good reason. They enter into this profession with the desire to help people. They cannot imagine a time when their practice may be considered unethical. The reality is that counselors do not practice without risk. They carry liability insurance, attend risk management seminars, and complete continuing education units in counseling ethics in order to protect themselves, their clients, and their license. Although the number of inquiries about ethical practice is on the rise (ACA, 2013), the actual number of filed complaints is still very small compared to the number of practicing counselors.

## Certification

Whereas a license is established and governed by the state, certification is available to counselors through various other entities such as the National Board for Certified Counselors (NBCC), which offers the National Certified Counselor (NCC) credential. It is often difficult for people outside the counseling profession to understand why state licensure is more important than certification through a national body such as NBCC. As an example, most people go to a hairdresser or barber to get their hair done or cut. This person may be extremely skilled and have graduated from a great program (that is, similar to the counselor's CACREP). She or he may have gone for advanced training at a specialty school in another state and become certified in a particular color or cut method; this certification is similar to certification as a National Certified Counselor (NCC), for example. However well prepared (degree program) and trained (certificate) that hairdresser or barber is, she or he cannot touch someone's hair without having a state license.

So, outside of becoming an NCC, what types of certifications are available for clinical mental health counselors? Some certifications are natural extensions of counselors' areas of interest, whereas others support the type of work environment in which they practice. This section continues with two certifications offered by the National Board for Certified Counselors and two offered by alternate professional entities. Be sure to explore these and other certifications to determine your best fit.

**CERTIFIED CLINICAL MENTAL HEALTH COUNSELOR** The dominant certification for clinical mental health counselors is the Certified Clinical Mental Health Counselor (CCMHC)

designation through NBCC. The CCMHC is earned after successfully taking and passing the Clinical Mental Health Counseling exam. This exam is used in a number of states for licensure as an LMHC. At the national level, the exam is required for certification as a CCMHC. In addition to the exam, the counselor must also hold the NCC and show proof of requisite training and experience. For further information about becoming a CCMHC, visit the NBCC Web site at [www.nbcc.org/Specialties/CCMHC](http://www.nbcc.org/Specialties/CCMHC).

**MASTER ADDICTIONS COUNSELOR** The Master Addictions Counselor (MAC) designation was developed as a joint venture between NBCC and the International Association of Addictions and Offender Counseling (IAAOC), which is a division of ACA. The MAC certification shows evidence of a specialty in addictions counseling and allows those credentialed to seek employment with the US Department of Transportation as a substance abuse professional. Candidates for the MAC must successfully take and pass the Examination for Master Addictions Counselors (EMAC) and show proof of graduate or continuing education in addictions and a substantive work experience in addictions counseling. For further information about becoming a MAC, visit the NBCC Web site at [www.nbcc.org/Specialties/MAC](http://www.nbcc.org/Specialties/MAC).

**CLINICALLY CERTIFIED FORENSIC COUNSELOR** The Clinically Certified Forensic Counselor (CCFC) is one of many certifications offered by the National Association of Forensic Counselors (NAFC). CCFC certification indicates competency in working with offenders. Counselors who are licensed in their state and have three years of experience working with offenders or ex-offenders are eligible to take the certification exam. More information about forensic counseling can be found in Chapter 12 of this text. For further information about becoming a CCFC, visit the NAFC Web site at [www.nationalafc.com](http://www.nationalafc.com).

**REGISTERED PLAY THERAPIST** The Registered Play Therapist (RPT) is a certification offered by the Association for Play Therapy (APT) to state-licensed counselors who have specialty training and experience in play therapy. The RPT designation indicates that the counselor has supervised work experience as a play therapist and has met multiple standards of training competency in play therapy. In addition, certified RPTs can elect to become RPT-Ss, or Registered Play Therapist-Supervisors. For further information about becoming an RPT, visit the APT Web site at [www.a4pt.org](http://www.a4pt.org).

These are but a few examples of the many forms of certification available to mental health counselors as you continue in your career. Work environment, client population, and personal interest will determine the certifications you pursue. By attending continuing education events and professional conferences, reading various journals, and participating in networking with colleagues, you will find the advanced certifications that best complement your licensure. If you think of licensure as the meat and potatoes of your professional credentials, certifications are really the fantastic side dishes and desserts that set you apart from others in your area.

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## Conclusion

This chapter has served as your introduction into the profession of clinical mental health counseling. As you have learned, clinical mental health coun-

selors have specialized training in their graduate programs. CACREP standards dictate the training for accredited programs. The National Counselor

Examination and the National Clinical Mental Health Counseling Examination serve as testing points to provide evidence of academic and clinical competency. Supervised work experience, supervisor endorsement, and state-specific continuing education allow candidates to be licensed

at the state level. Certification as an NCC or NCMHC is also available to clinical mental health counselors. Finally, certifications from outside professional organizations provide additional opportunities for mental health counselors to showcase their experience and talents to prospective clients.

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# Ethical and Legal Issues

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## CHAPTER OVERVIEW

Ethics and legal issues are some of the most challenging that practicing counselors will face. This chapter introduces readers to the American Counseling Association (ACA) and the American Mental Health Counselors Association (AMHCA) codes of ethics and how they apply to the practice of counseling. Readers will be exposed to various ethical decision-making models that may be used to guide counselors as they approach ethical dilemmas in practice. Legal issues and concerns that are relevant to clinical mental health practice will be discussed. Finally, specific ethical and legal concerns and their relevant codes will be provided so that readers can begin to learn how to apply the professional codes of ethics to common ethical dilemmas.

## LEARNING OBJECTIVES

The learning objectives for this chapter are designed to be consistent with the 2009 Council for Accreditation of Counseling and Related Educational Programs Standards (CACREP, 2009). As such, upon completion of this chapter, the student will have knowledge of the following clinical mental health counseling standards:

1. Understands ethical and legal considerations specifically related to the practice of clinical mental health counseling. (A.2)
2. Is aware of professional issues that affect clinical mental health counselors (e.g., core provider status, expert witness status, access to and practice privileges within managed care systems). (A.7)
3. Demonstrates the ability to apply and adhere to ethical and legal standards in clinical mental health counseling. (B.1)

Additionally, students will have knowledge of the following core entry-level standards:

1. Ethical standards of professional organizations and credentialing bodies, and applications of ethical and legal considerations in professional counseling. (G.1.j.)

## INTRODUCTION

A cornerstone to every profession is a code of ethics developed by the profession for the profession. In the case of clinical mental health counselors, there are a number of codes of ethics under which they may fall. Regardless of professional affiliation, the

code of ethics developed and adopted by the American Counseling Association often serves as the gold standard in legal complaints. Although you will likely take a separate course in ethics, in this chapter we review the broad principles of ethics that undergird the profession of clinical mental health counseling, consider ethical decision-making models as they apply to the contemporary practice of counseling, address specific codes to which you may adhere, explore legal considerations in the profession, discuss common ethical complaints and sanctions, and evaluate ethical dilemmas through the use of selected case studies.

## **ETHICS AND CLINICAL MENTAL HEALTH COUNSELING**

The discussion of ethics in clinical mental health counseling begins with an overview of general ethical principles. Ethics is “a discipline within philosophy that is concerned with human conduct and moral decision making” and “standards of conduct or actions taken in relation to others” (Remley & Herlihy, 2010, p. 3). In other words, ethics is both a process of decision making and the behavioral outcome. You might wonder why those training to be helping professionals, dedicated to serving the greater good of vulnerable client populations, even have codes of ethics. It seems that the very nature of what counselors do would require an ethical approach. Ideally, that is the case. However, as a profession it is important to develop, publish, and uphold a standard of ethics in order to set minimum professional standards and develop a system of accountability to protect clients and practitioners alike.

Historically, there are references to ethics, morals, and values in virtually all world religions. Philosophers such as Plato have long explored and debated the finer points of ethical decisions. Essentially, ethics provides a moral map but rarely offers explicit answers. In fact, ethics tends to provide us with multiple answers, and then the individual making the decision has to determine which path on that moral map to take. Ethics is one of those arenas in which there may be more than one right answer.

Let’s take a look at a brief case example to see how this might be true. Your client, Kevin, is doing well in therapy. During this particular session, he informs you that he has lost his job due to a recent plant closure and will not be able to continue seeing you because of his inability to pay your fees. How might you respond? When I present this scenario to beginning counselors, they often have a host of questions: How long have I been seeing Kevin? What have I been seeing him for? What does it mean that he’s been “doing well”? Did he know that the plant was going to close? Granted, this is a brief scenario, but even with this small amount of information some ethical responses can begin to be developed. For example, some counselors decide that they will continue to see Kevin on a pro bono basis. This appears to be ethical in that the client continues to get services and there is no abandonment of the client. However, from a practical perspective, how many pro bono clients can any counselor afford to take? Another take on this case example is to refer Kevin to a clinic that charges according to a sliding scale so that he can afford to continue treatment. Although this is a very different answer, such an action may also be ethical in that the client continues to receive treatment. Others respond that they will continue to see Kevin while allowing him to essentially run up a tab in therapy that he can pay when he is once again gainfully employed. This approach may also be ethical in that the client continues to receive services, and in this case, the counselor has an opportunity to perhaps receive compensation for the services. So here is one ethical dilemma with perhaps three very different but still ethical responses!

Although the case of Kevin provides only a brief example, it demonstrates that ethical decisions can be very complex and can have numerous answers. In this chapter, we look at ethical decision-making models that will help you arrive at the conclusion that best fits your values and the needs of your client.

As a clinical mental health counselor, you may have a number of codes to adhere to. You will find that codes have more in common than they do differences. For the purposes of this text, we explore the two primary codes that apply to clinical mental health counselors: the code of the American Counseling Association (found at [www.counseling.org/Resources/aca-code-of-ethics.pdf](http://www.counseling.org/Resources/aca-code-of-ethics.pdf)) and the code of the American Mental Health Counselors Association (found at [www.amhca.org/assets/news/AMHCA\\_Code\\_of\\_Ethics\\_2010\\_w\\_pagination\\_cxd\\_51110.pdf](http://www.amhca.org/assets/news/AMHCA_Code_of_Ethics_2010_w_pagination_cxd_51110.pdf)).

### **American Counseling Association Code of Ethics**

Considered the gold standard of counselor ethics, the American Counseling Association code is the umbrella under which all counselors fall. Dating back to the early 1960s, the first code was developed for the organization, formerly known as the American Personnel and Guidance Association (APGA). Donald Super, in his role as president of APGA, called for the first code of ethics. The initial code took eight years to develop. Two years after the code was published, the association began collecting case examples of ethical dilemmas from counselors. By 1965, ACA (operating as APGA) published its first ethical standards casebook. Both the code and the casebook have been revised many times in the history of the organization (Kennedy, 2005).

By 1990, the profession of counseling had changed dramatically. Despite several revisions along the way, an extensive revision of its code was necessary to address emerging trends in contemporary counseling. This time, the revision was a more transparent process with ACA members invited to submit ideas for the code and to comment on the initial draft. A final product was published in 1995, with another comprehensive revision occurring in 2005 (Kennedy, 2005). More recently, the code has gone through yet another comprehensive revision.

Why do the codes need to be revised so often? Shouldn't ethics be like morals and stay the same through the years? In actuality, the code of ethics is a dynamic document that requires practitioners to revisit it regularly to ensure that it meets the needs of their clients and the standards of the profession of counseling. Codes are rewritten to reflect a broadening awareness of multicultural factors, to address social changes, and to ensure applicability to a modern society.

It is essential to take note of the purposes of the code. The ACA Code of Ethics serves five main purposes:

1. The Code enables the association to clarify to current and future members, and to those served by members, the nature of the ethical responsibilities held in common by its members.
2. The Code helps support the mission of the association.
3. The Code establishes principles that define ethical behavior and best practices of association members.
4. The Code serves as an ethical guide designed to assist members in constructing a professional course of action that best serves those utilizing counseling services and best promotes the values of the counseling profession.

5. The Code serves as the basis for processing of ethical complaints and inquiries initiated against members of the association (ACA, 2005, p. 3).

As you can see, the ACA code is instrumental in clarifying the professional responsibilities of all counselors and guides their practice. It also serves to protect clients of all types of counselors.

### **American Mental Health Counselors Association Code of Ethics**

Whereas the ACA Code of Ethics provides primary direction for the work of counselors, most clinical mental health counselors are also governed by the ethical code of the American Mental Health Counselors Association (AMHCA). To better understand this code, it is important to understand AMHCA as an organization.

The American Mental Health Counselors Association was formed in the mid-1970s when it became apparent that the counselors falling under the umbrella of the APGA, the organization which later became ACA, held a multitude of specialties and functioned in a variety of work settings. Mental health counselors discovered a need for a subgroup to focus on mental health counseling concerns and investigated the creation of a new division within APGA. However, APGA had passed a moratorium on the creation of new divisions, so AMHCA developed as a freestanding entity; it later rejoined APGA when the moratorium was lifted. Membership grew rapidly, and this committed group of individuals began to formalize its professional identity through the development of leadership, training standards, and a code of ethics (Colangelo, 2009).

AMHCA and ACA have not always been content as partners. AMHCA membership often felt that ACA was too spread out and unfocused. AMHCA prided itself on truly serving the clinical mental health counselor and promoting associated legislation. Over the 1990s, AMHCA membership continued to grow, ACA membership fell, and ACA moved away from the type of legislative efforts important to AMHCA. As such, the two organizations separated in terms of finances and administrative hierarchy. However, AMHCA continues to maintain its status as an official division of ACA (Colangelo, 2009), and thus its code of ethics falls within that structure.

The AMHCA code was first written in 1976 when the organization formed and was most recently revised in 2010 ([www.amhca.org](http://www.amhca.org)). Its preamble distinguishes the code as being specific to mental health counselors and highlights the commitment mental health counselors have to ongoing education of themselves and about the clients they serve (AMHCA, 2010).

The AMHCA code defines its purposes as

1. To assist members to make sound ethical decisions
2. To define ethical behaviors and best practices for Association members
3. To support the mission of the Association
4. To educate members, students and the public at large regarding the ethical standards of mental health counselors (AMHCA, 2010, p. 1)

From a technical perspective, only AMHCA members are governed by this code. However, taking that technical perspective meets only the letter of the law, not the spirit. All clinical mental health counselors should consider the AMHCA code when faced with ethical conflicts. Why? The AMHCA code not only encompasses all the core values and

principles of the ACA code but also provides a section specific to client rights. So although counselors may not fall under both codes, a distinction discussed in the next section, they should consider them both as they formulate ethical decisions.

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## VOICE FROM THE FIELD 2.1

Being a self-admitted ethics geek, it is hard to pinpoint the exact time in my professional career when I became interested in counseling ethics. During my PhD program, I began to do more research into ethics and ethical practice. Toward the end of my PhD program, I saw that the president of ACA was seeking volunteers to serve on its various committees. One committee option was the ACA Ethics Committee.

I figured it was a long shot, but I submitted my application and was later surprised when the president appointed me to a three-year term on the Ethics Committee. I was both nervous and excited about this professional opportunity. This is when my true passion for ethics came alive. I got to work side by side with the leading ethics experts in our field. We debated issues of ethical practice, and through each dialogue we had, and each ethics hearing we conducted, I learned about the importance of valuing the gray in counseling and ethical decision making. During my time on the ACA Ethics Committee, I was appointed to chair the ACA Code of Ethics revision process. Our task force met for three years as we crafted what is now the 2005 ACA Code of Ethics. If someone were to have told me during my graduate training that someday I would be chairing the task force that would be writing ethics policy and standards that would impact the entire profession, I would have thought he or she were a little . . . well . . . crazy. Helping write the ACA Code of Ethics was one of the highlights of my professional career, an experience I will never forget. It was a privilege to work with such visionaries and scholars in creating ethical standards in a wide range of areas, such as diversity, end-of-life issues, technology, boundaries, and a host of others.

I think our profession has to address the cutting-edge ethical issue of social media, as more and more people are using it; according to some reports, if you were to count all the people in the world that use social media, it would be the third largest country in the world! Because of the vast potential of emerging technology, along with legitimate ethical concerns about it, counselors must further learn about the ways to use it to best serve their clients. I also think that the profession will continue to grapple with traditional ethical issues such as confidentiality, boundaries, and dual relationships, especially in various cultural and rural communities.

When I teach my graduate ethics course to counseling students, I give each student a ribbon on the first day of class. This ribbon has three stripes—one white, one black, and one gray—and is emblematic of what I hope my students will take away from my ethics course. I want them not to study or memorize a bunch of rules or ethics standards to avoid getting into professional trouble, but, more important, to embrace the gray of ethics; to recognize the importance that sometimes ethical dilemmas are multifaceted and complex. Counseling professionals have to become comfortable in their “thinking” about ethics, as well as their “feeling” about ethics and about the gray space in each and every ethical challenge . . . it is what I call the “head” and “heart” process of ethics. I encourage any graduate student and new professional to consider joining a professional ethics committee. Learn all you can about ethics. Share your passion for the gray!

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### Which Code Do I Fall Under?

Which code do you fall under as a clinical mental health counselor? This is a complex question with a deceptively simple answer: it depends. First of all, it depends on an individual’s

professional affiliations. If counselors are a member of ACA and of AMHCA, they fall under both codes. The ACA code is used when counselors hold no membership; and because ACA is the parent organization and AMHCA a division, it is likely that even counselors with only AMHCA membership are to uphold ACA standards as well. The second consideration is state law. Each state has the independent liberty to elect to adhere to the ACA, AMHCA, or state-specific codes. Many states choose to use the AMHCA code because it encompasses the ACA code and is specific to professional mental health counselors. However, many other states use the ACA code as the “parent” code for all counselors. Ultimately, it is individual counselors’ responsibility to understand both their professional memberships and state law.

Be aware that the two codes discussed here are not the only codes under which clinical mental health counselors may fall. Those seeking credentialing as a National Certified Counselor will fall under the National Board for Certified Counselors (NBCC) code. Those electing to obtain additional certification, for example, as a Certified Substance Abuse Counselor, will need to adhere to that code as well. As previously mentioned, the good news is that ethical codes have more in common than they do differences. However, it is each individual’s obligation to understand and uphold all of these codes in his or her practice as an ethical counselor. Most licenses and certifications require ongoing continuing education in ethics in order to keep professionals in touch with these guidelines. By complying with those standards of career-long learning, clinical mental health counselors will be able to maintain an understanding of ethical codes and current trends in the profession.

## Ethical Decision-Making Models

Identify a time when you had to make a particularly difficult decision in which there was no one right answer. How did you determine what to do? What steps did you take? In counseling the ethical codes are the framework for all ethical decisions; however, they do not tell anyone how to make those decisions. A professional may know that something is wrong, but be unsure about how to make it right. Of great importance to the ethical counselor is the use of ethical decision-making models. The foundation of all ethical decision making is this set of fundamental principles originally conceptualized by Kitchener (1984):

1. **Autonomy**—Counselors believe in the client’s right to independence and ability to choose.
2. **Nonmaleficence**—Counselors believe that they have an obligation to do no harm.
3. **Beneficence**—Beyond doing no harm, counselors believe in the obligation to do good and to be of help to the client.
4. **Justice**—Counselors treat clients the same under the same conditions.
5. **Fidelity**—Counselors are loyal, faithful, and trustworthy in order to support the client.

These central principles represent the base on which ethical codes and ethical decision-making models are built. The ultimate goal of these principles is to create a trusting environment that represents the client’s best interests. This is crucial to keep in mind in the discussion of how to determine whether an ethical dilemma exists and how best to address it.

Ethical decision-making models are stepwise means to approach an ethical dilemma. In the ACA Code of Ethics purpose statement, counselors are specifically asked to use an ethical decision-making process whenever they face an ethical dilemma (ACA, 2005). Because numerous ethical decision-making models exist, and because counselors differ

in their values and expectations related to ethical decision making, they “are expected to be familiar with a credible model of decision making that can bear public scrutiny and its application” (ACA, 2005, p. 3). Using such a model, counselors can then make sound ethical decisions that are in the best interests of the clients and public they serve.

In short, ethical counselors are required to utilize an ethical decision-making model when faced with an ethical quandary. If proof of doing so is requested, the counselor should be able to produce the model and discuss the steps taken, including how the counselor arrived at the outcome and the actions taken as a result.

Because an ethical decision-making model is essential to use, and because no one model is empirically validated above another, this discussion focuses on a number of well-known and often used models in the counseling profession. As you review these, recognize that some of these models fit particular theories, whereas others fit particular types of mental health counseling. It is incumbent on counselors to find and utilize the model that best fits the problem or challenge at hand. And, as always, it is their professional responsibility to document the process.

There are numerous ethical decision-making (EDM) models available for counselors. ACA provides counselors with “A Practitioner’s Guide to Ethical Decision Making” (Forester-Miller & Davis, 1996) as a guide in deciding how to make ethical decisions. ACA offers a blended model that incorporates multiple well-known EDMs, and it serves as the basis for discussion in this chapter.

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## VOICE FROM THE FIELD 2.2

I originally developed an interest in ethics when I noticed the lack of actual ethical decision making (i.e., the use of an ethical decision-making model or systemized plan) occurring among practitioner colleagues, field supervisors, and recent graduates. Instead, it seemed more common practice to “talk one’s way out” of a gray area with a client and then document one’s actions. Although some in this circle went as far as consultation with other professionals—which is a good thing—following an actual plan when faced with a gray area or ethical dilemma seemed to occur infrequently. Additionally, it appeared that many master’s-level students understood the definition of ethical decision-making (EDM) models and had learned about them, yet stopped short of applying this awareness into practice. Frankly, in my 10 years of supervising master’s-level field experiences, I cannot recall a field experience supervisor using and/or teaching an actual ethical decision-making model to an intern. This is not to say that these supervisors and others are not doing so, but I never experienced it. This concerned me.

Implementing an ethical decision-making model is listed as number two of the top ten risk management strategies that may lower counselors’ risk of liability (Wheeler & Bertram, 2008). So although EDM models seemed not to be common practice, use of them may protect practitioners from legal risk.

Becoming aware of what seemed to be limited use of ethical decision-making approaches made me wonder how ethical decisions were being made by practitioners. I also speculated often about the larger ethical responsibility we have toward each other as practitioners and that counselor educators and supervisors have for counselors in training/students, and counselor educators and practitioners have for the welfare of the general public, one of the foundations of our ethical code (ACA, 2005). I began to consider how I could help in this area of professional counseling, and this led to my considering application to the ACA Ethics Committee.

I would be remiss if I didn’t also admit to an odd, but maybe human, fascination with violations of ethical practice in professional counseling. Many of us think of the standard counseling course in

ethics as typically tough but nonetheless interesting—and sometimes even exciting—to consider the gray in human behavior that goes astray for what, to the onlooker, seems illogical. At present, the two most common violations of ethical practice are intimate relationships with clients and inadequate informed consent. In our day-to-day practice, we wonder how others can cross professional boundaries and enter into sexual misconduct with those they have a professional obligation to protect and help. And, often we assume informed consent is a sort of “check off the box” procedure; that is, we tell the client how to reach us during a crisis, how we work, when we break confidentiality, and we find out who makes up the client’s support system. Often, we don’t keep in mind that adequate and appropriate informed consent consists of these elements plus a regular check-in with the client to assess for his or her comprehension. So how is it that others commonly cross professional boundaries and rarely check in with clients for comprehension, when we know the associated risks of both? Seems irrational, doesn’t it? This is the personal side of my interest in ethics—an interest in the side of human behavior that involves a paradox of logic and illogic; that is, knowing better but doing it nonetheless.

Being a member of the Ethics Committee enabled me to participate in adjudications that investigated ethical violations of the ACA membership and in delving deeply into the many ethical codes. Reviewing the codes in relation to potential violations, and discussing matters with other committee members, can be fulfilling for those who appreciate complex discussions about gray areas, which also have to follow a particular level of structure. Most of us have a proclivity for a particular area of study or population in which we enjoy being immersed. Ethics is that area for me.

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**KITCHENER** The first EDM addressed is one of the oldest applied to the counseling profession. In 1984, Kitchener wrote a groundbreaking article on the application of moral principles to ethical decision making. In it, she asserted that the five moral principles previously mentioned undergird all ethical concepts (Kitchener, 1984). The moral principles of autonomy, nonmaleficence, beneficence, justice, and fidelity have been widely accepted in the fields of helping professions as crucial to ethical decisions. Kitchener posited that these principles serve as the foundation for understanding the ethical dilemma and thus generating the best solutions. For example, ethical dilemmas about privacy or confidentiality are often impacted by the moral principle of autonomy. When a counselor breaks a client’s confidentiality, the counselor is not allowing the client to make the decision about who knows his or her information. Is this always unethical? Of course not! Within autonomy are embedded concepts related to competence. If someone is a minor, mentally compromised, or a threat, that person is not competent to make autonomous decisions. It is in such situations that the various ethical codes may actually seem to contrast with one of the primary principles, such as client autonomy.

In other words, even the principles our ethical codes are built on are not absolute. Rather, when using the Kitchener EDM, we are asked to consider the five moral principles as *prima facie* binding. This simply means that we are obligated to abide by the concepts outlined within the five moral principles “unless there are special circumstances or conflicting and stronger obligations” (Kitchener, 1984, p. 52). The conditions that overturn these principles must be strong ones, as you can imagine, and may even be dictated by law.

**BENEFICENCE MODEL** The concept of beneficence was introduced through Kitchener’s model. Later, a model built on that principle emerged and has been effectively used in counseling. Sileo and Kopala’s (1993) Beneficence model is composed of an A-B-C-D-E worksheet intended to promote ethical decisions that serve to help the client in the

situation; thus the term *beneficence* is applied. The A-B-C-D-E worksheet attempts to make abstract ethical dilemmas concrete and problem solving more practical. Although there are no perfect solutions, and the steps of the worksheet are not ordered sequentially for all dilemmas, this worksheet serves as a handy guide, particularly for the beginning counselor. A brief overview of the model follows:

**A. Assessment**

1. What is the client's mental state?
  - a. What are his/her strengths, support systems, weaknesses?
  - b. Is a psychiatric/medical consult necessary?
2. How serious is the client's disclosure? Is someone at risk for physical harm?
3. Are there cultural values and beliefs which should be considered while assessing the client?
4. What are my values, feelings, and reactions to the client's disclosure?

**B. Benefit**

1. How will the client benefit by my action?
2. How will the therapeutic relationship benefit?
3. How will others benefit?
4. Which action will benefit the most individuals?

**C. Consequences and Consultation**

1. What will the ethical, legal, emotional, and therapeutic consequences be for:
  - a. The client?
  - b. The counselor?
  - c. Potential clients?
2. Have I consulted with colleagues, supervisors, agency administrators, legal counsel, professional ethics boards, or professional organizations?

**D. Duty**

1. To whom do I have a duty?
  - a. My client?
  - b. The client's family?
  - c. A significant other?
  - d. The counseling profession?
  - e. My place of employment?
  - f. The legal system?
  - g. Society?

**E. Education**

1. Do I know and understand what the ethical principles and codes say regarding this issue?
2. Have I consulted the ethical casebooks?
3. Have I recently reviewed the laws that govern counseling practice?
4. Am I knowledgeable about the client's culture?
5. Have I been continuing my education through journals, seminars, workshops, conferences, or course work? (Dinger, 1997, p. 37)

Sileo and Kopala (1993) are quick to point out that the worksheet does not provide perfect solutions. There are no formulas for ethical decision making. However, once an ethical dilemma is identified, the worksheet does help counselors evaluate potential courses of action.

**FORESTER-MILLER AND DAVIS** The final EDM investigated here is one that is a bit older, but considered seminal in the field: the Forester-Miller and Davis model. This model is derived from earlier seminal works including Kitchener's and is contained in a document housed on the ACA Web site entitled "A Practitioner's Guide to Ethical Decision Making." Forester-Miller and Davis (1996) suggest that the first step in any ethical decision is to determine whether there is a problem. There are numerous challenges in the counseling field but not all of them are unethical. Some behaviors are unethical, some illegal, and others are unprofessional. Can you think of a behavior that a counselor might engage in that is unprofessional but is not illegal or unethical? For example, what if a counselor is routinely 10 minutes late? Or what if a counselor accepts checks but doesn't deposit them for several weeks? Or how about the counselor who decorates her office and herself in all purple, and purple only? These are examples of things that may be unprofessional but are rarely unethical or illegal. Conversely, counselors may engage in illegal behaviors that are not unethical. For example, counselors might speed to an appointment or park illegally when they get there. The point is that when looking at problematic or troubling events, the first step is always to determine whether an ethical problem even exists.

The second step according to Forester-Miller and Davis (1996) is to consult the ACA Code of Ethics. In order for an issue to be an ethical dilemma, it must align with one or more of the codes. Of course, the counselor may also look to AMHCA and other relevant codes to determine how the issue is addressed there. The counselor is then encouraged, in the third step, to "[d]etermine the nature and dimensions of the dilemma" (Forester-Miller & Davis, 1996, p. 3). This simply means that the counselor looks at the moral principles, such as autonomy and beneficence, that were previously discussed. In addition, the counselor is instructed to consult the relevant professional literature that might guide the process. A final part of this step is to consult with other professionals. The act of consultation is critical and shows that the counselor did not act in isolation when making ethical decisions.

The fourth step of the Forester-Miller and Davis model is to generate all possible courses of action. This brainstorming activity is to help the counselor come up with any and all outcomes, even those that might be discarded. It is suggested that the counselor engage the help of a least one colleague in this effort to uncover ideas that he or she may be blind to in the moment. The fifth step involves an actual decision. After brainstorming and consulting, it is time to select and commit to a course of action. The process thus far indicates a willingness to find the best solution prior to acting. Of course, before acting on this decision, the counselor will engage in the sixth step, which is to evaluate this plan of action. Submit the choice to three tests: justice, publicity, and universality. To do so, ask yourself the following:

1. Would I treat other people the same way in a similar situation? (justice)
2. If this action were reported in the news, would I feel OK about my choice? (publicity)
3. Would I recommend this action to another counselor who consulted with me? (universality)

If the counselor can answer positively to all three questions, he or she is ready to engage in the seventh step and actually take the action (Forester-Miller & Davis, 1996).

To review, the model housed on the ACA Web site follows seven steps:

1. Identify the problem.
2. Apply the ACA Code of Ethics.
3. Determine the nature and dimensions of the dilemma.

4. Generate potential courses of action.
5. Consider the potential consequences of all options; choose a course of action.
6. Evaluate the selected course of action.
7. Implement the course of action. (Forester-Miller & Davis, 1996, p. 4)

## LEGAL ISSUES IN COUNSELING



Being an ethical counselor means understanding the association and state codes under which the profession falls, developing the ethical sensitivity needed to determine when dilemmas exist, and having an ethical decision-making model to follow to address these dilemmas. Part of the decision-making process involves investigating state or federal laws that may impact the decision. Although many counselors think they generally know what is and is not legal, the vast discrepancies in state laws require serious scrutiny into how ethical counselors practice legally.

First it is important to distinguish between the types of legal concerns that counselors may face. Criminal law would address issues such as felonies. For example, if a counselor were to embezzle from his or her office, that would fall under criminal law. Sex with a minor client would fall under criminal law, as would sex with an adult client in some states. Legal considerations that fall under the criminal heading are usually more obvious to counselors and carry severe penalties. Consequences of breaking laws and being prosecuted in a criminal court are intended to be punishments, such as incarceration. Civil law is different, however. Consequences of civil lawsuits are intended as redress; that is, as a means of compensating the victim for the wrong done to him or her. Civil cases can range from breaking confidentiality to slander to use of improper treatment techniques.

The reality is that anyone can sue anyone for anything. The proliferation of daytime court reality shows provides abundant evidence that we are a litigious society. Counselors do not practice without risk. They carry malpractice or liability insurance to help protect them should they ever need to defend their actions. Most counselors will never need to call upon this insurance policy, but in reality no one is immune to the potential of criminal charges or a lawsuit. It is important to be well prepared. Student counselors who join ACA or AMHCA receive liability insurance free as part of their membership, which will be useful during field placements. Following graduation, a liability policy is considered a necessity in risk management. Of course, the best defense is never to cross a legal boundary when working with clients, but such crossings do occur from time to time. Counselors must be well aware of state and federal laws that impact their work with clients.

Typically, each state will address a number of issues in its legal code. This code may be buried in terms for the medical profession but is likely used with counselors and other helping professionals as well. In other words, all of the laws will not be found under a simple heading “Laws About Counselors” in any state code or the federal code. Student counselors will become aware of the relevant laws during their graduate program, may take a jurisprudence exam about laws in their state prior to licensure, and will constantly seek continuing education to ensure they are aware of changes in the legal structure.

What types of laws impact the practice of counseling? There are many. Laws are on the books related to record keeping and storage, client confidentiality, minor consent and other forms of informed consent, billing and insurance, duty to warn, duty to protect, competency examinations, use of specific assessment instruments, privileged communication,

and so on. The specifics of these laws are beyond the scope of this chapter or this text. Individual counselors need to seek out the state laws that impact them and their practice prior to engaging in such practice.

### **The Counselor in the Courtroom**

While on the subject of legal issues, this text would be remiss if it did not also address the counselor in the courtroom. The preceding discussion alluded to the counselor as defendant. That is not a comfortable or desirable place for anyone in the profession to be. However, it may happen. What is also likely to happen is that the counselor will be invited into the courtroom for another purpose: for example, to testify, provide a deposition, produce records, or serve as a competency examiner. Although it is the rare counselor who is sued at the criminal or civil level, virtually every counselor I have ever met has received a subpoena or been involved in a client's court case at some level.

### **Subpoenas**

What is a subpoena and how should a counselor respond? A subpoena is a document requesting one's testimony or records. It can be issued by a court or an attorney (Wheeler & Bertram, 2012). A *subpoena ad testificandum* requests the counselor's testimony and is most likely issued by a court. A *subpoena duces tecum* requests the counselor's records or other documents, and may be issued by a court or an attorney.

Counselors have a number of steps to follow when they receive a subpoena. First, they should accept the subpoena. On television and in movies people often run from the subpoena server. As professionals, counselors are expected to receive this legal document and respond to it. Next, counselors consult with their attorney as well as their supervisor. If a counselor works for an agency, the agency has a right to know that the counselor has received a subpoena, and it probably has a protocol in place about how to respond. Counselors must not ignore a subpoena or they will be held in contempt of court.

Does receiving a subpoena mean the counselor has to produce all and tell all? Absolutely not. It begins the process, but is not the complete definition of the process. For example, I have received a subpoena at the end of a workday to produce records the next day. However, subpoenas must be delivered to allow sufficient time to respond. In this case, I was able to get a delay in order to have adequate time to determine the legal and ethical response. As another example, say that a counselor receives a subpoena to produce records or testimony that his or her client does not want the counselor to share, and the counselor lives in a state where he or she has privileged communication. The counselor may call upon that privilege. Privileged communication is simply any communication that occurs within the context of a legally protected relationship (Remley & Herlihy, 2010). Not all counseling relationships meet this legal standard. For example, I am licensed in a state where privileged communication is offered only to licensed counselors. For those who do not seek licensure or who have not yet earned their license, privileged communication does not exist. An attorney who works with medical and helping professionals will serve as a good guide for a counselor should any legal issues arise.

What about court testimony? As previously mentioned, a counselor may be asked to testify on behalf of a client or because of a subpoena. The profession's ethical code is clear that counselors do not provide forensic testimony about clients they have counseled (see ACA code, E.13.c. Client Evaluation Prohibited; ACA, 2005). On the other hand, if a

counselor is hired as an evaluator, then he or she can provide such testimony. However, a counselor cannot be seeing a minor client who is dealing with issues related to his parents' divorce and then offer court testimony related to who should have custody. In this instance, a counselor may have an opinion, but cannot share it.

Finally, counselors are guided by their ethical code to provide only the minimal information needed for any disclosure, even if giving more information is legal. If they receive a request for records, they must ascertain what records are specifically needed. If the client record contains records for a referring source, such as discharge paper from a hospital, counselors are not legally authorized to share that information. In many cases, a summary of the records is acceptable to the court. It is the rare occasion when a court truly wants or needs an entire client record. Generally, counselors will keep their client informed about the subpoena and consult with the client about the appropriate response.

## **COMMON ETHICAL AND LEGAL DILEMMAS IN CLINICAL MENTAL HEALTH COUNSELING**

Now that ethical codes, ethical decision making, and legal issues have been covered, the discussion will move on to those dilemmas that are common in the ethical and legal practice of counseling. This section looks at general areas of ethical and legal concern and is not intended to replace a course in ethics or additional ethical education.

### **Informed Consent and Confidentiality**

Have you ever thought about the level of privacy and confidentiality involved in counseling? You have probably assumed that what is said in counseling stays in counseling. However, this is not always the case. Confidentiality originated when society deemed the individual's right to seek treatment as greater than society's right to know why the individual was seeking treatment. As the helping professions have evolved, the concept of confidentiality has garnered a number of exceptions including duty to warn and protect from harm, court orders, and cases of malpractice.

Limits to confidentiality must be clearly explained to clients in language they can understand (see ACA code A.2.c. Developmental and Cultural Sensitivity; ACA, 2005). Typically, this process is referred to as *informed consent*. Informed consent actually includes a number of elements including risks and benefits of treatment, payment policies, and confidentiality. Informed consent is provided by the treating counselor, not a secretary or administrative person, when counseling is initiated. But informed consent is not a single event; it is actually a process. As such, the counselor is responsible for reminding the client about the limits of confidentiality throughout the treatment process. The ACA Code of Ethics contains an entire section (section B) on the idea of confidentiality and introduces the section with this foundation for understanding the importance of the topic:

Counselors recognize that trust is a cornerstone of the counseling relationship. Counselors aspire to earn the trust of clients by creating an ongoing partnership, establishing and upholding appropriate boundaries, and maintaining confidentiality. Counselors communicate the parameters of confidentiality in a culturally competent manner. (ACA, 2005, p. 7)

In addition, the AMHCA code contains a section (section I.A.2) dedicated to confidentiality with an emphasis on the need to protect any information about clients whether counselors work with them in clinical practice, research and assessment, or teaching and

evaluation (AMHCA, 2010). Although the ACA code addresses the idea of consent, the AMHCA code goes several steps further to discuss types of information that are considered confidential, the storage and disposal of such information, and ethical uses of electronic information. In this section of its code, counselors will also find directions related to confidentiality in specific situations such as when clients have a communicable or life-threatening illness, when a third-party payer requests information for insurance, and when information must be disclosed due to abuse or protection of life.

## Competence and Malpractice

Competence and malpractice are not only legal concerns but also ethical concerns. Is the counselor properly trained, certified, and licensed to provide services? Under what governing authority is the counselor granted the ability to work with a specific population or in a specific state? These are some of the ethical questions that must be answered by counselors.

Of course, not every type of counseling requires a specialty credential. Most master's programs in counseling produce graduates who are generalists. In other words, upon graduation these prelicensed counselors have the academic and skill competencies to provide general services. Prior to licensure, counselors in all states acquire numerous hours of practice under the direction of a clinical supervisor who meets the requirements of the state board. During this supervised work experience, beginning counselors may start on a path toward a specialty. When faced with a new client, all counselors should ask themselves, "Am I competent to provide services to this client?"

When competence is an issue or when treatment interventions are poorly chosen, legal and ethical issues may arise. The ACA Code of Ethics (2005) specifically addresses competence and malpractice in several areas:

- Counselors are ethically required to avoid harming clients. (A.4.a)
- Counselors may refer if they are not competent or comfortable with working with clients who have a terminal illness and are making end-of-life decisions. (A.9.b)
- Counselors assess and monitor their effectiveness with clients and work to improve their skills on an ongoing basis. (C.2.d)
- Counselors do not practice when impaired and take steps to avoid burnout. (C.2.g)
- Counselors use interventions that have empirical support or inform their clients that the intervention is not yet proven. (C.6.e)

Even though many components of the Code of Ethics address competence and malpractice, the reality is that no one can measure competence. Counselors can be licensed and certified yet still be of harm to a client if they are not also practicing ethically within their limits. Consulting with colleagues and a supervisor about competence is one means of checking one's own limits.

## Boundary Issues

Some of the most difficult challenges professional counselors face are with boundaries. Boundaries are the limits counselors place on their relationships with others. Typical boundary concerns include gift giving, bartering, and multiple relationships.

Many counselors do not consider the ramifications of gift giving as they start their work. However, it is not uncommon for a client to want to commemorate an occasion or

holiday with a token of appreciation for his or her counselor. This may sound innocent, but the many facets of such an overture must be looked at. Consider the following:

- A client overhears you telling a coworker how much you enjoy sweets during the holidays. At her next appointment, she brings you a batch of her “famous chocolate chip cookies.” Do you accept them?
- You have worked with a client for several months and he has come for his last session. He brings you a card holder that he thinks would look nice on your desk as a way of saying thank you for working with him. Do you accept it?
- You provide services in a children’s clinic. One of your regular clients paints a picture for you. Do you accept it?
- One of your adult clients with a developmental disorder sells scarves at a local flea market. She makes one just for you. Do you accept it?
- You have worked for quite some time with a family from another country as family members have faced the acculturation issues of moving to your area. They visit their country of origin over the summer. Upon their return, they bring you a small piece of pottery from their country as a token of their appreciation. Do you accept it?

Some counselors simply make a policy that they do not accept gifts of any kind. This may work in that it provides a hard and fast rule with no exceptions. But is it ethical? The ACA Code of Ethics (2005) includes the following language about gift giving:

**A.10.e. Receiving Gifts** Counselors understand the challenges of accepting gifts from clients and recognize that in some cultures, small gifts are a token of respect and showing gratitude. When determining whether or not to accept a gift from clients, counselors take into account the therapeutic relationship, the monetary value of the gift, a client’s motivation for giving the gift, and the counselor’s motivation for wanting or declining the gift.

Similar to gift giving, bartering involves an exchange of goods or services. With bartering, however, the client chooses to exchange goods or services for counseling services. In most instances, bartering involves a professional wishing to perform some skilled labor in exchange for services or someone who has goods worth an identified value that can be exchanged. The addition of bartering to the Code of Ethics came in the 2005 revision; prior codes discouraged bartering under any circumstance.

Counselors tend to fall into one of two camps related to bartering: they either prohibit it completely or see it as a potential solution for clients that is respectful of their culture. Either way, bartering comes with a host of complications. The counselor engaging in bartering should have “the burden of proof to demonstrate that (a) the bartering arrangement is in the best interests of [his/her] client; (b) is reasonable, equitable, and undertaken without undue influence; and (c) does not get in the way of providing quality psychological services to [his/her] client” (Corey, Corey, & Callahan, 2007, p. 282).

Perhaps the most challenging boundary issue counselors face is that of multiple relationships. Formerly known as dual relationships, counselors were advised to avoid these relationships in earlier versions of the ethical code. However, professional organizations such as ACA recognize that being a counselor does not preclude one’s right to be a human, shop in local stores, hire local contractors, and the like. By simply going about their lives, counselors may encounter clients living out their lives. Occasional “sightings” of clients are not uncommon and are certainly not unethical. However, ethics is called

into question if a counselor takes on a friend or family member as a client. The codes typically prohibit such relationships. However, what if a teller at your bank makes an appointment with you? What if the roofer you hired has an assistant who used to be your client? What if a teacher in your child's school wants you to work with her son?

As you can imagine, multiple relationships can be tricky to navigate. The ACA code (2005) is clear on a few points:

**A.5.a. Current Clients** Sexual or romantic counselor–client interactions or relationships with current clients, their romantic partners, or their family members are prohibited.

**A.5.b. Former Clients** Sexual or romantic counselor–client interactions or relationships with former clients, their romantic partners, or their family members are prohibited for a period of 5 years following the last professional contact.

However, the code is less strict about nonromantic relationships.

**A.5.c. Nonprofessional Interactions or Relationships (Other Than Sexual or Romantic Interactions or Relationships)** Counselor–client nonprofessional relationships with clients, former clients, their romantic partners, or their family members should be avoided, except when the interaction is potentially beneficial to the client.

**A.5.d. Potentially Beneficial Interactions** When a counselor–client nonprofessional interaction with a client or former client may be potentially beneficial to the client or former client, the counselor must document in case records, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the client or former client and other individuals significantly involved with the client or former client. Such interactions should be initiated with appropriate client consent. Where unintentional harm occurs to the client or former client, or to an individual significantly involved with the client or former client, due to the nonprofessional interaction, the counselor must show evidence of an attempt to remedy such harm. Examples of potentially beneficial interactions include, but are not limited to, attending a formal ceremony (e.g., a wedding/commitment ceremony or graduation); purchasing a service or product provided by a client or former client (excepting unrestricted bartering); hospital visits to an ill family member; mutual membership in a professional association, organization, or community.

Although the ACA code is more specific than it was in the past, there are still a lot of decisions left in the hands of individual counselors and heavily influenced by the specific circumstances involved. There are no cookbook solutions in the Code of Ethics, so this is an area that is full of challenges. To make ethical decisions about multiple relationships, counselors will want to engage in consultation with other professionals, follow an ethical decision-making model, and when possible, involve the client in the decision.

## Vulnerable Populations

Counselors are ethically charged with placing client welfare above all. In the ACA code (2005), that mandate is found here:

**A.1.a. Primary Responsibility** The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients.

However, not all clients are able to make their own decisions regarding their care, and some may not be aware of what is in their best interest. When working with clients who fall into the category of a vulnerable population, counselors have special considerations in the counseling relationship. Clients who are minors, suffering from breaks with reality, or unable to make their own decisions due to illness, injury, age, or other change to cognitive functioning, are considered vulnerable. Vulnerable persons “are unable to avoid risk of harm on their own and are dependent on others to intervene on their behalf” (Remley & Herlihy, 2010, pp. 121–122). Counselors need to recognize their duty to empower their clients to make their own decisions, which is in line with the concept of autonomy. However, autonomy and client safety are not always compatible. Counselors may find that they have to make decisions to protect their clients. These decisions often involve breaches in confidentiality, which have been previously discussed. In terms of vulnerable populations, clinical mental health counselors adhere to legal and ethical standards that protect the client and best meet his or her needs.

## **ACA ETHICS COMMITTEE**

The ACA Ethics Committee was established by the governing body of ACA, known as the ACA Governing Council. Specifically, the ACA Governing Council directs the Ethics Committee to educate ACA members about ethical concerns and the ACA Code of Ethics. In addition, the committee defines the process for adjudication of ethical complaints against members. Information about ethical complaints including the number of inquiries, complaints, and cases adjudicated is published annually by the committee (ACA, 2011).

So how exactly does the ACA Ethics Committee work to meet the directives of the ACA Governing Council? The committee works to educate counselors on the best ethical practices by keeping an up-to-date page on the ACA Web site that contains practitioner guides to understanding and implementing the Code of Ethics. The committee supports the work of the ACA task forces that are established to revise the code on a routine basis. Finally, the committee serves to adjudicate any cases that come before ACA (ACA, 2011).

ACA receives a number of ethical inquiries each year. An inquiry is simply a question posed to ACA as to whether or not something is ethical. These questions are posed to the Ethics Manager, who has a full-time paid position with ACA. If an inquiry has merit, the manager assists the person with the complaint process, which is a time-consuming task with many considerations. First of all, the person the complaint is about must be or have been a member of ACA at the time of the potential ethical violation. If the counselor being accused has never been a member of ACA, the association has no jurisdiction. Second, the complaint must clearly line up with one or more ethical codes. If the issue is not an ethical one, the ACA Ethics Committee has no jurisdiction. Finally, the complainant must be willing to complete all of the necessary paperwork and be willing to break his or her anonymity in order to file the complaint (ACA, 2011).

The ACA Ethics Committee receives and reviews each completed complaint application. Both the complainant and the accused are invited to a hearing and are allowed legal representation, if they like. Because ACA is a national organization, committee members, complainants, and the accused live in various parts of the country. Therefore, the hearings are conducted via conference call. If an ACA member is found guilty of an ethical offense, there may be sanctions or requirements such as completing continuing education hours in ethics. The committee also has the power to revoke ACA membership. Notice that

neither of these sanctions directly impacts a counselor's license. The complainant actually has to file a separate case with the state in order for a counselor's license to be suspended or revoked. ACA and state licensure boards work closely together to protect the public from unethical practices by counselors.

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## Conclusion

Clinical mental health counselors must practice within ethical standards created by the profession as well as according to laws created by society. To do so, counselors stay abreast of changes to ethical codes as well as relevant state and federal laws. Professional counselors employ an ethical decision-making model to address ethical concerns as they arise. In addition, they maintain a network of professionals to consult with in order to ensure compliance with standard professional expectations. Clinical mental health

counselors are aware of the roles and function of the ACA Ethics Committee as well as the ethical committees of other organizations and state licensure boards.

Being an ethical counselor sounds easy, but ethical dilemmas are complex. It is important for counselors to continue their education related to ethical matters and legal concerns by attending workshops and reading professional literature about ethical and legal considerations in counseling.

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