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## **New Mandates and Imperatives in the Revised ACA Code of Ethics**

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# Archival Feature: 2008–2009

## New Mandates and Imperatives in the Revised *ACA Code of Ethics*

David M. Kaplan, Michael M. Kocet, R. Rocco Cottone, Harriet L. Glosoff, Judith G. Miranti, E. Christine Moll, John W. Bloom, Tammy B. Bringaze, Barbara Herlihy, Courtland C. Lee, and Vilia M. Tarvydas

The first major revision of the *ACA Code of Ethics* in a decade occurred in late 2005, with the updated edition containing important new mandates and imperatives. This article provides interviews with members of the Ethics Revision Task Force that flesh out seminal changes in the revised *ACA Code of Ethics* in the areas of confidentiality, romantic and sexual interactions, dual relationships, end-of-life care for terminally ill clients, cultural sensitivity, diagnosis, interventions, practice termination, technology, and deceased clients.

The *ACA Code of Ethics* (American Counseling Association [ACA], 2005; available at [www.counseling.org](http://www.counseling.org)) has a significant impact on the counseling profession. All ACA members are required to abide by the ethics code and over 20 state licensing boards use the *ACA Code of Ethics* as the basis for adjudicating complaints of ethical violations (ACA, 2007, pp. 98–99). Because the *ACA Code of Ethics* is considered the standard for the profession, professional counselors can be held to the standards contained within by a court of law, regardless of whether or not they hold ACA membership (N. Wheeler, personal communication, April 5, 2007).

The *ACA Code of Ethics* is revised every 10 years, with the latest edition approved by the ACA Governing Council in October of 2005. In order to accomplish this task, an Ethics Revision Task Force was appointed in 2002 and charged with revising the ethics code to be congruent with changes that had occurred in the counseling profession since 1995, the date of the previous edition. The members of the Ethics Revision Task Force were John W. Bloom, Tammy B. Bringaze, R. Rocco Cottone, Harriet L. Glosoff, Barbara Herlihy, Michael M. Kocet (Chair), Courtland C. Lee, Judith G. Miranti, E. Christine Moll, and Vilia M. Tarvydas.

The revised *ACA Code of Ethics* drafted by the Ethics Revision Task Force and approved by the ACA Governing Council contains substantive new mandates throughout the document. The interviews that follow flesh out 10 of these new imperatives in the areas of confidentiality, romantic and

sexual interactions, dual relationships, end-of-life care for terminally ill clients, cultural sensitivity, diagnosis, interventions, practice termination, technology, and deceased clients. The interviews were conducted in 2006 by David Kaplan, the ACA Chief Professional Officer, with the members of the Ethics Revision Task Force previously listed. As a service to members, ACA ran the following columns consecutively in *Counseling Today* in 2006 (available to ACA members online at [www.counseling.org.ethics](http://www.counseling.org.ethics)).

### ■ The End of “Clear and Imminent Danger”

*David Kaplan:* For many, many years the *Code of Ethics* stated that confidentiality was to be broken if there was “clear and imminent danger.” The 2005 code now states in section B.2.a. that confidentiality is broken when there is “serious and foreseeable harm.” Could you tell ACA members why the Task Force changed the wording from “clear and imminent danger” to “serious and foreseeable harm”?

*Michael Kocet:* The task force felt that there were broader circumstances that needed to be brought into account. Also, the legal language of the *Tarasoff* ruling had an impact in terms of duty to warn and duty to protect and who is the foreseeable victim or if foreseeable harm can be identified.

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*DK:* So the word “foreseeable” actually came from the *Tarasoff* case?

*MK:* That is my understanding.

*DK:* How would you suggest that professional counselors think differently and make the shift from “clear and imminent danger” to “serious and foreseeable harm” when considering the need to break confidentiality?

*MK:* I still see the essence of breaking confidentiality revolving around “clear and imminent danger” but what “serious and foreseeable harm” does is to allow a broader scope of other circumstances where counselors need to seek consultation and seek ethical advice when considering the breaking of confidentiality.

*DK:* So “serious and foreseeable harm” is broader than “clear and imminent danger”?

*MK:* I think so. It recognizes that in some cultural and contextual situations clients may not have the need to maintain traditional confidentiality. For example, the client may ask that you automatically consult a member of his or her spiritual or religious community. I’ve also used the example of a counselor who is seeing a client who has a terminal illness, has exhausted all medical options, is psychologically healthy and lucid and rationale with no substance abuse or major depression and says, “I want to explore ending my life. I want your counseling and support through this process.” Since “serious and foreseeable harm” can be contextual, the counselor has the option of working with this client.

*DK:* Is “serious and foreseeable harm” always contextual.

*MK:* No. As an example, if a client says, “I am going to go home and shoot my partner,” that is objectively foreseeable harm.

*DK:* If we can focus on the word “foreseeable” for a moment, under the old 1995 *Code* a client who told us that a crime was committed in the past had that information kept confidential because it occurred in the past and there wasn’t any clear danger in the present. Does this also apply under the 2005 *Code*?

*MK:* I would agree. There is no foreseeable harm to an event that occurred in the past.

*DK:* A focus of the 2005 *Code* seems to be an emphasis on consulting with other professional counselors if you are considering breaking confidentiality.

*MK:* The Task Force supported a team approach. Consulting with other professionals when faced with an ethical situation is always a good step and helps you to think about different options. The bottom line is that two (or three or four) heads are better than one. Of course, you still have an obligation to only reveal information germane to the consultation.

*DK:* The focus of the 2005 *Code* on the importance of consulting with colleagues is in keeping with court

rulings that have come out since 1995 that indicate that in order to maintain minimal standards of care, a reasonable counselor will consult with other professional counselors when breaking confidentiality.

*MK:* Sure, and it also matches most, if not all, of the ethical decision-making models that are in texts and the literature. And in my opinion, consultation can be an ethics textbook, a journal article, or a telephone conversation in addition to a face-to-face office visit.

*DK:* That is really interesting; I hadn’t thought of that. Being a baby boomer, I usually think of face-to-face consultation.

Standard B.2.a of the new *Code of Ethics* specifies that counselors consult with other professionals when in doubt as to the validity of an exception. Does that mean that if a counselor does not consult when breaking confidentiality, that they have been unethical? In other words, are we at the point in the profession where we are saying that if you are about to break confidentiality, we know you have to consult and it is unethical not to do so.

*MK:* The key phrase is “when in doubt.” Let’s go back to the example of the client who says “I have a gun and I’m going to go home and shoot my partner.” To me, in that moment, that does not raise doubt about breaking confidentiality. But, for example, when we talk about something like HIV and AIDS, it does become grayer. For example, a client who says that they just found out that they are HIV positive, are angry and upset, and are going to have unprotected sex with their partner and neighbor is a situation that I would run by a colleague to get some consultation and feedback.

## ■ New Restrictions On Romantic/Sexual Relationships

*DK:* Today we are going to be talking about changes around sexual or romantic relationships specifically as they relate to Standard A.5 in the new 2005 *ACA Code of Ethics*. To start off, my understanding from the new code is that sexual or romantic interactions between a counselor and a current client continue to be prohibited.

*MK:* That is correct.

*DK:* However some things that do change include increasing the number of intervening years that must pass in order to have a romantic/sexual relationship with a former client and a new prohibition on romantic/sexual relationships with the family members and romantic partners of clients.

*MK:* Correct.

*DK:* So let’s start at the beginning. Sexual or romantic interactions with clients continue to be prohibited?

*MK:* Absolutely. The 2005 *ACA Code of Ethics* continues to recognize the harm that can be impacted upon

clients when they are sexually intimate with their counselor. The counseling relationship is one based on trust and so we must respect the power differential inherent in any counseling relationship regardless of the counselor's theoretical orientation or perspective. Engaging in any type of sexual or intimate relationship with a current client is abuse of power. Clients come into counseling emotionally and psychologically vulnerable and in need of assistance, and so a counselor trying to engage in such relationships would be trying to take advantage of that client and their vulnerabilities to meet their own needs. Relational/cultural theory frames this as striving for a "power with" instead of a "power over" relationship.

*DK:* So the reason that the 2005 *ACA Code of Ethics* continues to give no leeway and to ban all sexual or romantic interactions with clients is because we know that harm always occurs when that happens?

*MK:* Yes. Even if it appears on the surface that a client is open to a sexual/romantic relationship, there are always things that happen and the client could later turn around and say that he or she wasn't able to make a decision that was in their best interest at the time and therefore felt coerced.

*DK:* That relates to malpractice suits and the one exception that liability companies such as the ACA Insurance Trust make about sexual contact with a client. All liability insurance policies that I have seen provide a lawyer and defend a counselor if he or she is accused of sexual contact with a client. However, if the counselor is found guilty, the insurance company will not pay any monetary damages that are awarded and will also expect to be reimbursed by the counselor for all legal fees incurred in his or her defense. The fact that sexual contact is the only exclusion contained in a malpractice policy indicates how harmful sexual contact is to a client.

*MK:* This is an important piece for counselors to understand and to plan healthy alternative ways to meet their emotional and romantic needs.

*DK:* As mentioned above, the 2005 *ACA Code of Ethics* increases the prohibition on sexual and romantic interactions with former clients. The old 1995 code stated that counselors were to avoid sexual intimacies with former clients within 2 years of termination. The revised 2005 *Code* expands the timeframe to 5 years. Why did the Ethics Revision Task Force decide to increase this prohibition to 5 years?

*MK:* While some may see the exact number of years delineated as arbitrary, the reason a ban on sexual/romantic relationships with former clients was increased to 5 years was that we wanted there to be a little more time for the counselor to be reflective and to give more time for closure of the counseling relationship. It is

really important that enough time has passed for the power differential to be resolved. It is also important to recognize that counselors can decide to make the personal choice to never engage in romantic or sexual relationships with former clients even though the *ACA Code of Ethics* allows one to do so after a 5-year waiting period.

*DK:* For the first time in its history, the *ACA Code of Ethics* (in Standard A.5.b.) now explicitly prohibits sexual or romantic relationships with the family members or romantic partners of clients. It will be interesting to hear how that came up in the revision discussions and what the thinking was behind that.

*MK:* The Task Force prohibited sexual or intimate relationships with family members because counselors engaging in such relationships with clients' relatives can have a harmful impact on clients. For example, if a counselor were to have an intimate or sexual relationship with a sibling or a former partner of a client, that could have a potential risk of emotionally harming the client. The main goal of counseling should be to focus on the best interests and welfare of the client. Counselors cannot know each and every relationship or relative of clients, but counselors should not knowingly engage in such relationships.

*DK:* Let me give you a scenario: suppose a counselor is engaged to be married and finds out from looking at the wedding invitations that one of her long-term clients is a very close cousin of her fiancé. Does that mean that the counselor needs to call off her engagement?

*MK:* I talked to Rocco Cottone, Harriet Glosoff, and Judy Miranti, three members of the Ethics Revision Task Force, about this scenario. We agreed that it is critical to determine how clients define what "family members" means to them. In a cultural context, "family" can be nonblood relationships such as godparents or neighbors. It is not culturally appropriate to make assumptions about a client's worldview of who is and who is not a family member.

The key to this scenario is intention. In the case mentioned, neither the client nor the counselor was aware of this situation and therefore the counselor would not break off her engagement or wedding plans. Rather, the counselor should discuss with the client the change in relationship between the counselor and client (to be cousin and cousin-in-law so to speak). The client may decide to maintain the counselor-client relationship, but the counselor is obligated to explore the potential risks and benefits to the change in relationship (i.e., seeing each other at family gatherings). Since informed consent is an ongoing process, there would be a need to readdress confidentiality if the client decides to stay with the counselor. All of these considerations seem to be part of demonstrating sound professional judgment.

## Allowing Dual Relationships

*DK:* Last month we discussed a major change in the recent revision of the *ACA Code of Ethics*: changing the criterion for breaking confidentiality from “clear and imminent danger” to “serious and foreseeable harm.” This month we will be talking about another critical change in a core area of counseling ethics: allowing a dual relationship when it is beneficial to the client, supervisee, student, or research participant (*Author’s Note*. See Standards A.5.d; F.3.e; F.10.f; and G.3.d). It is interesting to note that the new 2005 *Code of Ethics* does not even mention the term *dual relationship*.

*Rocco Cottone:* The *dual relationship* term is really nondescript and does not give good guidance to the profession or to clients who have an ethical concern or complaint.

*MK:* And over time our professional culture had developed the notion that you had to back away from any circumstance that might present a dual relationship, even if there was a potential for benefit to the client.

*RC:* When you sit down and analyze the concept of dual relationships, you will find that it relates to three different types of relationships: sexual/romantic relationships, nonprofessional relationships, and professional role change. The first category, sexual and romantic relationships with current clients, is banned by the *Code of Ethics* because we have evidence of the damage that results. The second type of relationship, nonprofessional relationships, encompasses those activities where you might have contact or active involvement with a client outside of the counseling context. The third type of relationship that the old dual relationship term encompassed is a professional role change. An example is when you shift from individual counseling to couples counseling. Moving from one type of counseling to another with one client can be really confusing and ethically compromising.

So, in the end, moving away from the concept of dual relationships was really about the analysis of what the dual relationship term meant and the confusion it caused because of multiple meanings. The new ethics code addresses all three types of “roles and relationships with clients.”

*DK:* So instead of banning dual relationships across the board, the recent revision of the ethical code now allows professional counselors to interact with clients outside of a counseling session under certain conditions.

*RC:* Counselors may now interact with a client in a nonprofessional activity as long as the interaction is potentially beneficial and is not of a romantic or sexual nature. Even if it is a potentially beneficial relationship, counselors must use caution, forethought, and proceed with client consent whenever feasible.

*MK:* Focusing on assessing beneficial versus harmful interactions allows the counselor to really partner with the client to determine whether a potential relationship will help or hurt.

*DK:* Can you give some examples of potentially beneficial interactions that may now be allowed?

*MK:* One example is a wedding. Let’s say a long-term client announces that he or she is getting married. The counselor is then asked to the wedding because the client felt that the counseling was instrumental in working through issues that blocked the client from considering new relationships. From the client’s perspective, the counselor’s attendance at the wedding would be very meaningful.

A second example involves a counselor who lives in an extremely rural area, needs to get her car fixed, and has a client who is the only mechanic in town. A discussion with the client may lead to the clear conclusion that it is appropriate for the client to service the counselor’s car.

*RC:* Other examples include attending a graduation ceremony to honor a client’s academic accomplishment or attending a funeral to show respect to a client. It could be as simple as buying cookies from a Girl Scout or as complex as being actively involved in a shared community (e.g., a political party or a disability community) where you are working hand-in-hand with clients, students, supervisees, or research participants. Counselors should not feel guilty for engaging in more than one role as long as it is potentially beneficial to the client.

*DK:* How does bartering fit into this new concept? What if a client would like to do yard work, carpentry, home repair, etc. in return for your services?

*RC:* Well, the standard we are talking about (A.5.d. Potentially Beneficial Interactions) doesn’t in any way supersede the long-standing standard on bartering (A.10.d).

*DK:* One of the impressive things about Standard A.5.d. Potentially Beneficial Interactions is that it gives a very nice roadmap for how to ensure that the focus is on the client’s best interest when the issue of an interaction outside of counseling, supervision, teaching, or research arises.

*MK:* Right. The counselor needs to have a thorough discussion with the client, supervisee, student, or research participant about both the potential benefits and the potential harm that could occur. It is then critical that the counselor document this discussion in case records along with the rationale for engaging in the interaction.

*DK:* As we have pointed out in previous columns, a major theme through the new *Code of Ethics* is consult, consult, consult! Is the issue of a potentially beneficial interaction with a client, student, supervisee, or research participant an area that comes under this theme?

*MK:* Absolutely. If the counselor has any reservations, it is very useful to consult with a supervisor or colleague, search the literature, etc. There are many ways to consult.

*DK:* Dr. Cottone, you were the member of the Ethics Revision Task Force who spearheaded the change from banning dual relationships to evaluating beneficial versus harmful interactions. Why was this important to you?

*RC:* From a personal perspective, I have a son who has muscular dystrophy. I am very active in the community here in St. Louis and at the same time I have a practice that focuses on counseling individuals affected by muscular dystrophy. So the people I counsel are the people in the same community where I am an active volunteer. I sit side-by-side with my clients at the MDA telethons trying to raise money to save peoples' lives. I go to parties with my son where my clients are present, and we socialize. I began to realize there was nothing wrong with that. In fact, if I hadn't been involved in that kind of activity, my clients would have looked at me as if I really was not sincerely interested in helping people with their condition.

I want to thank my colleagues on the Task Force because they were very receptive to the idea of evaluating beneficial versus harmful interactions rather than an across the board ban on dual relationships. The ideas I brought to the Ethics Revision Task Force were significantly different from those in the prior code, so I applaud my colleagues for letting me express my view and improving on some of the ideas I had.

*DK:* Thanks for giving a very human touch to the new ethical code.

## ■ End-of-Life Care for Terminally Ill Clients

*DK:* The 2005 revision of the *ACA Code of Ethics* breaks new ground in addressing the needs of the terminally ill and end-of life care (*Author's Note*. See Standard A.9).

*Chris Moll:* Palliative end-of-life care is a growing area for all human service practitioners whether they are counselors, social workers, or psychologists. Through the new section on end-of-life care, ACA has become a pioneer in addressing the immediate needs of the terminally ill in our society. In addition, Standard A.9 was written to assist counselors for the next 10 years, and I think that this is truly visionary.

*DK:* Why did the Ethics Revision Task Force feel that it was important to address end-of-life care?

*Vilia Tarvydas:* The ACA Ethics Committee had been periodically receiving inquiries about end-of-life care. The number of inquiries grew with the implementation of the Oregon assisted suicide law and some prominent cases, such as the Terry Schiavo right-to-die case in

Florida. It became obvious to us that our code was not giving sufficient guidance to counselors.

*CM:* We are affirming the right of a person to determine their level of care and if that means talking with their doctor about hastening their death then that's where that person's right of determination is. We recognize that this is as controversial for many counselors with particular religious values and morality stances as the issue of abortion.

We are not taking a moral stance on this and we are not promoting physician-assisted suicide. What we are promoting is an individual's right to determine his or her own choice.

*DK:* Isn't the new end-of-life care section about more than physician-assisted suicide?

*VT:* Absolutely! It is really all about helping a client maximize his or her quality of life. The section is focused on helping terminally ill clients live with a decent quality of life until they die; it recognizes the terminal illness but focuses on the need to be alive until the moment of death, to make choices, get emotional support, and meet holistic needs while the client is still alive.

*CM:* The new section focuses on the end-of-life developmental stage that affects clients, their family, their legacy, and their community of friends. It is about developing and implementing plans that will increase and enhance a client's ability to make decisions and remain as independent and/or self-determining as possible.

*VT:* And the new ethical code section makes it clear that professional counselors can play an important role in providing end-of-life care for terminally ill clients.

*DK:* The recent revision of the *ACA Code of Ethics* calls for confidentiality to be broken to protect a client from "serious and foreseeable harm" (*Author's Note*. See Standard B.2.a). Does the new section speak to confidentiality with a terminally ill client who wishes to consider hastening his or her death?

*CM:* Standard A.9.c states, "Counselors who provide services to terminally ill individuals who are considering hastening their own deaths have the option of breaking or not breaking confidentiality, depending on applicable laws and the specific circumstances of the situation and after seeking consultation or supervision from appropriate professional and legal parties." So in and of itself, a statement from a terminally ill client that he or she wants your help in thinking through the issue of hastening his or her death does not constitute serious and foreseeable harm and thus would not automatically call for the breaking of confidentiality.

*DK:* Can an ethical complaint be filed with ACA against the counselor for violating the edict to "do no harm" if the counselor agrees to assist a terminally ill client explore the hastening of his or her own death?

*VT*: Standard A.9.b states that “Recognizing the personal, moral, and competence issues related to end-of-life decisions, counselors may choose to work or not work with terminally ill clients who wish to explore their end-of-life options. Counselors provide appropriate referral information to ensure that clients receive the necessary help.” Because of this statement, counselors cannot be brought up on charges to the ACA Ethics Committee of doing harm by helping a terminally ill client explore end-of-life decisions. The other side is that counselors who feel that their own morality and personal views will not allow them to assist terminally ill clients who wish to explore end-of-life options cannot be brought up on charges for refusing to assist the client, as long as they provide appropriate referral information. (*Author’s Note*. Please note that state laws that conflict with this response take precedence.)

*DK*: Does competence play into the decision about whether to provide end-of-life care to terminally ill clients?

*VT*: Yes. The provision of end-of-life care is a very specialized and complicated matter. It requires knowledge of holistic approaches—not just counseling interventions but also knowledge of medicine and the exploration of spirituality. There are very particular types of skills involved and counselors who are in a general practice at times will need to consult with or refer to a variety of professionals.

*CM*: Competence in working with a terminally ill client means having the ability to integrate the client’s physical, emotional, social, spiritual, cultural, and family needs into a plan that helps him or her effectively work through this last developmental life stage.

*DK*: Let’s get back to the important aspirational aspect of Standard A.9. End-of-Life Care for Terminally Ill Clients. While we have been focusing on mandates, this standard actually has a preponderance of aspirational statements.

*CM*: This was not just written as a “nuts and bolts” standard. As I stated before, it is important to remember that we are working with clients on a developmental moment in their life that will affect how peacefully they die, what their legacy will be, and the impact they have on their family and community of friends.

*VT*: Counselors are different from such professionals as clinical psychologists because in addition to assisting the client with solving problems they may experience, we focus on assets and the growth and development that one can experience during the dying process. So the Quality of Care, Standard A.9, was written to make sure that we don’t get lost in the stampede to focus on the actual moment of death or the method of death—so we do not get bogged down purely in

legal details. The Quality of Care standard focuses on making sure that we are attuned to helping clients obtain high-quality end-of-life care for their physical, emotional, social, and spiritual needs; exercising the highest degree of self-determination possible; giving them every possible opportunity to engage in informed decision making regarding their end-of-life care; and receiving complete and adequate assessment regarding their ability to make competent, rational decisions on their own behalf from a mental health professional who is experienced in end-of-life care practice.

*DK*: Both of you, as well as the entire Ethics Revision Task Force, are to be congratulated for writing a very sensitive and helpful new section that focuses on the best interests of a client with a terminal illness.

## ■ A New Focus on Cultural Sensitivity

*DK*: Courtland and Tammy, it is clear that the revised *ACA Code of Ethics* has a new focus on cultural sensitivity.

*Courtland Lee*: That was a primary charge of the Ethics Revision Task Force; to look at the revision with an eye on making the *Code* more culturally sensitive. To accomplish this, we kept two questions in mind: (1) how do we need to rethink things in terms of changing population demographics and issues of multiculturalism and (2) what is missing from the *Code* that will make it more culturally sensitive.

*Tammy Bringaze*: We realized that multiculturalism and diversity impacts every area of our life and our practice. It affects our sensitivity toward the people we serve. As such, instead of just having one section focusing on cultural sensitivity, we infused multiculturalism and diversity throughout the entire *Code of Ethics*.

*CL*: As an example, until now it has been considered unethical to receive gifts from clients. However, in some cultures, giving a gift is really considered to be the highest form of praise and to refuse a gift is considered culturally insensitive. So we revised the standard on receiving gifts (A.10.e) to reflect this. It now reads “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.”

*DK*: So based on the last sentence of A.10.e, one of the implications of gift receiving is that even within a cultural context, counselors should not accept a gift that has a substantial monetary value.



*CL:* Right! While it is important to understand and appreciate the cultural context of a client, the counselor has to use some common sense.

*DK:* Let's focus on confidentiality. Standard B.1.a talks about how important it is for counselors to maintain cultural sensitivity regarding confidentiality, privacy, and the disclosure of information.

*CL:* Much of this is based on the difference between individualistic and collectivist cultures.

*TB:* For example, I work with Afghan refugees and the idea of confidentiality has a very different meaning in their culture. It is much more communal. There is really the sense among the Afghans of trying to look out for one another and pull together. The other day, I had an Afghan woman come in and sit down in the middle of another woman's session and neither blinked an eye. So I thought, "Well, okay. If it works for them, it works for me." If a counselor were not sensitive to the collectivist norm of the Afghan culture, he or she might feel pretty angry or agitated at the client and ask the "intruder" to leave immediately. If that were done, I'm afraid the counselor would lose the relationship with both clients.

*DK:* So, an implication is that there are some cultures where confidentiality is less important than it is for the dominant American culture.

*TB:* Yes, I definitely think so.

*CL:* Another example of the importance of cultural sensitivity regarding confidentiality and the disclosure of information revolves around disciplining a child. When an African American kid tells you, "I got in trouble and I'm afraid to go home because my mom is going to give me a whipping!" it sounds really harsh, as if the kid is going to get the heck beat out of him with a whip. But in the African American community the term *whipping* generally refers to a form of mild discipline. So understanding how words and meanings are different in different cultures is important.

*DK:* So staying with this discipline example from a cultural prospective, there would be times when a child reports a "whipping" that would not necessarily trigger mandated reporting laws.

*CL:* That's right.

*DK:* Let's turn to assessment. Standard E.8. Multicultural Issues/Diversity in Assessment talks about the importance of recognizing the effects of age, color, culture, disability, ethnic group, gender, race, language preference, religion, spirituality, sexual orientation, and socioeconomic status on test and inventory administration, interpretation, and use.

*CL:* An important aspect of Standard E.8 is that a counselor must make sure that any inventory or test they utilize has been normed on the population that the counselor is using the instrument with. Back in the 1970s, a group of

people—I think from the San Francisco Bay area—instituted a lawsuit against the school system because of the large number of African American school children who were in special education classes. The outcome was a moratorium on testing until instruments could be normed on the African American population.

*DK:* The *Code of Ethics* also now speaks to multiculturalism and diversity in supervision.

*TB:* We have recognized the ethical complexity of having to speak to the cultures of at least three people in supervision: the supervisor, the supervisee, and the client. As we add people, we need to be sensitive to the many cultural layers.

*CL:* I hope that this will start a new dialogue and research on multicultural and diversity issues in supervision. This is something we talk about, but we really don't know a lot about. In particular, when there is a cross-cultural supervisory relationship, it is critical for both the supervisor and supervisee to understand and be sensitive to each other's cultural view and how that view impacts the counseling process.

*DK:* Is there a specific example that comes to mind?

*CL:* I was supervising a graduate student, a White woman who was doing career counseling with a Latino client. My student was getting really frustrated because every time a viable option was explored the client would say, "That sounds like a good career change, but I have to ask my father." My student had a feminist worldview and felt strongly that the client should not have to check with her father because she was an adult and had free choice. I had to talk to my supervisee about her client's culture and that the role of the father in protecting his unmarried daughter is an important part of the Latino culture. I therefore encouraged my supervisee to develop a consultative relationship with the father.

*DK:* Does the revised ethical code infuse multiculturalism and diversity into counselor education and training?

*TB:* For the first time, there is a statement in the ethical code that counselor educators must infuse multicultural and diversity material into all courses and workshops (Standard F.11.c).

*DK:* CACREP does not require every course to have multicultural/diversity material in it. So is it reasonable to say that this goes beyond national training standards?

*TB:* We are going beyond current expectations and requirements and raising the bar for the profession. I am very proud of that.

*DK:* What would you say to a counselor educator who states that an ethical mandate to infuse multiculturalism and diversity into coursework is a violation of academic freedom?

*CL:* I would state that a professor's ethical responsibilities to the counseling profession supersede his or her role

as an academic. I don't know if that would hold up in court, but that's how I see it.

*DK:* As a final topic, the revised *ACA Code of Ethics* attends to multiculturalism and diversity in research (Standard G.1.g.). What should counselors know about this?

*TB:* Researchers need to speak to some basic questions: Can the research benefit a diverse group of people? Can the research be applied to a diverse population? Are there any aspects of the research protocol that will be perceived as culturally insensitive by participants?

*DK:* Has all of the effort to infuse multiculturalism and diversity throughout the revised *ACA Code of Ethics* moved the profession forward?

*CL:* Well, I think that remains to be seen. This *Code* has just hit the street. We'll have to see what unfolds in the next few years. I am very optimistic!

## Permission to Refrain From Making a Diagnosis

*DK:* Standard E.5.d. of the revised *ACA Code of Ethics* states, "Counselors may refrain from making and/or reporting a diagnosis if they believe it would cause harm to the client or others." Would it be safe to say that this is a cutting edge statement?

*Harriet Glossoff:* Most definitely! In looking at ethical codes from other mental health professions, I don't ever remember seeing anything like this.

*DK:* What was the impetus behind the decision to explicitly give counselors a tool to refrain from making or reporting a diagnosis if it is in the best interest of their client to do so?

*MK:* The Ethics Revision Task Force recognized that diagnosis is certainly a piece of what many counselors do, but that, at the same time, we need to acknowledge that information contained in an official file can have long lasting implications and should not be treated lightly. It goes back to the idea of "do no harm."

*DK:* How can diagnosis be harmful?

*MK:* Recording a formal diagnosis in either a client's chart or record has the potential to be harmful if that information can be used against the client by a third party. In addition, some counselors lose the fact that they are seeing an individual with their own nuances, their own histories, their own life circumstances, and their own family circumstances which might frame a diagnosis.

*DK:* There are some clinicians who list an "adjustment disorder" for virtually every client under the rationale that it is the most benign diagnosis that is eligible for reimbursement. Is that ok?

*HG:* That is a direct conflict with Standard E.5, Diagnosis of Mental Disorders. The purpose of diagnosis is to inform our treatment. Professional counselors simply do not misdiagnose on purpose.

*DK:* Are there any other ways in which diagnosis can be harmful?

*HG:* Yes, when a diagnosis is made prematurely. In the absence of sufficient data, it is better to refrain from making a diagnosis than to guess and list one that is probably incorrect.

*MK:* For example, a 9-year-old boy misdiagnosed with ADHD may end up with long lasting identity and self-concept issues due to that misdiagnosis. The child may interpret normal energetic behaviors as personal deficits and the need to rely on drugs to cure these personal deficits.

*DK:* Is Standard E.5 anti-diagnosis?

*HG:* No, not at all. The ethical purpose of diagnosis is to help us help clients.

*MK:* The Task Force recognized that diagnosis can promote the well-being of a client, especially when the client is involved in the process.

*DK:* That is interesting. Can you talk a little more about how a diagnosis can be used to promote the well-being of a client?

*MK:* I have worked with clients who experienced a sense of relief after receiving their diagnosis. They felt that it was helpful to have a name that went along with their symptoms/issues and to know that other people have experienced the same thing. It helped these clients to feel that they weren't crazy. A weight was lifted as they realized their problem wasn't a personal failing.

*HG:* I agree. There are clients that actually are very relieved when they hear a diagnosis saying, "Oh, thank goodness, that explains why I do what I do."

*DK:* What are some scenarios that come to mind when thinking about the new *Code of Ethics* Standard E.5.d that permits counselors to refrain from making or reporting a diagnosis?

*MK:* In some cultures, when a death occurs it is common to have "visions" or to hear the voices of deceased family members. A counselor relying on a Western perspective might diagnose these visions as hallucinations. However, it would be important for the counselor to recognize the cultural issues at play and that classifying the client as having visual and auditory hallucinations might be inappropriate and harmful. This example shows the importance of recognizing historical and social prejudices that have caused the misdiagnosis of individuals.

*HG:* Another example that comes to mind is when people who have security clearances in the military or high positions in government come in for services. It is possible that the filing of an Axis I diagnosis with a health

insurance company will cause these individuals to lose their security clearances. As such, it would be important to highlight the issue of diagnosis and insurance reimbursement during your informed consent process and to refrain from making a diagnosis if it will help the individual keep security clearances.

*DK:* What about Axis II?

*HG:* There are times when I have had a client who fits all of the criteria of a personality disorder yet I refrained from making the diagnosis. Why? Because I knew that they were going to Google “Borderline Personality Disorder,” read the description, and feel doomed to a life of unhealthy relationships. It was not in the best interest of the client to make an Axis II diagnosis.

*DK:* So the Ethics Revision Task Force did not make a distinction between the different *DSM* axes in terms of the ability to refrain from making a diagnosis?

*MK:* No. The responsibility to refrain from making a diagnosis when it is in the best interest of the client to do so cuts across all five *DSM* axes and across any type of diagnosis.

*DK:* When a decision is made to refrain from making a diagnosis, who makes that decision? Is it the counselor or the client?

*HG:* The spirit of the ethical code is that the decision is made in collaboration with the client. However, there are times when a client’s request needs to be superseded by clinical judgment.

*DK:* When a client requests his or her records, does the new standard on refraining from making a diagnosis allow the counselor to say to a client, “I will be glad to share parts of my records with you, but not my diagnosis”?

*HG:* I think so. But counselors only limit a client’s access to records when there is compelling evidence that such access would cause harm.

*DK:* What about a supervisor or agency that insists on a diagnosis for every session of every client because that is the only way that they can receive reimbursement?

*HG:* Standard D.1.g of the *ACA Code of Ethics* states that the acceptance of employment in an agency or institution implies that the counselor is in agreement with the general policies and principles of that agency or institution. Counselors strive to reach agreement with employers as to acceptable standards of conduct that allow for changes in institutional policy conducive to the growth and development of clients.

Standard D.1.h follows up by stating that it is our ethical responsibility as counselors to alert our employers to policies and practices that conflict with the *ACA Code of Ethics*. In the case of an agency that is asking a counselor to violate Standard E.5.d and require a diagnosis when it is not in the client’s best interest, I would brainstorm alternate forms of funding (such

as grants) with supervisors and management so that the agency was not reliant on reimbursement solely from *DSM* diagnoses.

*MK:* The example of an employer requiring a diagnosis in order to obtain reimbursement brings the importance of advocacy to the forefront. The counselor can advocate for the client by letting the supervisor, agency, or insurance company know why it was in the best interest of the client to refrain from making a diagnosis. The counselor can also assist the client to advocate for him- or herself.

*DK:* In some ways, having the new Standard E.5.d in the *ACA Code of Ethics* makes it easier for the counselor to say to an agency or a supervisor: “Here it is in writing from the American Counseling Association: ‘Counselors may refrain from making and/or reporting a diagnosis if they believe it would cause harm.’”

*MK:* That is another aspect of advocacy. The *ACA Code of Ethics* represents the collective values of our profession. It is the responsibility of every counselor to educate agencies, insurance companies, and mental health professionals from other disciplines about the concepts within the ethical code.

## New Mandates for Selecting Interventions

### C.6.e. Scientific Bases for Treatment Modalities.

Counselors use techniques/procedures/modalities that are grounded in theory and/or have an empirical or scientific foundation. Counselors who do not must define the techniques/procedures as “unproven” or “developing” and explain the potential risks and ethical considerations of using such techniques/procedures and take steps to protect clients from possible harm. (See A.4.a., E.5.c., E.5.d.)

*DK:* The new Standard C.6.e of the *ACA Code of Ethics* states that counselors now need to use interventions and approaches that are grounded in theory and/or have an empirical or scientific foundation. If there is no theoretical or empirical support for a particular technique or procedure, the counselor must inform the client that the technique or procedure is “unproven” or “developing” and discuss potential risks and other ethical considerations. Why did the Ethics Revision Task Force add this new standard?

*Barbara Herlihy:* There was concern that some counselors implement techniques that grow out of their own bias, are faddish, or clearly unproven in a scientific way. The Task Force felt that counselors need to have a rationale for treatments and procedures that are grounded in an established theory or have a supporting research base.

*Judy Miranti:* Much of the discussion about the need to have theoretical or empirical grounding focused on sexual orientation issues in counseling—specifically around reparative/conversion therapy.

*DK:* Let's come back to the reparative/conversion therapy issue in just a moment. First, I do think we need to acknowledge that the new Standard C.6.e, Scientific Bases for Treatment Modalities, advances the profession.

*JM:* It moves the profession forward by telling counselors that while eclecticism or the application of several techniques could be therapeutic, the treatment modalities selected need to be research based.

*BH:* The new standard on scientific bases for treatment modalities reminds us that the counseling profession has developed quite a body of literature both in theory and research that guides us toward effective practice. As such, our work needs to remain grounded in this carefully developed research base.

*DK:* You mentioned that one of the discussion points around this standard was conversion/reparative therapy—an approach that purports to “convert” homosexuals to heterosexuality.

*JM:* Both the Ethics Revision Task Force and the ACA Executive Committee felt that it was important to look at the biases and prejudices involved in conversion/reparative therapy and the possible harm that this approach can cause.

*DK:* Since the 2005 *Code of Ethics* has been published, the Ethics Committee has formally ruled that conversion/reparative therapy does fall under C.6.e and that any counselor using this approach must tell clients that conversion/reparative therapy is developing or unproven.

*BH:* Although conversion/reparative therapy may have been the first specific technique, procedure, or modality that has been identified as needing to be labeled as “developing” or “unproven,” it is important to note that Standard C.6.e. Scientific Bases for Treatment Modalities wasn't aimed exclusively at that approach. This new standard was designed to focus broadly on any technique, procedure, or modality that might be controversial and whose effectiveness or appropriateness is unfounded or not grounded in research.

*DK:* Why didn't the Ethics Revision Task Force decide to specifically state in the ethical code that conversion/reparative therapy is banned?

*JM:* This did come up and some Task Force members felt that we should be specific and list approaches that are unethical.

*BH:* But in the end, we decided that this would set a precedent—the *ACA Code of Ethics* has never listed specific interventions or approaches that are unethical—and that it was not in the best interest of the counseling profession to start now.

*JM:* We would not have been able to be all-inclusive and to be assured that we had listed every intervention that should be banned. Therefore, a “laundry list” of forbidden interventions would lead counselors to assume that any intervention not on the list was fully approved by ACA.

*DK:* And you would worry about harmful techniques, procedures, and modalities that were left off the list or were developed after the list was published.

*JM:* Exactly!

*DK:* How does a professional counselor know whether a technique, procedure, or modality needs to be labeled as unproven or developing? In other words, how does a counselor determine whether Standard C.6.e. Scientific Bases for Treatment Modalities applies to the intervention or approach they are using with a client?

*BH:* When in doubt about the scientific base of a technique, procedure, or modality use the standard: consult, consult, consult. Call a former professor. Call an expert. Talk to some colleagues. But by all means, consult.

*JM:* Utilize resources on the ACA and other Web sites. Keep current with the research by going to workshops and reading professional books and journals, and stay in contact with other practitioners who can serve as consultants.

*DK:* This is a good time to remind readers that the ACA Manager for Ethics and Professional Standards, Paul Fornell (800-347-6647 ext.314 or [pfornell@counseling.org](mailto:pfornell@counseling.org)) provides free ethics consultation to ACA members and that our best-selling book *ACA Ethical Standards Casebook* by Herlihy and Corey was just revised to include the 2005 ACA ethical standards and can be ordered at 1-800-347-6647 ext.222 or [www.counseling.org/publications](http://www.counseling.org/publications) Free ethics resources are also available to ACA members at [www.counseling.org/ethics](http://www.counseling.org/ethics)

So far we have been talking about Standard C.6.e. Scientific Bases for Treatment Modalities in terms of the techniques, procedures, and modalities that counselors use with their clients. Does it also apply when the counselor is asked for a referral?

*BH:* If a client requested an approach that was not grounded in theory or an empirical/scientific foundation, it would be my responsibility to thoroughly discuss the unproven or developing nature of the approach, the limitations of that approach, and alternative approaches. If the client proceeded to choose that intervention after this thorough discussion, it would be my responsibility to facilitate that process and provide a referral.

*DK:* The ACA Ethics Committee has just completed an extensive paper on the subject of referrals for conversion/reparative therapy and other interventions that do not have a scientific base that very much supports your

statement. An abridged version was published on pages 14–15 of the July 2006 edition of *Counseling Today* and the complete document is available at [www.counseling.org/ethics](http://www.counseling.org/ethics)

Switching gears, what do you think ACA needs to do to assist professional counselors with the new Standard C.6.e. Scientific Bases for Treatment Modalities?

*JM:* We should consider developing a Web site section for practitioners fashioned around this section that provides information on proven treatment modalities. We also need to help professional counselors define the potential risks and ethical considerations of specific approaches. Students and counselor educators have access to the most recent literature but practitioners in the field may not.

*DK:* Please convey thanks to the entire Ethics Revision Task Force for yet another new section that advances the profession. Any final thoughts?

*BH:* Professional counselors need to understand that Standard C.6.e. Scientific Bases for Treatment Modalities was not meant to be rigid and imply that only techniques, procedures, or modalities that have been supported by experimental studies with random selection can be utilized. If that were the case, we would only use cognitive behavior therapy (CBT) because it is the easiest to study under experimental (or at least quasi-experimental) conditions. We have to think more broadly and inclusively than that and include qualitative and other approaches. The point is that we don't want counselors using biased approaches that are not thought through and have no evidence of validity.

## A New Requirement to Have a Transfer Plan

**C.2.h. Counselor Incapacitation or Termination of Practice.** When counselors leave a practice, they follow a prepared plan for transfer of clients and files. Counselors prepare and disseminate to an identified colleague or “records custodian” a plan for the transfer of clients and files in the case of their incapacitation, death, or termination of practice.

*DK:* What was the genesis of the new *ACA Code of Ethics* standard for Counselor Incapacitation or Termination of Practice?

*HG:* In our discussions about the new standard on safeguarding the confidentiality of a deceased client (B.3.f.), the Ethics Revision Task Force realized that the *ACA Code of Ethics* said nothing about the need to have a plan in place for assisting clients to transition to a new counselor or to obtain their records if the counselor left the practice, became incapacitated, or died.

*RC:* Right! We began to see this as a proactive issue—the importance of educating practitioners on the need to plan ahead for the day their practice ends.

*HG:* Even beginning counselors need to have a transfer plan. You may be young, healthy, and starting a new practice, and the last thing on your mind is thinking about illness or death. But what if you get hit by a car and can't resume work for a month or more? Who will see your clients? There has to be a transfer plan in place to ensure that your clients have access to both counseling and their records during your period of incapacitation. This is important for all counselors, but it is especially critical in a private practice.

*DK:* What are some ways that you can see a client being harmed if a transfer plan is not in place when a counselor dies, becomes incapacitated, or announces that he or she will shortly be moving to a different part of the country?

*HG:* The most obvious issue for me revolves around clients who are in the midst of counseling and need continued treatment—especially clients in a fragile state. Dealing with the fact that your counselor has died, become disabled, or is leaving in the middle of treatment can be very traumatic. It means that the client has to start from the beginning with a new counselor. A counselor without a transfer plan adds to that trauma, stress, and anxiety by the lack of a referral process. The client may have no idea who to turn to. Clients may also have no clue as to how a new counselor can obtain their notes and records.

*RC:* From a rehabilitation counseling perspective, a client's records can be critical for an application or reapplication for disability through a state agency, worker's compensation or Social Security. Having those records unavailable could cause much harm to a client.

*DK:* Are there any horror stories you know of?

*RC:* A former counselor in my community was in private practice and passed away. When she died, all of her private practice notes and files were thrown in the trash by her partner. The counselor had no transfer plan, and therefore had no means of communicating what should happen to those records.

The partner, who was a painter by trade, had to make the decision and just decided to pitch the notes. I spoke to him afterward and told him that he should have kept those records. His response was that he was not a counselor and therefore was not under any obligation to do so. Technically, he had no legal right to the records.

*HG:* There have also been examples of celebrities whose counseling records were released to the media when the counselors of the celebrities died.

*DK:* From the issues and examples you list, it sounds like the need to have a transfer plan ties into the ethical imperative that we must not abandon clients.

*HG:* Exactly! And it also relates to the issue of informed consent.

*DK:* My assumption is that the transfer plan needs to be incorporated into the informed consent process.

*HG:* Yes, it should. Standard A.2.b. (Types of Information Needed) of the revised ethical code notes that the informed consent process should include information about the continuation of services upon the incapacitation or death of the counselor.

*RC:* Clients should be given the plan in writing so that they know whom to contact if the counselor suddenly becomes unavailable. Counselors can easily do this by incorporating a transfer plan into their written informed consent document and making sure that clients receive a copy of this document.

*DK:* Is there a specific format counselors should utilize for their transfer plan?

*HG:* There is no one particular format. The Ethics Revision Task Force felt that specifying a format would be overly prescriptive. A counselor just needs to make sure that the important points are covered.

*DK:* What are the important points to cover in a transfer plan?

*RC:* The plan needs to state what clients should do to access their records and facilitate continued services if the counselor becomes inaccessible through death, disability, or change of location.

*HG:* This would include explicitly stating in your informed consent brochure who the custodian of your records will be and the complete contact information for that person. This custodian should then notify active clients upon receipt of the records.

*DK:* Should the plan also include staff?

*HG:* Yes. The administrative assistant, receptionist, or another counselor within your practice should be informed about the plan so that he or she knows where to transfer the records. This colleague or staff member can also give out the custodian's contact information if clients have misplaced their copy of the informed consent brochure.

*DK:* For those in independent practice, what are the options for choosing a custodian?

*RC:* Ideally, it should be another mental health professional.

*HG:* The most logical person would be the colleague you use for backup or on-call purposes when you are away or otherwise unavailable.

*DK:* Would either a lawyer or a certified public accountant be acceptable as a records custodian?

*HG:* I would be more comfortable with a mental health professional or someone who is part of the practice and already has access to the records, such as the administrative assistant or receptionist.

*RC:* Using a professional counselor or other mental health professional as your records custodian speaks to the

need for confidentiality. Standard B.6.h. (Reasonable Precautions), a related standard to the one we are discussing, states that "Counselors take reasonable precautions to protect client confidentiality in the event of the counselor's termination of practice, incapacity, or death."

*DK:* Is a handshake agreement with your records custodian enough?

*RC:* No. Whoever the custodian is, the arrangement should be in writing. If it is only a verbal agreement, your estate may decide not to honor your wishes.

*DK:* Any final thoughts on this new standard of the *ACA Code of Ethics*?

*HG:* This standard is particularly germane to those who are thinking about the issue of retirement. Even if you retain your records after you retire, clients need to know how to reach you if they need their records. And even after retirement, you do need to designate a custodian in the event you die or become incapacitated.

*RC:* My final thought is that ACA members should know that the Ethics Revision Task Force took a proactive/educational approach rather than a punitive approach to this and all other sections of the revised *Code of Ethics*. Focusing on a transfer plan is all about preparing counselors to address unforeseen circumstances in a way that best serves their clients.

*HG:* Agreed. The new Counselor Incapacitation or Termination of Practice standard (C.2.h.) is offered in the spirit of preventing a sense of abandonment, protecting client welfare, and preserving confidentiality as best as possible in a difficult situation.

## ■ New Concepts About the Ethical Use of Technology in Counseling

*DK:* Today we are talking about Standard A.12 of the revised *ACA Code of Ethics*, Technology Applications. When you compare the small section on computer technology in the 1995 *Code* with the revamped and substantially expanded section on technology applications in the revised code, it seems like the comparison between an old Radio Shack Tandy TRS-80 (complete with amber or green screen) and a current Dell XPS dual core processor.

*John Bloom:* The Ethics Revision Task Force got away from the 1995 emphasis on computer applications and expanded the section to include all technology, including the often overlooked application of telephone counseling which actually predated computer counseling by decades.

*CM:* We have come a long way since those years. And we know that unknown technologies will emerge before the code needs to be revised in 2015. As such, we tried to anticipate additional applications and issues that

will occur within the next 10 years before the next code is written.

*DK:* So that explains why the old code had less than ½ column devoted to technology while the revised code has what is now the largest single section in the *ACA Code of Ethics*, measuring in at a whopping 2¼ columns.

*JB:* In 1995 we were dealing with this unknown entity called the Internet. We weren't sure about its capabilities or shortfalls because at that time there was little or no research to document the effectiveness of computer-based counseling. As such, the previous standards were written almost out of fear and ignorance of the unknown and so emphasized what not to do. Now, 10 years later, we are starting to build a body of research which suggests technology-assisted counseling can be effective and so we were able to build positive and proactive statements about how to proceed with technology. So one of the reasons that the section is greatly expanded is that counseling can now embrace technology rather than fear it.

*DK:* In 1999, under the leadership of President Donna Ford, ACA promulgated *Ethical Standards for Internet On-Line Counseling*. Is that document still in force?

*JB:* No. The current *Code of Ethics* incorporated and updated all previous ACA documents on ethics.

*DK:* As previously mentioned, the expanded section on technology takes up over two full columns in the revised *Code of Ethics*. Let me present a fantasy scenario to you: If you and the *Code of Ethics* were on a sinking ship and you only had enough time to save three of the many new statements in A.12 about technology applications in counseling before the ship went under water, which three would you save and why?

*CM:* I would first save Standard A.12.e Laws and Statutes. Technology-assisted counseling, whether conducted by telephone, Internet, e-mail, or other application, often results in the crossing of jurisdictional lines. So laws which apply in Texas may not apply in New York. It is incumbent upon a counselor to know and be in compliance with all laws in both their state or jurisdiction and the state or jurisdiction of the client.

*DK:* Is there a specific example that comes to mind?

*JB:* The states of Washington and Colorado have idiosyncratic disclosure laws that counselors need to know about when they provide technology-assisted counseling to any resident of those two states. The cyber-counselor should be aware that most legal authorities believe that counseling takes place where the client is. So if you accept a client from outside your own state, it would be wise to check with the licensing board in that state for the rules and regulations with which you must comply and to determine if you must be licensed in the state in which the client resides.

*DK:* To help our member do this, a complete list of counselor licensing board Web sites is available on the ACA

Web site at <http://www.counseling.org/Counselors/LicensureAndCert.aspx>

*JB:* My first priority for rescue from the sinking ship would be the standard dealing with informed consent (A.12.g). If we are conscientious about being ethical, we need to do a good job of clearly defining for clients the pros and cons and the limitations and successes of the use of technology. Also, counselors often fail to realize that when they provide services utilizing technology that they are not just talking about potential clientele from across the hall or across the city, but across the nation and across the world. It is easy to neglect language differences, cultural differences, and time zone differences that come with having the world at your cyber doorstep.

*DK:* In our sinking ship scenario, what third new ethical statement revolving around technology would you rescue?

*JB:* One that I find a lot of people haven't thought about yet is A.12.d (Access), which focuses on accessibility issues. Oftentimes when counselors have thoughts about accessibility, the focus is on the important need for lower income families to have access to computers and other technology. But there is another critical arena that needs to be considered: the need for clients, students, or supervisees with a disability to utilize our technology-related services. For example, individuals who have a visual disability may not be able distinguish colors on a screen or even see the screen at all.

*DK:* Does the issue of technology accessibility for those with a disability include compliance with the Americans with Disabilities Act (ADA)?

*CM and JB (simultaneously):* Absolutely!

*CM:* ADA requires that counselors, counselor educators, and supervisors provide reasonable accommodations so that a client, student, or supervisee with a disability can see the computer screen, use the keyboard, utilize drop down and other types of menus and, in general, be able to access any of our services. The federal government's Web site for complete information on ADA requirements is [www.ada.gov](http://www.ada.gov)

*JB:* A great resource for determining the accessibility of an ACA member's or other Web site, is Web Exact. The Web address is: [Webxact.watchfire.com](http://Webxact.watchfire.com)

*DK:* The new technology standard on World Wide Web sites (A.12.h) has many important ethical imperatives including the need to verify the identity of a cyber-client. Why is that important?

*CM:* For the purposes of confidentiality, it is important to know that the person you are communicating with at any given time is the same person with whom you obtained informed consent and with whom you established a counseling relationship. In other words, you need to know that the individual at the other end

of the cybercounseling is your actual client and not a parent, partner, friend, or hacker.

*DK:* A second reason for establishing client identity right from the start revolves around the issues of suicide and homicide. What if a client gives you an alias and then at some point tells you that he or she is going to kill him- or herself or someone else? If all you have is an alias and false contact information, the ambulance, police, or other responsible party cannot respond to protect a life.

*JB:* A final reason for establishing client identity is that minors may seek counseling without their parents' knowledge and therefore may pose as adults. It may be both an ethical and legal violation to provide services to a minor without parental permission, and the responsibility lies with the counselor to ensure that the client is old enough to give informed consent.

*DK:* How can you verify the identity of clients when you cannot see them?

*JB:* The counselor and client can create and exchange a confidential password at the beginning of a session.

*CM:* You can also set up a webcam with the client. Most computer stores can get you set up fairly inexpensively.

*DK:* The technology section in the ethics code talks about the need to use encrypted Web sites and e-mail communications whenever possible.

*JB:* We don't want to break confidentiality by having a hacker break into our cybercounseling and communications with clients. Encryption is not as difficult as it sounds and is cost effective.

*DK:* Do you have any resources or Web sites for counselors to learn how to encrypt?

*JB:* There is an excellent article titled "How Encryption Works" at [www.howstuffworks.com/encryption.htm](http://www.howstuffworks.com/encryption.htm).

*DK:* Another new technology-related ethical imperative is that counselors must now strive to provide Web site translation capabilities for clients who have a different primary language. Are there any Web resources to assist counselors in these efforts?

*JB:* I would encourage counselors to check out [www.freetranslation.com](http://www.freetranslation.com).

*DK:* At this point our readers may be feeling that we have added more technology-related ethical imperatives than they can handle. How would you respond to a professional counselor who says, "This is overwhelming; I have a degree in counseling, not information technology. I can't do all of this stuff."

*CM:* The purpose of the new technology statements in the revised *Code of Ethics* was to inform, not to overwhelm. Standard A.12 is meant to be educational, visionary, and inspirational. It therefore outlines areas that professional counselors need to learn about if they choose to utilize technology in their direct services, teaching, or supervision.

*JB:* There are many resources available to help educate counselors and counselor educators about incorporating technology into their practice, teaching, and supervision. The newly revised *ACA Ethical Standards Casebook* by Barbara Herlihy and Gerald Corey (available at [www.counseling.org/publications](http://www.counseling.org/publications) or 800-347-6657, ext. 222) gives helpful examples covering each of the points in Standard A.12. NBCC provides a training program that leads to the credential of Distance Credentialed Counselor ([www.cce-global.org/credentials-offered/dccmain](http://www.cce-global.org/credentials-offered/dccmain)). Employee assistance programs (EAPs) are fast becoming experts in Internet counseling and can be excellent resources.

*DK:* ACA has a number of resources available in addition to the *ACA Ethical Standards Casebook*. The second addition of *Cybercounseling & Cyberlearning: Strategies & Resources* (available at [www.counseling.org/publications](http://www.counseling.org/publications) or 800-347-6647 ext 222) and the online continuing education course *Cybercounseling: Going the Distance For Your Clients* (available at <http://www.counseling.org/Resources/ProfessionalDevelopment/TP/Home/CT2.aspx>) are both excellent guides for online counseling and distance learning. And, of course, Paul Fornell, the ACA Manager for Ethics and Professional Standards, provides personal attention to your specific needs and questions at [pfornell@counseling.org](mailto:pfornell@counseling.org) or 800-347-6647, ext. 314.

## Protecting the Confidentiality of the Deceased

**B.3.f. Deceased Clients.** Counselors protect the confidentiality of deceased clients, consistent with legal requirements and agency or setting policies.

*DK:* Why did the Ethics Revision Task Force feel a need to add a standard (B.3.f.) addressing the confidentiality of a deceased client?

*JM:* I don't think we had any initial intent to say, "We're going to protect the confidentiality of our clients in death." It evolved as we focused on client welfare. And it turned into a very unique part of the revised ethics code.

*MK:* The Task Force felt that addressing the welfare of a client means protecting confidentiality in perpetuity and therefore confidentiality should not end when a client passes away. There may be circumstances where an individual does not want information shared, even upon his or her death, and so a counselor needs to make a reasonable assessment of when and where it's appropriate to maintain that confidentiality. A person's death should not mean that any and all information about that person in the counseling relationship is open to public scrutiny or discussion.



*DK:* Let's look at a scenario: A 22-year-old client commits suicide and his mother approaches you and says, "I need to know if my son really hated me when he killed himself."

*JM:* This is a difficult situation, but the welfare of the deceased client is paramount.

*MK:* I agree. The welfare of the client is still existent, even after death. The bottom line comes down to the issue that we still have to protect the son's privacy, even after he dies, and to make our best clinical judgment in terms of what he would want done with the information. If we make a determination that the client would give consent to the requested information being shared with his mother and we have some prior documentation to that effect, then I would go ahead and respond to the mother. But if there is uncertainty, I would keep the client's statements about his mother confidential.

*DK:* So are you essentially saying that whatever rules applied while the client was alive would also apply after he or she died?

*JM:* Yes.

*MK:* Here is a scenario I use when I train counselors. An elderly client dies and the adult children start a legal court fight over the estate. One daughter says, "Dad went to counseling so he must have been crazy. I'll check with his counselor and look at the counseling records. It'll prove that dad didn't know what he was talking about and that he was not in his right mind when he left the house to my brother." We would honor the counseling relationship even after the client was deceased and protect the privacy and confidentiality of the father by refusing the daughter's request to review her father's case notes.

*DK:* Let's look at a scenario that involves positive sentiments. A client dies tragically and before his or her time. During the counseling, the client said some very loving and heartfelt statements about family members. Would it be appropriate for the counselor to contact the grieving family and say, "I'm really sorry to hear what happened. I just wanted to let you know that your partner or your father or your mother had some very loving things to say about you?"

*JM:* Your professional judgment is going to come into play. You don't have to divulge all the particulars. If the client said some loving things about family members, I think it would be a comfort to them in their grief to know that.

*DK:* What is the role of informed consent in protecting the confidentiality of a deceased client?

*MK:* It is now important to build into the informed consent process the concept that confidentiality does not stop upon the death of a person.

*DK:* Is it appropriate for a counselor to go to the funeral of a deceased client who has died unexpectedly?

*JM:* The counselor needs to ask her or himself the question: What would be the purpose of going to the funeral?

*MK:* Based on an honest appraisal of that question, the counselor would have to assess whether going to the funeral would be beneficial or harmful to the memory of the deceased client. In that respect, it is no different from evaluating the beneficial versus harmful aspects of attending a client's wedding or graduation ceremony. If your professional judgment clearly indicates it would be beneficial, you can choose to go to the funeral service. It may be prudent to sit in a chair off to the side where you don't have to necessarily interact with others. You can pay your respects to the client and then leave without having to interact with too many people. If someone asks you how you know the deceased, you can simply state that you worked with him or her professionally. On the other hand, if the client's family clearly knew about and might have even been involved in the counseling at times, you might be more active in paying your respects if there is reason to believe that the family would be comfortable with, and comforted by, your presence.

*DK:* Can the case history of a deceased client be used when teaching classes or as an example during a professional presentation?

*JM:* The same rules apply as to a living client. You can use case examples for educational purposes as long as identifying information is removed so that the client cannot be identified.

*DK:* What should be done with the records of a deceased client?

*MK:* Once again, the same rule applies as for a client who is living. The *ACA Code of Ethics* does not state a specific length of time to keep records. However, many state licensing laws require that records be kept for 7 years. Therefore, 7 years is a reasonable amount of time to keep the file of a deceased client.

*DK:* Speaking of records, what is the appropriate way to react to a subpoena for information from the file of a deceased client?

*MK:* If I made a professional judgment that divulging information could in any way harm my deceased client I would, with the assistance of the lawyer provided by my liability insurance company such as the ACA Insurance Trust, decline to provide information.

*JM:* At the point that the court indicated that I had no choice but to comply with the subpoena, I would give the minimal amount of information possible. I would protect the client's confidentiality as much as possible, even after death.

*DK:* To wrap up, what would you say is the key to Standard B.3.f and protecting the confidentiality of a deceased client?

*MK:* That the counseling relationship exists even through death. We continue to honor that relationship after a client dies. As such, whatever statements in the *ACA Code of Ethics* applied when the client, supervisee, student, or research participant was alive continue to apply after they are deceased. If a counselor would not disclose

information when a client was alive, he or she should not disclose that information after the client's death.

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