Pre-Chapter Self-Inventory

Directions: For each statement, indicate the response that most closely identifies your beliefs and attitudes. Use the following code:

5 = I strongly agree with this statement.
4 = I agree with this statement.
3 = I am undecided about this statement.
2 = I disagree with this statement.
1 = I strongly disagree with this statement.

1. A person who comes from a troubled family background is generally unlikely to become a good family therapist.
2. I would never divulge in a family session any secrets given to me privately by one of the members.
3. In practicing couples counseling, I would also be willing to see them for individual sessions in addition to conjoint therapy.
4. Counselors have an ethical responsibility to encourage spouses to leave partners who are physically or psychologically abusive.
5. I would not be willing to work with a couple if I knew that one of the individuals was having an affair.
Ethical Issues in Couples and Family Therapy

6. It is ethical for family therapists to use pressure and even coercion to get a reluctant client to participate in family therapy.

7. Therapists who feel justified in imposing their own values on a couple or a family can do considerable harm.

8. In couples or family therapy, I would explain about confidentiality at the very beginning.

9. Most family therapists, consciously or unconsciously, work to keep the family together.

10. There are ethical problems in treating only one member of a family.

11. I would be willing to work with a single member of a family and eventually hope to bring the entire family into therapy.

12. Before accepting a family for treatment, I would obtain supervised training in working with families.

13. Before working with families, I need to know my issues with my own family of origin.

14. Skill in using family therapy techniques is far more important to success in this area than knowing my own personal dynamics.

15. I support requiring continuing education in the field of couples and family therapy as a condition for renewal of a license in this area.
Much of the practice of couples and family therapy rests on the foundation of systems theory, which views psychological problems as arising from within the individual’s present environment and the intergenerational family system. Symptoms are believed to be an expression of dysfunctions within the system, which are passed along through numerous generations. The idea that the identified client’s problem might be a symptom of how the system functions, not just a symptom of the individual’s maladjustment and psychosocial development, was a revolutionary notion. The family systems perspective is grounded on the assumptions that a client’s problematic behavior may (1) serve a function or purpose for the family, (2) be a function of the family’s inability to operate productively, or (3) be a symptom of dysfunctional patterns handed down across generations. However, other theoretical frameworks also guide the practice of family therapy, including Bowen’s multigenerational family therapy, Satir’s human validation process model, Whitaker’s experiential approach, structural family therapy, strategic family therapy, and the social construction models of family therapy (Corey, 2005b).

Goldenberg and Goldenberg (2004) urge therapists to view all behavior, including the symptoms expressed by the individual, within the context of the family and society. Although traditional approaches to treating the individual have merit, expanding the perspective to consider clients as members of their family, community, and society may enhance therapists’ understanding. The Goldenbergs claim that a systems orientation does not preclude dealing with the individual but does broaden the traditional emphasis to address the roles individuals play in the family.

The systems perspective views the family as a functioning entity that is more than the sum of its members. The family provides the context for understanding how individuals behave. Actions by any individual member influence all the other members, and their reactions have a reciprocal effect on the individual. For instance, an acting-out child may be expressing deep conflicts between the mother and the father and may actually be expressing the pain of an entire family. Family therapists often work with individuals, the couple, and parents and children to get a better understanding of patterns that affect the entire system and to develop strategies for change.

Although contemporary couples and family therapists usually base their clinical practice on a foundation of systems theory, the majority of family therapists integrate concepts and techniques from various theoretical orientations to produce their own blend of methods based on their training, personality, and the population of families they serve (Hanna & Brown, 2004). Nichols and Schwartz (2004) also maintain that family therapy is moving toward integration. They believe that it does not make sense to study only one model and to neglect the insights of others.

Many master’s programs in counseling now offer a specialization in relationship counseling or couples and family therapy. Components of the training program in couples and family therapy include the study of systems theory, an
examination of family of origin, the use of live supervision, and an emphasis on ethical and professional issues specific to working with couples and families.

Many of the ethical issues we have already discussed take on special significance when therapists work with more than one client. Most graduate programs in couples and family therapy now require a separate course in ethics and the law pertaining to this specialization, with an increased emphasis on ethical, legal, and professional issues unique to a systems perspective. The professional practice of couples and family therapy is regulated by state laws, professional specialty guidelines, ethics codes, peer review, continuing education, managed care, and consultation (Goldenberg & Goldenberg, 2004). Some specific areas of ethical concern for family therapists that we discuss in this chapter include ethical standards of practice, therapist values, therapist responsibility, gender sensitivity, confidentiality, and informed consent and the right to refuse treatment.

Ethical Standards in Couples and Family Therapy

The AAMFT Code of Ethics (2001) provides a framework for many of the ethical issues we will consider in this chapter. In addition to the AAMFT code, two useful resources for issues involving couples and family therapy are the Ethical Casebook for the Practice of Marriage and Family Counseling (Stevens, 1999) and the American Association for Couples and Family Therapy Ethics Casebook (Brock, 1998). In addition, many states have their own professional organizations that outline ethical standards for the practice of couples and family therapy.

We begin our discussion by considering the AAMFT’s (2001) code in each of eight core areas, followed by a brief discussion of what this means for therapists.

1. Responsibility to clients. “Marriage and family therapists advance the welfare of families and individuals. They respect the rights of those persons seeking their assistance, and make reasonable efforts to ensure that their services are used appropriately” (Principle I).

As the focus of therapy shifts from the individual to the family system, a new set of ethical questions is raised: Whose interests does the family therapist serve? To whom and for whom does the therapist have primary loyalty and responsibility? the client identified as being the problem? the separate family members as individuals? the family as a whole? By agreeing to become involved in family therapy, the members can generally be expected to place a higher priority on the goals of the family as a unit than on their own personal goals.

2. Confidentiality. “Marriage and family therapists have unique confidentiality concerns because the client in a therapeutic relationship may be more than one person. Therapists respect and guard confidences of each individual client” (Principle II).

Confidentiality assumes unique significance in the practice of couples and family therapy. This issue arises within the family itself in deciding how to deal with secrets. Incest, extramarital affairs, contagious diseases, or physical or psychological abuse of a partner or children may be involved. Should the therapist
attempt to have families explore all their secrets? What are the pros and cons of revealing a family secret when some members are likely to suffer from extreme discomfort if it is disclosed? Family therapists have different perspectives on maintaining confidentiality. Some treat all information they receive from a family member just as if the person were in individual therapy. Others refuse to see any member of the family separately, claiming that doing so fosters unproductive alliances and promotes the keeping of secrets. Still others tell family members that they will exercise their own judgment about what to disclose from an individual session in a couples or family session.

3. **Professional competence and integrity.** “Marriage and family therapists maintain high standards of professional competence and integrity” (Principle III).

This principle implies that clinicians keep abreast of developments in the field through continuing education and clinical experiences. A single course or two in a graduate counseling program is hardly adequate preparation for functioning ethically and effectively as a counselor with couples or families. Here are some questions that can be productively explored: How can therapists know when their own personal problems are likely to hamper their professional work? What are some ways in which therapists can best maintain a level of competence? How can therapists use their values in a constructive fashion?

4. **Responsibility to students and supervisees.** “Marriage and family therapists do not exploit the trust and dependency of students and supervisees” (Principle IV).

The code cautions practitioners to avoid multiple relationships, which are likely to impair clinical judgment. As you saw in Chapters 7 and 9, perspectives differ on how best to handle dual relationships and avoid exploiting the trust and dependency of clients, students, and supervisees. What are your views about dual relationships as they apply to couples and family therapy? students and supervisees? Can you think of a possible dual or multiple relationship that would not interfere with your objectivity or lead to exploitation? What concerns might you have about dual relationships between marriage and family therapists and students or supervisees?

5. **Responsibility to research participants.** “Investigators respect the dignity and protect the welfare of research participants, and are aware of federal and state laws and regulations and professional standards governing the conduct of research” (Principle V).

Researchers must carefully consider the ethical aspects of any research proposal, making use of informed consent procedures and explaining to participants what is involved in any research project. If there is a conflict between research purposes and therapeutic purposes, how would you resolve it? What are some multicultural considerations in doing research in this area? What obstacles do you see to doing research in this area?

6. **Responsibility to the profession.** “Marriage and family therapists respect the rights and responsibilities of professional colleagues and participate in activities that advance the goals of the profession” (Principle VI).

Ethical practice requires measures of accountability that meet professional standards. It is expected that couples and family therapists will contribute time to the betterment of society, including donating services. What would you say
about the ethics of those therapists who do not contribute any of their professional time pro bono? What do you see as your ethical obligation to advance the goals of your profession? What activities do you participate in (or expect to participate in) for professional advancement?

7. Financial arrangements. “Marriage and family therapists make financial arrangements with clients, third party payers, and supervisees that are reasonably understandable and conform to accepted professional practices” (Principle VII).

Couples and family therapists do not accept payment for making referrals and do not exploit clients financially for services. They are truthful in representing facts to clients and to third parties regarding any services rendered. Ethical practice dictates a disclosure of fee policies at the onset of therapy. What steps would you take to inform your clients about your fee policies? Would you charge for missed appointments? What are some ways in which clients can be exploited financially?

8. Advertising. “Marriage and family therapists engage in appropriate informational activities, including those that enable the public, referral sources, or others to choose professional services on an informed basis” (Principle VIII).

Ethical practice dictates that practitioners accurately represent their competence, education, training, and experience in couples and family therapy. Therapists do not advertise themselves as specialists (for example, in sex therapy) without being able to support this claim by virtue of their education, training, and supervised experience. How would you advertise your services? How might you promote yourself as a couples and family practitioner?

Special Ethical Considerations in Working With Couples and Families

Why do couples seek therapy? This question was the basis of a survey of 147 married couples seeking marital therapy, which was conducted by Doss, Simpson, and Christensen (2004). The most commonly reported reasons for seeking couples therapy were problematic communication and lack of emotional affection. Other reasons included the desire to improve the relationship for the sake of the children (19% of couples) and positive feelings for their spouse or relationship (22% of couples).

A number of ethical considerations are unique to couples and family therapy. Because most couples and family therapists focus on the family system as the client rather than on the individual’s dynamics, potential ethical dilemmas can arise from the first session, which need to be clarified. Because of the increased complexity of their work, couples and family therapists are faced with more potential ethical conflicts than are practitioners who specialize in individual therapy. Therapists who work with cohabitating couples or multiple family members often encounter dilemmas that involve serving one member’s best interest at the expense of another member’s interest.

In their interventions, therapists need to consider that the status of one partner or family member does not improve at the expense of the other partner.
or another family member. Gladding, Remley, and Huber (2001) maintain that therapists can respond to ethical dilemmas over conflicting interests of multiple individuals by identifying the couple or family system as the focus of treatment rather than a single individual as the primary “client.” Therapists who function as an advocate of the system avoid becoming an agent of any one partner or family member. Working within a framework that conceptualizes change as affecting and being affected by all family members, practitioners are able to define problems and consider plans for change in the context of the family system.

Gladding and colleagues also address these ethical concerns faced by couples and family counselors (p. 62):

- Can therapists automatically assume the right to define couples’ and families’ presenting problems in terms of their own therapeutic orientation?
- How much concerted effort can therapists exert in convening all significant family members for therapy sessions?
- Should willing individual relationship partners or several family members seeking assistance go untreated because one individual refuses to participate?
- Under what situations, if any, should therapists impose their control on couples and families? If so, to what extent should they impose it in seeking change in the relationship system?
- How much intrasystem stress should be engendered or allowed to materialize in the pursuit of change?
- What are the ethical implications inherent in employing paradoxical procedures?
- How can the impact of working with couples and families within the larger context of service agency constraints be pursued ethically?

Contemporary Professional Issues

In this section we identify a few of the current professional issues in the practice of couples and family therapy. These include the personal, academic, and experiential qualifications necessary to practice in the field.

Personal Characteristics of the Family Therapist

In Chapter 2 we addressed the significance of the personal characteristics of the therapist as a major factor in creating an effective therapeutic alliance. Self-knowledge is particularly critical for family therapists, especially with regard to family-of-origin issues. When therapists work with a couple or a family, or with an individual who is sorting out a family-of-origin issue, their perceptions and reactions are likely to be influenced by their own family-of-origin issues. Therapists who are unaware of their own vulnerabilities are likely to misinterpret their clients or steer clients in a direction that will not arouse their own anxieties. Therapists who are aware of their own emotional issues are less likely to get entangled in the problems of their clients.
Many trainers of family therapists believe that a practitioner’s mental health, as defined by relationships with his or her family of origin, has implications for professional training. It is assumed that trainees can benefit from an exploration of the dynamics of their family of origin because it enables them to relate more effectively to the families they will meet in their clinical practice.

Getz and Protinsky (1994) take the position that personal growth is an essential part of training for couples and family counselors and that knowledge and skills cannot be separated from a helper’s internal dynamics and use of self. They write: “Trainees can and should be referred for personal therapy, but their issues, when identified as affecting their work, are addressed preferably in training” (p. 183). Getz and Protinsky point to growing clinical evidence that a family-of-origin approach to supervision is a necessary dimension of training for therapists who want to work with families. They contend that the reactions of therapists to their clients’ stories tend to reactivate therapists’ old learned patterns of behavior and unresolved problems. Through studying their own family of origin, students are ultimately able to improve their ability to counsel families.

In writing on the personal training of family therapists, Aponte (1994) describes his person/practice model, which is based on the premise that therapy is a personal encounter within a professional framework. Although he acknowledges that theory and technique are essential to the professional practice of family therapy, he stresses that the process is affected wholly through the relationship between therapist and client. For Aponte, training the person of the therapist calls for trainees to examine their personal issues in relation to the therapy they do: “The touching of therapists’ and clients’ lives in therapy beckons therapists to gain mastery of their personal selves in their clinical relationships” (p. 4).

Educational Requirements for Family Therapy

All couples and family training programs acknowledge that both conceptual knowledge and clinical skills are necessary to become a competent family therapist. As training programs have evolved, major didactic and experiential components have been identified. Family therapy training programs use three primary methods of training: (1) didactic course work; (2) the use of master therapist videotapes plus trainee tapes for postsession viewing by the trainees and supervisors; and (3) regular supervision by an experienced family supervisor who, together with trainees, may watch the session behind a one-way mirror or on videotape (Goldenberg & Goldenberg, 2004). In addition to these methods of training, trainees are now likely to be exposed to a variety of current issues in the field of family therapy. Some of these include gender awareness, cultural sensitivity, and an understanding of the impact of larger systems on family functioning (Goldenberg & Goldenberg, 2004). It is essential for students to gain experience in working with a variety of families from different ethnic and socioeconomic backgrounds who have various presenting problems. A program offering both comprehensive course work and clinical supervision provides the ideal learning situation.
Experiential Qualifications for Family Therapy

In training couples and family therapists, primary emphasis must be given to the quality of supervised practice and clinical experience. Academic knowledge comes alive in supervised practicum and internship experiences, and trainees learn how to use and sharpen their intervention skills. It is through direct clinical contact with families, under close supervision, that trainees develop their own styles of interacting with families. A variety of supervisory methods can be employed to assist trainees in learning by doing, including the use of audiotapes, videotapes, written process notes, co-therapy, corrective feedback by telephone, live supervision, and calling the trainee out of the family session for consultation.

Most graduate programs employ both didactic and experiential methods and supervised practice. Didactic methods include lectures, group discussion, demonstrations, instructional videotapes of family therapy sessions, role playing, and assigned readings. Clinical experience with families is of limited value without regularly scheduled supervisory sessions. Live supervision can be conducted by a supervisor who watches and guides the sessions behind a one-way mirror and offers useful feedback and consultation to the trainee on how he or she is working with a family (Goldenberg & Goldenberg, 2004). Family therapy trainees can also profit from the practice of co-therapy, which provides trainees with opportunities to work closely with a supervisor or a colleague. A great deal of the supervision can take place immediately after and between sessions.

Experiential methods include both personal therapy and working with issues of one’s own family of origin. A rationale for personal therapeutic experiences is that such exploration enables trainees to increase their awareness of transference and countertransference, which assists trainees in relating more effectively to the families they will meet in their clinical practice.

If clinicians are seeing families as part of their work, and if their program did not adequately prepare them for competence in intervening with families, they are vulnerable to a malpractice suit for practicing outside the boundaries of their competence. Those practitioners who did not receive specialized training in their program need to involve themselves in postgraduate in-service training or special workshops.

The Case of Ludwig. Ludwig is a counselor whose education and training have been exclusively in individual counseling. Ella comes to him for counseling, but, after more than a dozen sessions with Ella, Ludwig realizes that much of her difficulty lies not just with her but with her entire family system. By this time Ludwig has established a strong working relationship with Ella. Because he has no experience in family therapy, he ponders what to do. He thinks of referring Ella to a colleague who is well trained in family therapy, but he realizes that doing so could have a detrimental effect on her. One of Ella’s problems has been a sense of abandonment by her parents. He wants to avoid giving her the impression that he, too, is abandoning her. He decides to stay with her and
work with her individually. Much of the time is spent trying to understand the
dynamics of the family members who are not present.

- Do you agree with Ludwig’s clinical decision? Do you agree with his rationale?
- From your perspective, would it have made a difference if he had consulted
  with Ella? Would it have made a difference if he had consulted with or
  obtained supervision from a colleague?
- Even though Ludwig was not trained as a family therapist, what if he had
decided to see the entire family and attempted to do family therapy for the
benefit of his client? Would you be inclined to do that?
- What if Ludwig had been trained in family systems but, when he suggested
  family sessions to Ella, she refused? What would you do if faced with such a
dilemma?
- Assume that Ludwig decided to see each family member individually to learn
  how each viewed the family system. In this process he discovered a great dis-
crepancy between Ella’s description of the family and what the other family
members said. Ludwig became convinced that his client was either misread-
ing the family or was not presenting an accurate description of her problem.
What is your opinion of his analysis? Does it raise any concerns for you?

Values in Couples and Family Therapy

In Chapter 3 we explored the impact of the therapist’s values on the goals and
direction of the therapeutic process. We now consider how values take on spe-
cial significance in counseling couples and families. Values pertaining to mar-
riage, the preservation of the family, divorce, traditional and nontraditional
lifestyles, gender roles and the division of responsibility in the family, child
rearing, and extramarital affairs can all influence therapists’ interventions.
Therapists may take sides with one member of the family against another; they
may impose their values on family members; or they may be more committed
to keeping the family intact than are the family members themselves. Con-
versely, therapists may have a greater investment in seeing the family dissolve
than do members of the family.

The value system of the therapist has a crucial influence on the formulation
and definition of the problems the therapist sees in a family, the goals and plans
for therapy, and the direction the therapy takes. The International Association
of Marriage and Family Counselors (2002) ethics code states: “Members do not
impose personal values on families or family members” (I.F.). Counselors who,
intentionally or unintentionally, impose their values on a couple or a family can
do considerable harm. Ethical issues are raised in establishing criteria of psy-
chosocial dysfunction, assessing the problems of the identified patient in the
family context, and devising treatment strategies.

In their discussion of the valuing components of the professional practice
of couples and family therapy, Gladding and colleagues (2001) agree with the
assumption that the content of values is important and cannot be ignored, yet
they place emphasis on the process of valuing, which includes the values,
beliefs, and resultant actions they encompass. They note that too often values are represented as static positions construed as right or wrong rather than as a process that requires continual reconsideration and reclarification. They compare this to the process therapists use to understand cultural diversity. Respect for a client's culture or ethnicity involves initial acceptance of differences, exploration of those differences, and subtle explanations of how a given ethnic group's customs differ from the larger culture. In a like manner, couples and family therapists have the role of assisting couples and families in negotiating the values they want to retain, modify, or discard.

We want to emphasize again that it is not the function of any therapist to make decisions for clients. Family therapists do not decide how members of a family should change. The role of the therapist is to help family members see more clearly what they are doing, to help them make an honest evaluation of how well their present patterns are working for them, and to help and encourage them to make necessary changes.

What values and experiences of yours might influence how you would work with couples and families? To assist you in formulating your personal position, consider two cases that raise value issues that could affect the course of therapy.

**The Case of Sharon.** Sharon is a 25-year-old client who says, "I'm never going to get married because I think marriage is a drag. I don't want kids, and I don't want to stay with one person forever." Here are the inner dialogues of four therapists regarding her case.

**Therapist A:** She seems very selfish to me. With her attitude, it's probably a good idea that she doesn't intend to get married. I wonder why she is in therapy?

**Therapist B:** Well, she doesn't have to be married. Mental health doesn't necessarily require that one be married. I certainly would want to communicate to her that remaining single is acceptable. But I would like to explore with her how she went about making this decision.

**Therapist C:** Why is she so opposed to marriage? I wonder if she is talking more about her family than marriage?

**Therapist D:** I feel sorry for her. She must have had some very painful experiences growing up. She must have had a terrible relationship with her father that prevents her from forming healthy relationships now. If I can only get to the underlying problem, I know she will be able to overcome her negative experiences.

- What is your reaction to Sharon's statement?
- What is your reaction to each of the therapist's responses to her?
- What implied value is each therapist expressing?
- Why would you want to challenge (or accept) Sharon's decision?
- In what ways do you think you might work with Sharon differently from the four therapists? If you don't feel comfortable with a commitment to marriage and a family yourself, do you think you could be objective enough to help her explore some of the possibilities she might be overlooking?
The Case of Frank and Judy. During the past few years Frank and Judy have experienced many conflicts in their marriage. Although they have made attempts to resolve their problems by themselves, they have finally decided to seek the help of a professional marriage counselor. Even though they have been thinking about divorce with increasing frequency, they still have some hope that they can achieve a satisfactory marriage.

We will present the approaches of three couples counselors, each holding a different set of values pertaining to marriage and the family. As you read these responses, think about the degree to which each represents what you might say and do if you were counseling this couple.

Counselor A. This counselor believes it is not her place to bring her values pertaining to the family into the sessions. She is fully aware of her biases regarding marriage and divorce, but she does not impose them or expose them in all cases. Her primary interest is to help Frank and Judy discover what is best for them as individuals and as a couple. She sees it as unethical to push her clients toward a definite course of action, and she lets them know that her job is to help them be honest with themselves.

- What are your reactions to this counselor’s approach?
- How would you, as a counselor, keep your values from interfering with the therapy process?

Counselor B. This counselor has been married three times herself. Although she believes in marriage, she is quick to maintain that far too many couples stay in their marriages and suffer unnecessarily. She explores with Judy and Frank the conflicts that they bring to the sessions. The counselor’s interventions are leading them in the direction of divorce as the desired course of action, especially after they express this as an option. She suggests a trial separation and states her willingness to counsel them individually, with some joint sessions. When Frank brings up his guilt and reluctance to divorce because of the welfare of the children, the counselor confronts him with the harm that is being done to them by a destructive marriage. She tells him that it is too much of a burden to put on the children to keep the family together at any price.

- What, if any, ethical issues do you see in this case? Is this counselor exposing or imposing her values?
- Do you think this person should be a marriage counselor, given her bias?
- What interventions made by the counselor do you agree with? What are your areas of disagreement?

Counselor C. At the first session this counselor states his belief in the preservation of marriage and the family. He feels that many couples take the easy way out by divorcing too quickly in the face of difficulty. He says that most couples have unrealistically high expectations of what constitutes a “happy marriage.” The counselor lets it be known that his experience continues to teach him that divorce rarely solves any problems but instead creates new problems that are often worse. The counselor urges Frank and Judy to consider
the welfare of their three dependent children. He tells the couple of his bias toward saving the marriage so they can make an informed choice about initiating counseling with him.

- What are your personal reactions toward the orientation of this counselor?
- Do you agree with him stating his bias so obviously?
- What if he were to keep his bias and values hidden from the couple and accept them into therapy? Do you think he could work objectively with this couple? Why or why not?

Commentary. This case shows how the value system of the counselor determined the direction counseling took. The counselor who is dedicated to preserving marriage and family life is bound to function differently from the counselor who puts primary value on the welfare of individual family members. What might be best for one family member is not necessarily in the best interests of the entire family. It is essential, therefore, for counselors who work with couples and families to be aware of how their values influence the goals and procedures of therapy. Ethical practice should challenge clients to look at their own values and to choose a course of action that is best for them.

Gender-Sensitive Couples and Family Therapy

Gender-sensitive couples and family therapy attempts to help both women and men move beyond stereotyped gender roles. Sexist attitudes and patriarchal assumptions are examined for their impact on family relationships. With this approach, family therapy is conducted in an egalitarian fashion, and both therapist and client work collaboratively to empower individuals to choose roles rather than to be passive recipients of gender-role socialization.

All therapists need to be aware of their values and beliefs about gender. In Chapter 4 we discussed the importance of counselors’ being aware of how their culture has influenced their personality. The way people perceive gender likewise has a great deal to do with their cultural background. A challenge to all family therapists is to be culturally sensitive, gender sensitive, and to avoid imposing their personal values on individuals, couples, and families. A standard of IAMFC (2002) addresses the issue of cultural factors:

Members recognize the influence of world view and cultural factors (race, ethnicity, gender, social class, spirituality, sexual orientation, educational status) on the presenting problem, family functioning, and problem-solving skills. Counselors are aware of indigenous healing practices and incorporate them into treatment when necessary or feasible. Members are encouraged to follow the guidelines provided in the Multicultural Competencies. (I.G.)

Counselors who work with couples and families can practice more ethically if they are aware of the history and impact of gender stereotyping as it is reflected in the socialization process in families, including their own. Effective practitioners must continually evaluate their own beliefs about appropriate
family roles and responsibilities, child-rearing practices, multiple roles, and nontraditional vocations for women and men. Counselors also must have the knowledge to help their clients explore educational, vocational, and emotional goals that they previously deemed unreachable. The principles of gender-aware therapy have relevance for counselors as they help clients identify and work through gender concepts that have limited them.

Feminist Perspective on Family Therapy

Some feminist therapists have been critical of the clinical practice of family therapy, contending that it has been filled with outdated patriarchal assumptions and grounded on a male-biased perspective of gender roles and gender-defined functions within the family. Feminists assert that our patriarchal society subjugates women, blames them for inadequate mothering, and expects them to accept their contribution to their problem.

A feminist view of family therapy focuses on gender and power in relationships and encourages a personal commitment to challenge gender inequity. They espouse a vision of a future society that values equality between women and men. Examining the power differential in their relationships often helps partners demystify differences between them. Feminist family therapists share a number of roles, each of which is based on a specific value orientation: They make their values and beliefs explicit so that the therapy process is clearly understood; they strive to establish egalitarian roles with clients; they work toward client autonomy and client empowerment; and they emphasize commonalities among women. In short, they do have an agenda to challenge traditional gender roles and the impact this socialization has on a relationship and a family.

Feminist therapists do not take a neutral stance with respect to gender roles and power in relationships. They advocate for definite change in the social structure, especially in the area of equality, power in relationships, the right to self-determination, freedom to pursue a career outside the home, and the right to an education.

Therapists can best function in the interests of both female and male clients by challenging them to examine self-contradictions. The therapist’s task is to help clients decide who and what they want to be in the context of their lives, not what the therapist thinks they should be. Feminist therapists state that all therapists have values and that they believe it is important to be clear with clients about these values. This is different, however, from imposing values on clients. An imposition of values is inconsistent with viewing clients as their own best experts. Clients should be encouraged to make their own choices, and their choices need to be supported by their therapist.

A Nonsexist Perspective on Family Therapy

Regardless of their particular theoretical orientation, it is incumbent upon family therapists to take whatever steps are necessary to account for gender issues
in their practice and to become nonsexist family therapists. Margolin (1982) provides a number of recommendations on how to be a nonsexist family therapist and how to use the therapeutic process to challenge the oppressive consequences of stereotyped roles and expectations in the family. One recommendation is that family therapists examine their own behavior for comments and questions that imply that wives and husbands should perform specific roles and hold a specific status. For example, a therapist can show bias in subtle and nonverbal ways, such as looking at the wife when talking about rearing children or addressing the husband when talking about any important decisions that need to be made. Further, Margolin contends that family therapists are particularly vulnerable to the following biases: (1) assuming that remaining married would be the best choice for a woman, (2) demonstrating less interest in a woman’s career than in a man’s career, (3) encouraging couples to accept the belief that child rearing is solely the responsibility of the mother, (4) showing a different reaction to a wife’s affair than to a husband’s, and (5) giving more importance to satisfying the husband’s needs than to satisfying the wife’s needs. She raises two important questions dealing with the ethics of doing therapy with couples and families:

- How does the therapist respond when members of the family seem to agree that they want to work toward goals that (from the therapist’s vantage point) are sexist in nature?
- To what extent is the therapist culturally sensitive, especially when the family’s definition of gender-role identities differs from the therapist’s view?

As you read the case examples that follow, consider your own values. How do you think about gender, and do your views influence your perception of these cases? How might your values affect your way of counseling in each case?

**The Case of Marge and Al.** Marge and Al come to marriage counseling to work on the stress they are experiencing in rearing their two adolescent sons. The couple directs the focus toward what their sons are doing and not doing. In the course of therapy, the counselor learns that both Marge and Al have full-time jobs outside the home. In addition, Marge is a full-time mother and homemaker, but her husband refuses to share any domestic responsibilities. Marge doesn’t question her dual career. Neither Marge nor Al shows much interest in exploring the division of responsibilities in their relationship. Instead, they focus the sessions on getting advice about how to handle problems with their sons.

- What would you do with their presenting problem, their trouble with their sons? What might the behavior of the sons imply?
- Is it ethical for the therapist to focus only on the expressed concerns of Marge and Al? Does the therapist have a responsibility to challenge this couple to look at how they have defined themselves and their relationship through assumptions about gender roles?
• If you were counseling this couple, what might you do? How would your interventions reflect your values in this case?

As you think about this case and the following one, ask yourself how your values regarding traditional wives and mothers might affect your relationship with clients like Marge and Melody.

✓ The Case of Melody. Melody, 38, is married and has returned to college to obtain a teaching credential. During the intake session she tells you that she is experiencing conflicting feelings and is contemplating some major changes in her life. She has met a man who shares her interest and enthusiasm for school as well as many other aspects of her life. She is considering leaving her husband and children to pursue her own interests for a change. Which of the following reactions reflect how you think? Would you verbalize them?

• “Perhaps this is a phase you are going through. It happens to a lot of women who return to college. Maybe you should slow down and think about it.”
• “You may have regrets later on if you leave your children in such an impulsive fashion.”
• “Many women in your position would be afraid to do what you are thinking about doing.”
• “I hate to see you divorce without having some marriage counseling first to determine whether that is what you both want.”
• “Maybe you ought to look at the prospects of living alone for a while. The idea of moving out of a relationship with your husband and right into a new relationship with another man concerns me.”

If Melody were your client, what values of yours would influence your interventions?

✓ The Case of Naomi. The White family (consisting of wife, husband, four children, and the wife’s parents) has been involved in family therapy for several months. During one of the sessions, Naomi (the wife) expresses the desire to return to college to pursue a law degree. This wish causes tremendous resistance on the part of every other member of her family. The husband says that he wants her to continue to be involved in his professional life and that, although he admires her ambitions, he simply feels that it would put too much strain on the entire family. Naomi’s parents are shocked by their daughter’s desire, viewing it as selfish, and they urge her to put the family’s welfare first. The children express their desires for a full-time mother. Naomi feels great pressure from all sides, yet she seems committed to following through with her professional plans. She is aware of the sacrifices that would be associated with her studies, but she is asking for everyone in the family to make adjustments so that she can accomplish some goals that are important to her. She is convinced that her plans would not be detrimental to the family’s welfare. The therapist shows an obvious bias by giving no support to Naomi’s aspirations and by not asking the
family to consider making any basic adjustments. Although the therapist does not openly say that she should give up her plans, his interventions have the result of reinforcing the family’s resistance.

- Do you think this therapist is guilty of furthering gender-role stereotypes? Do his interventions show an interest in the well-being of the entire family?
- What are other potential ethical issues in this case?
- Being aware of your own bias regarding gender roles, how would you work with this family?
- Assume that the therapist had an obvious bias in favor of Naomi’s plans and even pushed the family to learn to accept her right to an independent life. Do you see any potential ethical issues in this approach? Do you think a therapist can remain neutral in this kind of case? Explain your stance.

Responsibilities of Couples and Family Therapists

Margolin (1982) argues persuasively that difficult ethical questions confronted in individual therapy become even more complicated when a number of family members are seen together. She observes that the dilemma with multiple clients is that in some instances an intervention that serves one person’s best interests could burden another family member or even be countertherapeutic. Under the family systems model, for example, therapists do not focus on the individual but on the family as a system. Such therapists avoid becoming agents of any one family member, believing that all family members contribute to the problems of the whole family. Ethical practice demands that therapists be clear about their commitments to each member of the family.

Therapist responsibilities are also a crucial issue in counseling with couples. This is especially true when the partners do not have a common purpose for seeking counseling. How do therapists carry out their ethical responsibilities when one partner comes for divorce counseling and the other wants to work on saving the marriage?

In addition to clinical and ethical considerations, Margolin reminds us that legal obligations may require therapists to put the welfare of an individual over that of a relationship. For example, the law requires family therapists to inform authorities if they suspect child neglect or abuse or become aware of it during the course of therapy. Even though reporting this situation may mean the end of therapy for the family, clearly the therapist’s ethical and legal responsibility is to help the threatened or injured person. In the case of domestic violence, clinicians agree that conducting couples therapy while there is ongoing domestic violence presents a potential danger to the abused and is unethical. If the abuser has completed a course of treatment, there may be a possibility of doing therapy with the couple, depending on the assessment provided by the treatment facility. In situations involving domestic violence, there are both ethical and legal issues to consider. In cases where there are conflicts between ethical and legal dimensions of practice, it is especially important for family therapists to seek consultation.
At times couples and family therapists struggle over the issue of when to consult. This is especially true of situations in which a person (or couple or family) is already involved in a professional relationship with a therapist and seeks the counsel of another therapist. What course of action would you take if a husband sought you out for private counseling while he and his wife were also seeing another therapist for marriage counseling? Would it be ethical to enter into a professional relationship with this man without the knowledge and consent of the other professional? What might you do or say if the husband told you that the reason for initiating contact with you was to get another opinion and perspective on his marital situation and that he did not see any point in contacting the other professional?

Confidentiality in Couples and Family Therapy

The principle of confidentiality as it applies to couples and family therapists entails that practitioners not disclose what they have learned through the professional relationship except (1) when mandated by law, such as in cases of physical or psychological child abuse, incest, child neglect, or abuse of the elderly; (2) when it is necessary to protect clients from harming themselves or to prevent a clear and immediate danger to others; (3) when the family therapist is a defendant in a civil, criminal, or disciplinary action arising from the therapy; or (4) when a waiver has previously been obtained in writing. If therapists use any material from their practice in teaching, lecturing, and writing, they take care to preserve the anonymity of their clients. For therapists who are working with families, any release of information must be agreed to by all parties. However, there is an exception to this policy when a therapist is concerned that a family member will harm him- or herself, or will do harm to another person (Green, 2003). Another exception occurs when the law mandates a report.

Therapists have differing views on the role of confidentiality when working with families. One view is that therapists should not divulge in a family session any information given to them by individuals in private sessions. In the case of couples counseling, some practitioners are willing to see each spouse for individual sessions. Information given to them by one spouse is kept confidential. Other therapists, however, reserve the right to bring up certain issues in a joint session, even if one person mentioned the issue in a private session.

Some therapists who work with couples or entire families go further. They have a policy of refusing to keep information secret that was shared individually. Their view is that secrets are counterproductive for effective couples or family therapy. Therefore, “hidden agendas” are seen as material that should be brought out into the open during a couples or family session. Still another view is that therapists should inform their clients that any information given to them during private sessions will be divulged as they see fit in accordance with the greatest benefit for the couple or the family. These therapists reserve the right to use their professional judgment about whether to maintain individual confidences or not, claiming that this gives them more flexibility. Therapists
who have not promised confidentiality have more options and thus must carefully consider the therapeutic ramifications of their actions.

Benitez (2004) recommends that therapists who work with couples would do well to develop a policy with regard to information that is shared with the therapist by one member of the couple outside of the presence of the other member of the couple. Benitez advises that this policy should state that such information might be disclosed to the other member of the couple at the therapist’s discretion. This frees the therapist from being put in the position of keeping a secret of a client participating in conjoint therapy. However, each person must be informed of this policy in advance and also agree to this policy. According to Benitez, a “no secrets” policy is essential for therapists who offer couples counseling. Couples may need to be frequently reminded of this policy.

As a part of the informed consent process, it is absolutely essential to ethical practice that couples and family therapists clarify their position regarding confidentiality from the outset. The informed consent statement must include clarification as to who is the client and how personal matters that are expressed by a family member to the counselor on an individual basis will be dealt with during the course of family therapy (Smith, 1999). ACA’s (2005) standard dealing with couples and family counseling states: “In couples and family counseling, counselors clearly define who is considered ‘the client’ and discuss expectations and limitations of confidentiality. Counselors seek agreement and document in writing such agreement among all involved parties having capacity to give consent concerning each individual’s right to confidentiality and any obligation to preserve the confidentiality of information known” (B.4.b). When informed consent is done properly, family members are in a position to decide whether to participate in therapy and how much to disclose to the therapist. For example, a husband might disclose less in a private session if he knew that the therapist might bring these disclosures out in a conjoint session.

A Case of Therapist Quandary. A husband is involved in individual therapy to resolve a number of personal conflicts, of which the state of his marriage is only one. Later, his wife comes in for some joint sessions. In their joint sessions much time is spent on how betrayed the wife feels over having discovered that her husband had an affair in the past. She is angry and hurt but has agreed to remain in the marriage and to come to these therapy sessions as long as the husband agrees not to resume the past affair or to initiate new ones. The husband agrees to her demands. The therapist does not explicitly state her views about confidentiality, nor does she explain a “no secrets” policy, yet the husband assumes that she will keep to herself what she hears in both the wife’s private sessions and his private sessions. During one of the conjoint sessions, the therapist states that maintaining or initiating an affair is counterproductive if they both want to work on improving their marriage. The therapist states a strong preference that they agree not to have affairs during the time they are in therapy.

In a later individual session the husband tells the therapist that he has begun a new affair. He brings this up privately with his therapist because he feels some guilt over not having lived up to the agreement. But he maintains that the affair is
not negatively influencing his relationship with his wife and has helped him to tolerate many of the difficulties he has been experiencing in his marriage. He also asks that the therapist not mention this in a conjoint session, for he fears that his wife will leave him if she finds out that he is involved with another woman. Think about these questions in deciding on the ethical course of action:

- The therapist has not explicitly stated her view of confidentiality and has not issued a “no secrets” policy. Is it ethical for her to bring up the husband’s new affair in a conjoint session?
- How does the therapist handle her conviction regarding affairs in light of the fact that the husband tells her that it is actually enhancing, not interfering with, the marriage?
- Should the therapist attempt to persuade the husband to give up the affair? Should she persuade the client to bring up this matter himself in a conjoint session? Is the therapist colluding with the husband against the wife by not bringing up this matter?
- Should the therapist discontinue therapy with this couple because of her strong bias? If she does suggest termination and referral to another professional, might not this be tantamount to admitting to the wife that the husband is having an affair? What might the therapist say if the wife is upset over the suggestion of a referral and wants to know the reasons?

Informed Consent in Couples and Family Therapy

In Chapter 5 we examined the issue of informed consent and clients’ rights within the framework of individual therapy. Informed consent is a critical ethical issue in the practice of couples and family therapy. Before each individual agrees to participate in family therapy, it is essential that the counselor provide information about the purpose of therapy, typical procedures, the risks of negative outcomes, the possible benefits, the fee structure, the limits of confidentiality, the rights and responsibilities of clients, the option that a family member can withdraw at any time, and what can be expected from the therapist. When therapists take the time to obtain informed consent from everyone, they convey the message that no one member is identified as the source of all the family’s problems. Although getting the informed consent of each member of the family is ideal from an ethical point of view, actually carrying out this practice may be difficult. The more thorough and clear the preparation and informed consent process is, the easier it is for families to make decisions regarding their treatment, and as well, the more control the therapist has over future potential problems.

Clients have a right to know that the family system will be the focus of the therapeutic process and to know about the practical implications of this approach. Informed consent can be more complex than it appears. Many times families enter counseling with one person in the family being perceived as the one with the problem or the “identified patient.” After therapy commences, however, the entire family becomes the focus of the therapist’s intervention. Did these family members truly consent to become clients, or did they perceive
their role as consultants? Family members should have opportunities to raise questions and know as clearly as possible what they are getting involved in when they enter family therapy.

Kaplan (2000) uses an informed consent brochure as a basis for establishing a solid therapeutic relationship among participants in family therapy. Here are some of the steps in this informed consent procedure:

- Construct a thorough informed consent brochure.
- Ask the couple or family to arrive early before the first session so they have time to read the brochure.
- Ask the family if they have any questions about the therapeutic process based on their reading of the informed consent brochure.
- Review the policies and rules about confidentiality.
- Request from each family member a written acknowledgment that he or she has reviewed and understood the contents of the brochure.
- Give the family the brochure to take home for further reference.
- Ask about the brochure at the beginning of the second session.

This structured informed consent procedure increases the chances of instilling a sense of trust that is foundational for future therapy sessions.

As a part of any informed consent document, it is essential that the therapist’s policy be spelled out regarding the conditions for family therapy to begin. For instance, some family therapists will conduct family sessions even if certain members will not attend. Other family therapists consider it essential that all members of the family participate in the therapy process. This latter bias raises ethical questions about exerting pressure on an individual to participate, even if that person is strongly against being involved. Although coercion of a reluctant person is generally viewed as unethical, many therapists strongly suggest that a reluctant family member participate for a session or two to determine what potential value there might be in family therapy. Some resistance can arise from a family member’s feeling that he or she will be the main target of the sessions. This resistance can be lessened and perhaps even eliminated in a short period of time if the therapist refuses to allow the family to use one member as a scapegoat.

There is no professional agreement on whether it is necessary to see all the family for therapy to take place, but we believe it is particularly important when it comes to therapy with children. In so many instances the child is the first family member presented for therapy, which can put an inordinate burden on the child. Including the whole family in therapy provides more protection for the child, and as the whole system corrects itself, the family can become a source of support for the child.

Chapter Summary

The field of couples and family therapy is rapidly expanding and developing. With an expansion in educational programs comes the need for specialized training and experience. A thorough discussion of ethical issues must be part
of all such programs. A few of these issues are determining who is the primary client, dealing with confidentiality, policies on handling secrets, providing informed consent, counseling with minors, and exploring the role of values in family therapy.

The task of the therapist is to help a couple or a family explore and clarify their own values, not to influence them to conform to the therapist’s value system. Likewise, a key ethical issue is the impact of the therapist’s life experiences on his or her ability to practice effectively and objectively. As is true regarding all ethical issues, there is a significant relationship between sound ethical practices and clinical decision making. Family therapists may sometimes experience confusion, for example, regarding the ethical aspects of deciding who will attend family sessions. It is obvious, however, that such decisions cannot be made without a solid foundation in clinical theory and methodology. With increased knowledge and practical experience, therapists can make these ethical decisions with greater certainty. Being open to periodic supervision, seeking consultation when necessary, and being willing to participate in one’s own therapy are some ways in which couples and family therapists can refine their clinical skills.

Suggested Activities

1. In the practice of couples and family therapy, informed consent is especially important. As a class discussion topic, explore some of these issues: What are the ethical implications of insisting that all members of a family participate in family therapy? What kind of information should a family therapist present from the outset to all those involved? Are there any ethical conflicts in focusing on the welfare of the entire family rather than on what might be in the best interests of a family member?

2. Investigate the status of regulating professional practice in couples and family therapy in your state. What are the academic and training requirements, if any, for certification or licensure in this field?

3. In a small group, discuss the major ethical problems facing couples and family therapists. Consider issues such as confidentiality, enforced therapy involving all family members, qualifications of effective family therapists, imposing the values of the therapist on a family, and practicing beyond one’s competence.

4. Design a project to study your own family of origin. Interview as many relatives as you can. Look for patterns in your own relationships, including problems you currently struggle with, that might stem from your family of origin. What advantages do you see in studying your own family as one way to prepare yourself for counseling families?

5. Imagine that you are participating on a board to establish standards—personal, academic, and experiential—for family therapists. What do you think the minimum requirements should be to prepare a trainee to work with families? What would your ideal training program for couples and family therapists look like?
Ethics in Action CD-ROM Exercises

6. In video role play #4, The Divorce, the client (Janice) has made a decision to leave her husband and get a divorce. She says she does not want to work on her relationship anymore. The counselor (Gary) says he hates to hear that. Janice has not been happy for a long time, and she is tired of her husband’s temper and his moods. Gary brings up the kids and asks who will be the advocate for them. Janice thinks that if she is happy they will be happy. She says she will take care of the kids, but that she has to do something with her life. Gary concludes by asking, “Is divorce the best way to take care of them?”

Put yourself in this situation with a client similar to Janice. Assume that your client is experiencing a great deal of ambivalence about getting a divorce, even though she tells you she is convinced that her marital situation is hopeless. She pleads with you to tell her whether she should remain married or get a divorce. What approach might you take? If your client expects you to provide her with an answer, because she is coming to you as the expert, what would you do? Have one student role play the confused client who is searching for an answer and ask several students to give different ways of proceeding with this client.

7. Now let’s assume that the client in video role play #4 is struggling with staying versus leaving her husband. Using the responses of Counselors A, B, and C in the text for the case of Frank and Judy (see pages 447–448), have three students role play the counselors and interact with the client in the video.

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For additional readings, explore InfoTrac College Edition, our online library. Key words are listed in a form that enables the search engine to locate a wider range of articles in the online university library. Key words should be entered exactly as shown, including asterisks, “W1,” “W2,” “AND,” and other search engine tools. Go to http://www.infotrac-college.com and select these key word searches:

- ethic* AND family W1 therap*
- value* AND marri* W1 therapy
- gender W1 sensitive AND therapy
- confid* AND marital n4 family W1 therapy
- systems W1 approach AND family W1 therapy
- gender W1 sensitive AND family W1 therapy
- femin* AND family W1 therapy
Pre-Chapter Self-Inventory

Directions: For each statement, indicate the response that most closely identifies your beliefs and attitudes. Use the following code:

5 = I strongly agree with this statement.
4 = I agree with this statement.
3 = I am undecided about this statement.
2 = I disagree with this statement.
1 = I strongly disagree with this statement.

___1. Groups are useful mainly as a way to cut costs.
___2. Ethical practice requires that prospective group members be carefully screened and selected.
___3. It is important to prepare members so that they can derive the maximum benefit from the group.
___4. Requiring people to participate in a therapy group raises ethical issues.
___5. It is unethical to allow a group to exert pressure on one of its members.
___6. Confidentiality is less important in groups than it is in individual therapy.
7. Socializing among group members is almost always undesirable.
8. One way of minimizing psychological risks to group participants is to negotiate contracts with the members.
9. A group leader has a responsibility to teach members how to translate what they have learned in the group to their outside lives.
10. It is unethical for counselor educators to lead groups of their students in training.
11. Group psychotherapy cannot be conducted in an ethical manner over the Internet except in very limited circumstances.
12. It is the group leader’s responsibility to make prospective members aware of their rights and responsibilities and to demystify the process of a group.
13. Group members should know that they have the right to leave the group at any time.
14. Before people enter a group, it is the leader’s responsibility to discuss with them the personal risks involved, especially potential life changes, and help them explore their readiness to face these risks.
15. It is a sound practice to provide written ethical guidelines to group members in advance and discuss them in the first meeting.
Chapter 12

Introduction

We are giving group work special attention, as we did with couples and family therapy, because it raises unique ethical concerns. Groups have been increasing in popularity, and in many agencies and institutions they are the primary form of treatment. Along with this increased use of groups has come a rising ethical awareness. Practitioners who work with groups face a variety of situations that differ from those encountered in individual therapy.

In tracing the research trends in group counseling and psychotherapy, Barlow, Fuhriman, and Burlingame (2004) state that empirical research on group counseling has shown that a set of recognizable factors—such as skilled leaders, appropriately referred group members, and defined goals—create positive outcomes in groups. They conclude that group approaches can ameliorate a number of social ills. Research confirms that group treatment is more effective than no treatment, yet group therapy does not appear to be superior to other forms of therapy. A survey of more than 40 years of research shows an abundance of evidence that group approaches are associated with clients’ improvement in a variety of settings and situations (Barlow et al., 2004; Burlingame, Fuhriman, & Johnson, 2004).

Although there are some distinct advantages to group therapy, this mode of treatment appears to be underutilized because clients, and some therapists, view group therapy as a second-choice form of treatment. If groups are to flourish, group practitioners face the challenge of educating the public and health care professionals about this therapeutic approach. Clients are less frequently referred for group therapy than they are to individual treatment, and when clients are referred they may not always follow through and join a group (Trull, 2005).

Our illustrations of important ethical considerations in this chapter are drawn from a broad spectrum of groups, including therapy groups, counseling groups, personal-growth groups, psychoeducational groups, and structured groups. Obviously, these groups differ with respect to their member population, purpose, focus, and procedures, as well as in the level of training required for the facilitators of these groups. Although these distinctions are important, all groups face some common concerns: training group leaders, co-leadership issues, the ethical issues surrounding group membership, confidentiality in groups, values, uses and abuses of group techniques, and issues concerning consultation, referral, termination, and follow-up. We address these issues in this chapter.

Training and Supervision of Group Leaders

For competent group leaders to develop, training programs must make group work a priority. Such is not the case in some graduate training programs where not even one group course is required. Although some counselor training programs offer a sequence of two or three courses in group work, most have only one group course (Wilson, Rapin, & Haley-Banez, 2004). Most group courses include both the didactic and experiential aspects of group process.
With proper training in group work, competent practitioners will discover their limitations and recognize the kinds of groups they are competent to lead. Ethical practitioners familiarize themselves with referral resources and refrain from working with client populations that need special assistance beyond their level of competence. For practitioners to become competent group facilitators, specialized training is essential as a way to obtain proficiency and expertise in group process (Markus & King, 2003). When it comes to training doctoral level psychologists, comprehensive training standards have not been universally or rigorously followed. In a survey of group psychotherapy training during pre-doctoral psychology internships, Markus and King found that, much like graduate school programs, pre-doctoral clinical psychology internships do not routinely provide adequate group therapy training. The results of this survey suggest that there is a lack of depth and breadth of group therapy didactic offerings to psychology interns.

Professional Training Standards*

The Association for Specialists in Group Work (ASGW) revised the “Professional Standards for the Training of Group Workers” (ASGW, 2000), taking under consideration the “Best Practice Guidelines” (ASGW, 1998) and the “Principles for Diversity-Competent Group Workers” (ASGW, 1999). The ASGW training standards specify two levels of competencies and related training. First is a set of core knowledge and skill competencies that provide the foundation on which specialized training is built. At a minimum, one group course should be included in a training program, and it should be structured to help students acquire the basic knowledge and skills needed to facilitate a group. These group skills are best mastered through supervised practice, which should include a minimum of 10 hours (with 20 hours recommended) of observation and participation in a group experience. Specific course experiences can be developed from the knowledge and skill objectives delineated for these areas: nature and scope of practice; assessment of group members; the planning of group interventions with emphasis on environmental contexts and the implication of diversity; the implementation of specific group interventions; co-leadership practices; evaluation of process and outcomes; and ethical practice, best practice, and diversity-competent practice (Wilson et al., 2004).

Once counselor trainees have mastered these core knowledge and skills domains, they can acquire training in group work specializations in one or more of these four areas: (1) task groups, (2) psychoeducational groups, (3) group counseling, and (4) group psychotherapy. The ASGW standards detail specific knowledge and skill competencies for these specialties and recommend the number of hours of supervised training necessary for each.

The ASGW's (2000) training standards are the foundation for training group workers in most counselor education programs. The standards of the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2001) that deal with group work reflect much of this material. Both ASGW and CACREP have articulated minimal guidelines for experiential training. ASGW (2000) recommends 20 hours of observation and participation in a group as a member or a leader, and CACREP (2001) specifies a 10-hour requirement as a participant in a small-group activity. Attempts have been made to integrate the ASGW recommendations with the CACREP standards, outlining supervised clinical experience obtained in both practicum and internship programs. The CACREP standards require experience in individual and group counseling under supervision and, consistent with the ASGW training standards, indicate that at least one fourth of the direct service practicum be devoted to group work.

Whether core training in group work reflects minimal CACREP standards or the more specific ASGW standards, this training alone is not sufficient to prepare counselors for conducting groups on their own. Practitioners must still acquire training in a particular specialization in group work. The current trend in training for group workers focuses on learning group processes by becoming involved in supervised experiences. Both direct participation in planned and supervised small groups and clinical experience in leading various groups under careful supervision are needed to equip leaders with the skills to meet the challenges of group work.

Barlow (2004) describes a conceptual model of how to teach specialized group work competencies using a 3-year plan. Barlow maintains that doctoral training programs could consider layering the teaching of core and specialized skills over a few years. Such skills could be identified as they occur in other courses in the program. Over time, various classes could strategically cover experiential, academic, observational, and supervisory skills. Barlow contends that if this approach were implemented, students would be on their way to developing expertise in group skills.

Our Views on Training Group Workers

Professional codes, legislative mandates, and institutional policies alone will not ensure competent group leadership. Group counselor trainees need to confront the typical dilemmas they will face in practice and learn ways to clarify their views on these issues. This can best be done by including ethics in the trainees’ academic program as well as discussing ethical issues that grow out of the students’ experiences in practicum, internship, and fieldwork. One effective way to teach ethical decision making is by presenting trainees with case vignettes of typical problems that occur in group situations and encouraging discussion of the ethical issues and pertinent guidelines. We tell both students and professionals who attend our workshops that they will not always have the answers to dilemmas they encounter in their groups. Ethical decision making is an ongoing process that takes on new forms and increased meaning as practitioners gain
experience. It is critical that group leaders develop a receptivity to self-examination and to questioning the professionalism of their group practice.

In addition, we highly recommend three other experiences as adjuncts to a training program for group workers: (1) personal experience in a self-exploration group; (2) personal (private) psychotherapy; and (3) supervision.

**Self-Exploration Groups.** Group leaders need to demonstrate the willingness to do for themselves what they expect members in their groups to do: Expand their awareness of self and the effect of that self on others. As an adjunct to formal course work and internship training, participation in a therapeutic group can be extremely valuable. One of the best ways to learn how to assist group members in their struggles is to be a member of a group yourself. Yalom (2005) strongly recommends a group experience for trainees. Some of the benefits, he suggests, are experiencing the power of a group, learning what self-disclosure is about, coming to appreciate the difficulties involved in self-sharing, learning on an emotional level what one knows intellectually, and becoming aware of one’s dependence on the leader’s power and knowledge. He cites surveys indicating that 60 to 70% of group therapy training programs offer some type of personal-group experience. About half of these programs offer an optional group, and the other half a mandatory group.

**Personal Psychotherapy.** Sometimes issues surface in a group experience that may be more appropriately dealt with in personal (individual) therapy. We also encourage individual therapy as a way of enhancing trainees’ abilities to understand both themselves and others. Yalom (2005) believes that extensive self-exploration is necessary if trainees are to perceive countertransference feelings, recognize blind spots and biases, and use their personal attributes effectively in groups. Although videotaping, working with a co-leader, and supervision are all excellent sources of feedback, Yalom maintains that personal therapy is usually necessary for fuller understanding and correction.

**Supervision.** Markus and King (2003) maintain that comprehensive training must include intensive supervision by a competent group therapist. Although Markus and King endorse group supervision of group leader trainees as a powerful cognitive and emotional learning experience, they report that the majority of internships that provide supervision of group trainees tend to use the one-to-one model rather than offer opportunities for group supervision. Group supervision with group counselors provides trainees with many experiential opportunities to learn about the process and development of a group. In their investigation of group supervision with group counselors, Christensen and Kline (2000) emphasize that supervisees have many opportunities to learn through both participation and observation. Their investigation lent support to the numerous benefits of group supervision, a few of which include enhancement of knowledge and skills; ability to practice techniques in a safe and supportive environment; integration of theory and practice; richer understanding of patterns of group dynamics; opportunities to test one’s assumptions;
personal development through connection with others; and opportunities for self-disclosure and for giving and receiving feedback. Results of Christensen and Kline’s study supported previous findings of other researchers regarding group supervisory strategies. That is, supervisors need to assume a facilitative role in the supervision group, the stages of group development also apply to a supervision group, and it is important to address both content and process issues throughout group supervision.

Workshops that provide supervision for group trainees help them to develop the skills necessary for effective intervention. Also, this format helps interns learn a great deal about their response to criticism, their competitiveness, their need for approval, their concerns over being competent, and their power struggles. In working with both university students learning about group approaches and professionals who want to upgrade their skills, we often use a 5-day intensive workshop, which we find to be very effective.

As you consider the training of group leaders, ponder these questions for yourself:

- What makes you qualified to lead groups?
- Can you think of safeguards to minimize the potential risks of combining experiential and didactic methods?
- Does ethical practice demand that group leaders receive some form of personal therapy? Should this be group therapy or experience in a personal-growth group?
- What are your reactions to the suggestions we offered for training group workers?

Diversity Issues in Training Group Workers

Given the fact that the U.S. population is characterized by drastically increasing diversity, it is essential that group counselors be culturally competent practitioners (Bemak & Chung, 2004). An integral part of the training of group leaders is promoting sensitivity and competence in addressing diversity in all forms of group work. Being diversity competent is more complex in meaning than “respecting other people.” To fully assimilate the meaning into our personal and professional beings, it is important for us to have a common understanding of the principles on which diversity competence is built. The “Principles for Diversity Competent Group Workers” (ASGW, 1999) addresses issues such as racism, classism, sexism, heterosexism, and ableism with sensitivity and skill. These principles emphasize the practitioner’s responsibility to have a general understanding of the diverse cultural backgrounds of the group members so interventions are congruent with their worldviews.

Most of the ethics codes of the various professional organizations now give some attention to applying these principles when working with diverse client populations. Guidelines for competence in diversity issues in group practice are discussed in a variety of sources, some of which include Arredondo and colleagues (1996), ASGW (1999), APA (1993), Bemak and Chung (2004), and
DeLucia-Waack and Donigian (2004). Based on these sources, we have adapted the following guidelines for group practice:

- Group counselors emphasize appreciation, respect, and acceptance in cultural and racial identity for all cultures.
- Group counselors strive to understand how their cultural background interrelates with people from other cultural backgrounds.
- Group counselors consider the impact of adverse social, environmental, and political factors in assessing problems and designing interventions.
- Group counselors acquire the knowledge and skills necessary for effectively working with the diverse range of members in their groups. They seek consultation, supervision, and further education to fill any gaps and keep themselves current.
- Group counselors are aware of problems involved in stereotyping and avoid making the erroneous assumption that there are no differences between group members from the same ethnic, racial, or other group.
- Group counselors respect the roles of family and community hierarchies within a client’s culture.
- Group counselors assist members in determining those instances when their difficulties stem from others’ racism or bias, so they do not inappropriately personalize problems.
- Group counselors inform members about basic values that are implicit in the group process (such as self-disclosure, reflecting on one’s life, and taking risks).

An awareness of cultural diversity is particularly important for group work. In Chapter 4 we discussed the characteristics of the culturally competent counselor. If group counselors do not understand how their cultural background influences their own thinking and behavior, there is little chance they can understand how their group members are influenced by their cultural thinking and behavior.

The self-awareness, knowledge, and skill competencies described in Chapter 4 certainly apply to practitioners who work with groups. ASGW (1999) spells out the implications of the principles of diversity training for awareness of self, knowledge, and skills. In working with groups characterized by diversity, practitioners need to be aware of the assumptions they make about ethnic and cultural groups, and they are challenged to adapt their practices to the needs of the members. It is essential that the goals and processes of the group match the cultural values of the members of that group. It is critical that leaders become aware of their potential biases based on age, disability, ethnicity, gender, race, religion, or sexual orientation. Group counselors need to have an understanding of the diversity of cultural worldviews and their potential impact on relationships, behaviors, and clients’ willingness to become involved in a group experience. Although it is not realistic to assume that leaders will have knowledge about every culture, it is important that counselors understand that each person participates in a group from his or her own unique perspective (DeLucia-Waack & Donigian, 2004).
Ivey, Pedersen, and Ivey (2001) present the idea of multicultural intentionality, or the ability to work effectively with many varying types of individuals with diverse cultural backgrounds. To the key components of awareness, knowledge, and skills, they add the characteristics of humility, confidence, and recovery skills as critical to effective group leadership. These attributes mean that leaders do not have to possess all the answers, that they can learn from their members and from their own mistakes, and that they can develop confidence in their flexibility in challenging situations. The ability to recover from mistakes gracefully is more important than not making any mistakes.

What awareness, knowledge, and skills do you already possess that you can build on to help you develop the ability to work well with multicultural groups? To what degree are you able to respect the values and worldviews of group participants who may be very different from you? Take an active role in seeking out experiences that will enhance your ability to make connections with diverse group members. For a more detailed treatment of diversity issues in group work, see DeLucia-Waack and Donigian (2004), The Practice of Multicultural Group Work: Visions and Perspectives From the Field.

Co-Leadership

If you lead groups, you will probably work with a co-leader at some time. We think there are many advantages to the co-leader model. The group can benefit from the insights and feedback of two leaders. The leaders can complement and balance each other. They learn by discussing what goes on in the group and by observing each other’s style, and together they can evaluate what has gone on in the group and plan for future sessions. Also, co-leaders can share the responsibilities. While one leader is working with a particular member, the other can be paying attention to others in the group.

The choice of a co-leader is crucial and can have ethical implications. A group can suffer if its leaders are not working effectively together. If the leaders’ energies are directed at competing with each other or at some other power struggle or hidden agenda, there is little chance that the group will be effective.

Selection of a co-leader involves more than attraction and liking. Each of the leaders should be secure enough that the group won’t have to suffer as one or both of them try to “prove” themselves. We surely don’t think it is essential that co-leaders always agree or share the same perceptions or interpretations; in fact, a group can be given vitality if co-leaders feel trusting enough to express their differences of opinion. Mutual respect and the ability to establish a relationship based on trust, cooperation, and support are most important. Also, each person should be autonomous and have his or her own style yet be able to work with the other leader as a team.

In our view it is essential for co-leaders to spend some time together immediately following a group session to assess what has happened. Similarly, we believe that they should meet at least briefly before each session to talk about anything that might affect their functioning in the group.
At this point we ask you to draw up your own guidelines for selecting a co-leader:

- What would you most appreciate in a co-leader?
- If you found that you and your co-leader clashed on many issues and approached groups very differently, what would you do?
- What ethical implications are involved when a great deal of time during the sessions is taken up with power struggles and conflicts between the co-leaders?
- In what ways could you be most helpful to your co-leader?
- How could a co-leader be most helpful to you?

Ethical Issues in Group Membership

How can group leaders make potential members aware of the services they are providing? What information do clients have a right to expect before they decide to attend a group? People have a right to know what they are getting into before they make a commitment to become a part of any group. Informed consent requires that leaders make the members aware of their rights (as well as their responsibilities) as group participants. The section on informed consent in Chapter 5 applies to both individual and group counseling. Refer to that earlier discussion for further details.

Screening and Selection of Group Members

Group leaders are faced with the difficult task of determining who should be included in a group and who should not. Are groups appropriate for all people? To put the question in another way, is it appropriate for this person to become a participant in this type of group, with this leader, at this time? To answer this question, some type of screening, which involves interviewing and evaluating potential members, is often employed to select suitable members.

Assuming that not everyone will benefit from a group experience—and that some people may be psychologically harmed by certain group experiences—is it unethical to fail to screen prospective group candidates? Many group leaders do not screen participants, for various reasons. Some practitioners are clinically opposed to the notion of using screening as a way of determining who is suitable for a group, and some maintain that they simply do not have the time to carry out effective screening. Others believe that ethical practice demands careful screening and preparation of all candidates.

Unless careful selection criteria are employed, Yalom (2005) argues that group therapy clients may end up discouraged and may not be helped. He maintains that it is easier to identify the people who should be excluded from group therapy than those who should be included. Citing clinical studies, he lists the following as poor candidates for a heterogeneous outpatient intensive therapy group: brain-damaged people, paranoid individuals, hypochondriacs, those who are addicted to drugs or alcohol, acutely psychotic individuals, and antisocial personalities. In terms of criteria for inclusion, he contends that the
client’s level of motivation to work is the most important variable. From his perspective, groups are useful for people who have problems in the interpersonal domain, such as loneliness, inability to make or maintain intimate contacts, feelings of unlovability, fears of being assertive, and dependency issues.

Clients who lack meaning in life, who suffer from diffuse anxiety, who are searching for an identity, who fear success, and who are compulsive workers might also profit from a group experience. The ACA (2005) identifies the counselor’s responsibility for screening prospective group members:

Counselors screen prospective group counseling/therapy participants. To the extent possible, counselors select members whose needs and goals are compatible with goals of the group, who will not impede the group process, and whose well-being will not be jeopardized by the group experience. (A.8.a)

Screening is most effective when the leader interviews the members and the members also have an opportunity to interview the leader. While prospective group members are being screened, they should be deciding whether they want to work with a particular leader and whether the group in question is suitable for them. Practitioners should welcome the opportunity to respond to any questions or concerns prospective members may have, and they should actively encourage prospective members to raise questions about matters that will affect their participation.

It needs to be mentioned that not all theoretical orientations favor or agree with the notion of screening. For example, practitioners with a transactional analysis orientation often do not conduct screening. Many Adlerians believe screening does not fit with the democratic spirit of their theory. Some maintain that screening is done more for the comfort of the group leader than the good of the client. If a practitioner does not screen because of a theoretical value, we do not think this constitutes unethical practice. Furthermore, in some settings it is impractical to screen members prior to forming a group. In situations where it is not possible to conduct screening interviews, one alternative is to use the initial session to screen participants and to present informed consent guidelines.

Preparing Group Participants

To what extent are group counselors responsible for helping participants to benefit from their group experience? Many practitioners do very little to prepare members for a group. They are opposed to preparation on the grounds that it could inhibit a group’s spontaneity and autonomy. Others take the position that members need to be provided with some structure to derive maximum gains.

Yalom (2005) advocates exploring group members’ misconceptions and expectations, predicting early problems, and providing a conceptual framework that includes guidelines for effective group behavior. He views this preparatory process as more than the dissemination of information. He contends that it reinforces the therapist’s respect for the client, demonstrates that therapy is a collaborative venture, and shows that the therapist is willing to share his or her knowledge with the client. This cognitive approach to preparation has the goals
of providing a rational explanation of the group process, clarifying how members are expected to behave, and raising expectations about what the group can accomplish.

In our experience, working with groups, we have found that providing members with basic information about group process tends to eliminate some of the difficulties encountered in the early stages of a group. Our preparation procedures apply to most types of groups, with some modifications. At both the screening session and the initial group meeting, we explore the members’ expectations, clarify goals and objectives, discuss procedural details, explore the possible risks and values of group participation, and discuss guidelines for getting the most from a group experience (Corey, Corey, Callanan, & Russell, 2004; M. Corey & Corey, 2006). As part of member preparation, we include a discussion of the values and limitations of groups, the psychological risks involved in group participation, and ways of minimizing these risks. We also allow time for dealing with misconceptions that people have about groups and for exploring the fears or resistances the members may have. In most of our groups, members do have certain fears about what they will experience; until we acknowledge these fears and talk about them, very little productive work can occur. Further, we ask members to spend time before they come to the group defining for themselves what they most want to achieve. To make their goals more concrete, we usually ask them to develop a contract that entails areas of concern on which they are willing to work in the group. We also ask them to do some reading and to write about their goals and about the significant turning points in their lives.

At this point, we ask you to write down some things you might do to prepare people for a group. What ethical concerns do you have regarding preparation? What do you think would occur if you did little in the way of preparing group members?

Involuntary Participation

Can involuntary group membership be effective? Are there situations in which it is ethical to require or coerce people to participate in a group? How is informed consent especially critical in groups where attendance is mandatory?

Obviously, voluntary participation is an important beginning point for a successful group experience. Members will make significant changes only to the extent that they actively seek something for themselves. Unfortunately, not all groups are composed of clients who have chosen to be there. In some community agencies and inpatient facilities, the main therapeutic vehicle may be group therapy. People receiving services may be required to attend group sessions, sometimes several times a week. This involuntary participation is somewhat akin to compulsory education—people can be forced to attend but not to learn.

When group participation is mandatory, greater effort needs to be directed toward fully informing members of the nature and goals of the group, procedures to be used, the rights of members to decline certain activities, the limits of confidentiality, and what effect their level of participation in the group will
have on critical decisions about them outside of the group. When attendance at
group sessions is mandatory, group leaders must be certain that group mem-
bbers understand their rights and their responsibilities.

Consider these questions on involuntary membership:

- Do you think members can benefit from a group experience even if they are
  required to attend? Why or why not?
- What strategy might a leader use to foster more effective group participation
  while still giving the members true freedom of choice?
- From an ethical perspective, is it required that members of an involuntary
  group give consent? To what degree should members be informed about the
  consequences of the quantity or quality of their participation in a group?

Freedom to Leave a Group

Once members make a commitment to be a part of a group, do they have the
right to leave at any time they choose? Procedures for leaving a group should
be explained to all members during the initial session. Ideally, the leader and
the member cooperate to determine whether a group experience is proving to
be productive or counterproductive. We take the position that clients have a
responsibility to the leader and to other members to explain why they want to
leave. There are several reasons for this policy. It can be deleterious to members
to leave without having been able to discuss what they considered threatening
or negative in the experience. Further, it is unfortunate for members to leave a
group because of a misunderstanding about some feedback they have received.
Such a termination can be harmful to group cohesion, for the members who
remain may think that they caused a particular member’s departure. We tell
our members that they have an obligation to attend all sessions and to inform
us and the group if they decide to withdraw. Although members have a right to
leave, we ask them to talk about it out of respect for the needs of the remaining
members. If members even consider withdrawing, we encourage them to bring
this up for exploration in a session. We do not think it is ethical to use undue
pressure to keep these members, and we are alert to other members pressuring
a person to stay.

Psychological Risks

The fact that groups can be powerful catalysts for personal change means that
they are also risky. Our goal is not to make sure that all members are comfort-
able as much as to create a safe environment where they can take risks and
explore their discomfort. Although we don’t think groups can be free of risks,
ethical practice demands that group practitioners inform prospective partici-
pants of the potential hazards involved in the group experience. However,
merely informing participants does not absolve leaders of all responsibility.
Group leaders have an ethical responsibility to take precautionary measures to
reduce unnecessary psychological risks. ACA’s (2005) guideline is this: “In a
group setting, counselors take reasonable precautions to protect clients from physical, emotional, or psychological trauma” (A.8.b). Certain safeguards can be taken during the course of a group to avoid disastrous outcomes. Here are some of the risks that participants should know about (M. Corey & Corey, 2006):

- Members may experience some disruptions in their lives as a result of their work in the group.
- Group participants are often encouraged to be completely open. In this quest for self-revelation, privacy is sometimes surrendered.
- A related risk is group pressure. The participants’ right not to explore certain issues or to stop at a certain point should be respected. Also, members should not be coerced into participating in an exercise.
- Scapegoating is another potential hazard in groups. Unchallenged projection and blaming can have dire effects on the target person.
- Confrontation can be used or misused in groups. Harmful attacks on others should not be permitted under the guise of “sharing.”
- Even though a counselor may continue to stress the necessity not to discuss with outsiders what goes on in the group, there is no guarantee that all members will respect the confidential nature of their exchanges.

One way to minimize psychological risks in groups is to use a contract, in which leaders specify what their responsibilities are and members specify their commitment to the group by declaring what they are willing to do. If members and leaders operate under a contract that clarifies expectations, there is less chance for members to be exploited or damaged by a group experience.

Of course, a contract approach is not the only way to reduce potential risks, nor is it sufficient in itself to do so. One of the most important safeguards is the leader’s training in group process. Group counselors have the major responsibility for preventing needless harm to members. To fulfill this role, group leaders should have a clear grasp of the boundaries of their competence. As a rule, leaders should conduct only those types of groups for which they have been sufficiently prepared. A counselor may be trained to lead a personal-growth or consciousness-raising group but be ill-prepared to embark on a therapy group. Sometimes people who have attended a few intensive groups become excited about doing this type of group as leaders, even though they lack the requisite training. Oftentimes they are overwhelmed and unable to cope with what emerges in the group. Working with an experienced co-leader is one good way to learn and also a way to reduce potential risks.

**Confidentiality in Groups**

The ethical, legal, and professional aspects of confidentiality (discussed in Chapter 6) have a different application in group situations. Are members of a group under the same ethical and legal obligations as the group leader not to disclose the identities of other members or the content of what was shared in the group? The legal concept of privileged communication generally does not
apply in a group setting, unless there has been a statutory exception. Therefore, group counselors have the responsibility of informing members of the limits of confidentiality within the group setting, their responsibilities to other group members, and the absence of legal privilege concerning what is shared in a group (Anderson, 1996). One of the clear ethical responsibilities of members is to respect the communications of others in the group. Benitez (2004) recommends that group practitioners develop a group confidentiality agreement that addresses both the leader’s duty of confidentiality and the rules of confidentiality for the group members.

From the beginning of a group we discuss with members the purpose and limits of confidentiality. The APA (2002) standard also recognizes the limits of confidentiality in group therapy: “When psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality” (10.03). ACA’s (2005) ethics code specifies that “counselors clearly explain the importance and parameters of confidentiality for the specific group being entered” (B.4.a).

**How to Encourage Confidentiality.** The ASGW (1998) “Best Practice Guidelines” state the following regarding confidentiality:

Group Workers define confidentiality and its limits (for example, legal and ethical exceptions and expectations; waivers implicit with treatment plans, documentation, and insurance usage). Group Workers have the responsibility to inform all group participants of the need for confidentiality and potential consequences of breaching confidentiality; they must explain that legal privilege does not apply to group discussions (unless provided by state statute). (A.7.d)

Encouraging confidentiality is a special challenge for counselors who offer groups for children and adolescents in school settings. On this matter, ASCA’s (2004) *Ethical Standards for School Counselors* provides an important guideline:

The professional school counselor establishes clear expectations in the group setting and clearly states that confidentiality in group counseling cannot be guaranteed. Given the developmental and chronological ages of minors in schools, the counselor recognizes the tenuous nature of confidentiality for minors renders some topics inappropriate for group work in a school setting. (A.6.c)

Although most writers on ethical issues in group work make the point that confidentiality cannot be guaranteed, they also talk about the importance of teaching group members to avoid breaking confidences. Confidentiality in group situations is not easily enforced. Because members cannot assume that anything they say or hear in the group will remain confidential, they should be able to make an informed choice about how much to reveal.

It is our position that leaders need periodically to reaffirm to group members the importance of not discussing with outsiders what has occurred in the group. We talk with each prospective member about the necessity of maintaining confidentiality to establish the trust and cohesion required if participants are to reveal themselves in significant ways. We discuss this point during the screening
interviews, again during the pregrou or initial meetings, at times during the
course of a group when it seems appropriate, and again at termination. Most
people do not maliciously attempt to hurt others by talking with people outside
the group about specific members. However, it is tempting for members to share
their experiences with other people, and in so doing they sometimes make inap-
propriate disclosures. Because of this tendency to want to share with outsiders,
we repeatedly caution participants in any type of group about how easily and
unintentionally the confidentiality of the group can be compromised.

If you were to lead a group, which of the following measures might you
take to ensure confidentiality? Check any of the statements that apply:

____ 1. I would repeatedly mention the importance of confidentiality at
group meetings.
____ 2. I would require group members to sign a statement saying that
they fully understand their commitment to maintain the confiden-
tial character of the group.
____ 3. I would let members know that they would be asked to leave the
group if they violated confidentiality.
____ 4. With the permission and knowledge of the members, I would tape-
record all the sessions.
____ 5. I would say very little about confidentiality and leave it up to
group members to decide how they would deal with the issue.

Exceptions to Confidentiality. Group counselors have a responsibility to
define clearly what confidentiality means, explain its importance, and inform
members of the difficulties involved in enforcing it. Although group counselors
are expected to stress the importance of confidentiality and set a norm, they are
also expected to inform members about its limits. For example, if members
pose a danger to themselves or to others, the group leader would be ethically
and legally obliged to breach confidentiality. The other limitations for confiden-
tiality, which were discussed in Chapter 6, also apply to group work.

It is a good practice for group workers to give a written statement to each
member outlining the nature, purposes, and limitations of confidentiality and
acknowledging specific situations that would require the breaching of confi-
dences. It seems that such straightforwardness with members from the outset
does a great deal to create trust, for at least members know the consequences of
certain revelations to the group.

Of course, it is imperative that those who lead groups become familiar with
the state laws that have an impact on their practice. For instance, all states have
had mandatory child abuse reporting laws since 1967. Several states also have
mandatory elder abuse and dependent adult abuse reporting laws. The great
majority of states currently have laws requiring counselors to report clients’
threats to harm themselves or others.

If you lead a group at a correctional institution or a psychiatric hospital,
you may have to record in a member’s chart certain behaviors or verbaliza-
tions that he or she exhibits in the group. At the same time, your responsibility
to your clients requires you to inform them that you are documenting their verbalizations and behaviors and that this information is accessible to other staff.

Confidentiality with Minors. Do parents have a right to information that is disclosed by their children in a group? The answer to that question depends on whether we are looking at it from a legal, ethical, or professional viewpoint. State laws differ regarding counseling minors. It is important for group leaders to be aware of the laws related to working with minors in the state where they are practicing. Circumstances in which a minor may seek professional help without parental consent, defining an emancipated minor, or the rights of parents (or legal guardians) to have access to the records regarding the professional help received by their minor child vary according to state statutes.

Before any minor enters a group, it is a good practice to obtain written permission from the parents. Such a statement should include a brief description of the purpose of the group, the importance of confidentiality as a prerequisite to accomplishing these purposes, and your intention not to violate any confidences. Although it may be useful to give parents information about their child, this can be done without violating confidences. At the first session it is helpful to inform and discuss with minors their concerns about confidentiality and how it will be maintained. Such practices can strengthen the child’s trust in the counselor.

Group leaders have a responsibility in groups that involve children and adolescents to take measures to increase the chances that confidentiality will be kept. It is important to work cooperatively with parents and legal guardians as well as to enlist the trust of the young members. It is also useful to teach minors, using a vocabulary they understand, about the nature, purposes, and limitations of confidentiality. It is a good idea for leaders to encourage members to initiate discussions on confidentiality whenever this becomes an issue for them.

Confidentiality and Online Group Work. Ethical considerations pertaining to confidentiality and the questionable effectiveness of online counseling may be a factor in its limited uses in educational and practice settings (Krueger & Stockton, 2004). Humphreys, Winzelberg, and Klaw (2000) take the position that online group psychotherapy cannot ethically be conducted over the Internet, except in very limited circumstances. Internet group therapy involves typing, recording, copying, and distributing all the “interactions” that take place online. This makes ensuring clients’ privacy and confidentiality a very difficult matter. In addition, individuals cannot be reliably identified over the Internet. A person with access to a client’s computer could sign into online group counseling by using the password and the name of the actual client. The implications for lack of confidentiality and privacy are obvious here. Because of the difficulty of maintaining the confidential nature of a group, we are opposed to online group counseling on both ethical and clinical grounds.

Humphreys and colleagues (2000) state that some kinds of peer groups and self-help groups do utilize Internet technology, but they add that the astonishing
growth in the technology has outpaced the development of formal ethical guidelines for practitioners involved in online groups. Humphreys and colleagues write about a therapist's ethical responsibilities in self-help groups, discussion groups, and support groups that operate on the Internet, and they offer practical strategies for avoiding ethical problems.

Chang and Yeh (2003) provide a theoretical framework and practical guidelines for practitioners to implement online groups to address racial, cultural, and gender issues in working with Asian American men. They emphasize how important it is for group facilitators to set the tone for a group by creating initial ground rules from the outset, especially guidelines for dealing with confidentiality. Chang and Yeh suggest that in closed groups confidentiality can be maximized by instructing participants to avoid disclosing the concerns of other group members to people who are not part of the group. Group members should also be cautioned about not sharing passwords used to access the group with those who are not a part of the group. As the group is beginning, it is essential to address topics such as respectful communication, level of interaction, termination conditions, and opportunities for face-to-face contact.

Values in Group Counseling

Group counselors have the responsibility of being aware of their own values and the potential impact they have on the interventions they are likely to make. However, group counselors are sometimes timid about making their values known lest they influence the direction members are likely to take. Group counselors need to consider when it might be appropriate to expose their beliefs, decisions, life experiences, and values. The leader's central function is to help members find answers that are congruent with their own values, not to short-circuit the members' exploration by providing them with answers. We suggest that you refer to the discussion of value conflicts in Chapter 3 and consider specific areas in which you might be inclined to impose your values in the groups you lead. Reflect on any tendencies you may have to lead your clients in a certain direction, and think about ways to minimize the chances of imposing your values on them.

Certain behaviors of group leaders reveal their values: (a) demonstrating acceptance of the person of the client; (b) avoiding responding to sarcastic remarks with sarcasm; (c) being honest with members rather than harboring hidden agendas; (d) avoiding judgments and labeling of members, and instead describing the behavior of members; (e) stating observations and hunches in a tentative way rather than dogmatically; (f) letting members who are difficult know how they are affecting them in a nonblaming way; (g) detecting their own countertransference reactions; (h) avoiding misuse of their power; (i) providing both support and caring confrontations; and (j) avoiding meeting their own needs at the expense of the members (M. Corey & Corey, 2006).
Uses and Abuses of Group Techniques

Group techniques can be used to facilitate the movement of a group and to deepen and intensify certain feelings. We think leaders should have a clear rationale for using each technique. This is an area in which theory can be a useful guide for practice.

Techniques can also be abused or used in unethical ways. Here are some ways leaders might employ techniques unethically:

- Using techniques with which they are unfamiliar
- Using techniques to enhance their power
- Using techniques whose sole purpose is to create intensity because of the leader’s need for intensity
- Using techniques to pressure members, even when they have expressed a desire not to participate in an exercise

We use these guidelines in our practice to avoid abusing techniques in a group:

- Techniques used have a therapeutic purpose and are grounded in some theoretical framework.
- The client’s self-exploration and self-understanding is fostered.
- Techniques are devised for each unique client situation, and they assist the client in exploring some form of new behavior.
- Leaders modify their techniques so that they are suitable for the client’s cultural and ethnic background.
- Techniques are used to enhance the group process rather than to cover up the leader’s incompetence.
- Techniques are introduced in a timely and sensitive manner, and they are abandoned if they are not working.
- The tone of a leader is consistently invitational; members are given the freedom either to participate in or to skip a given experiment.
- Leaders use techniques in which they have received training and supervision.

Although it is unrealistic to expect that leaders will always know exactly what will result from an intervention, they should know how to cope with unexpected outcomes. For example, guided fantasies into times of loneliness as a child or physical exercises designed to release anger can lead to intense emotional experiences. If leaders use such techniques, they must be ready to deal with any emotional release. It is essential that group counselors become aware of the potential for encouraging catharsis to fulfill their own needs. Some leaders push people to express anger because they would like to be able to do so themselves. They develop techniques to focus the group on anger. Although these are legitimate feelings, expressing anger in the group may satisfy the leader’s agenda more than it meets the needs of the members. This question ought to be raised frequently: “Whose needs are primary, and whose needs are being met—the members’ or the leader’s?”
Therapist Competence

How can leaders determine whether they are competent to use a certain technique? Although some leaders who have received training in the use of a technique may hesitate to use it (out of fear of making a mistake), other leaders may not have any reservations about trying out new techniques. It is useful if leaders have experienced these techniques as members of a group and have a clear rationale for using them. Group counselors need to be able to articulate a theoretical orientation that guides the interventions they make in their groups.

Unfinished Business

Another major issue pertaining to the use of group techniques relates to providing immediate help for any group member who shows extreme distress during or at the end of a group session, especially if techniques were used to elicit intense emotions. Although some “unfinished business” promotes growth, there is an ethical issue in the use of a technique that incites strong emotional reactions if the client is abandoned at the end of a session because time has run out. Leaders must take care to allow enough time to deal adequately with the reactions that were stimulated in a session. It is unwise to introduce techniques in a session when there is not enough time to work through the feelings that might result or in a setting where there is no privacy or where the physical setup would make it harmful to employ certain techniques.

Our position on the ethical use of techniques is that group leaders need to learn about potential adverse effects. One way for group leaders to learn is by taking part in groups themselves. By being a group member and first experiencing a range of techniques, a therapist can develop a healthy respect for using techniques appropriately to meet clients’ needs. In our training workshops for group leaders, we encourage spontaneity and inventiveness in the use of techniques, but we also stress the importance of striking a balance between creativity and irresponsibility. The reputation of group work has suffered from the actions of irresponsible practitioners, mostly those who use techniques randomly without a clear rationale or without any sense of the potential outcome of techniques. If the group leader has a strong academic background, has had extensive supervised group experience, has participated in his or her own therapy or personal-growth experience, and has a basic respect for clients, he or she is not likely to abuse techniques.

The Consultation and Referral Process

Group counselors need to be aware of their limitations in working with certain types of clients. The willingness to consult with other professionals demonstrates wisdom and good faith on the practitioner’s part. For example, diversity-competent group workers are willing to seek consultation with traditional healers and religious or spiritual healers in the treatment of a diverse range of
problems of individual members. Group workers actively seek out educational experiences that foster their knowledge and understanding of skills for facilitating groups across differences (ASGW, 1998, 1999).

It is a good practice for leaders to explain to members their policies about consultation. When are they likely to consult? What measures do they take to protect confidentiality? Are they willing to have between-session consultations with group members? When and how might they refer? Here are some guidelines pertaining to the consultation and referral process:

- Group counselors can seek consultation and supervision when they are faced with ethical concerns or difficulties that interfere with carrying out their leadership functions.
- Leaders need to develop sensitivity to situations in which a referral is appropriate.
- Leaders learn about the resources within the community and help members make use of these resources.

As we discussed earlier, one way to protect against a malpractice suit is to demonstrate that consultation procedures were used in dealing with an ethical dilemma. If group leaders consult supervisors or other professionals, they are demonstrating good clinical practice, adhering to ethical guidelines, and minimizing their chances of malpractice.

Issues Concerning Termination

The final phase in the life of a group is critical, for this is when members have the task of consolidating their learning. At this time members need to be able to express what the group experience has meant to them and to state where they intend to go from here. Neglecting the process of termination can easily leave the members stuck and will limit opportunities for members to conceptualize what they learned from a group experience. For many group members endings are difficult because they realize that time is limited in their group. The ending of a group often triggers other losses that members have experienced. Thus, the termination of a group may involve a grieving process. It is important for leaders to focus on the feelings of loss that may permeate the atmosphere. These feelings need to be identified and explored, although they probably cannot be alleviated. Members need to face the reality of termination and learn how to say good-bye. If the group has been truly therapeutic, the members will be able to extend their learning outside the group, even though they may well experience a sense of sadness and loss.

The Termination Phase

The termination phase of a group provides an opportunity for members to clarify the meaning of their experience, to consolidate the gains they have made, and to make decisions about the new behaviors they want to carry away from
the group and apply to their everyday lives. The following professional issues are involved in the termination of a group:

- What responsibilities do group leaders have for assisting participants to develop a conceptual framework that will make sense of, integrate, and consolidate what they have learned in their group?
- To what degree is it the leader’s responsibility to ensure that members are not left with excessive unfinished business at the end of the group?
- How can group leaders help participants translate what they have learned as a result of the group into their daily lives? Should leaders assume that this translation will occur automatically, or must they prepare members for maximizing their learning?

Typically, the final phase of group work may be the one that leaders handle most ineptly, possibly owing to their lack of training or partly because of their own resistance to termination. Avoiding acknowledgment of a group’s termination may reflect discomfort on the leader’s part in dealing with endings and separations. When termination is not dealt with, the group misses an opportunity to explore concerns that may affect many members, and the clients’ therapy is jeopardized. When learning is not conceptualized, the ability to bring the meaning of the experience to real life is severely diminished.

Follow-Up and Evaluation

Throughout the life of a group, group leaders assist members in assessing their own progress and monitor their style of modeling. In this sense, evaluation is an ongoing process whereby members are taught how to determine if the group is helping them attain their personal goals. But group counselors also must assess both the process and the outcomes of their groups. Once a group has ended, follow-up group sessions provide an opportunity to do this. In our opinion, follow-up activities are useful to the members and to the group counselor as well. Both short-term follow-up (after 1 month) and long-term follow-up (after 3 months to a year) can be invaluable measures of accountability. (For more discussion on termination issues, see M. Corey & Corey, 2006.)

Chapter Summary

Along with the growing popularity of group approaches to counseling and therapy comes a need for ethical and professional guidelines for those who lead groups. There are many types of groups, and there are many possible uses of groups in various settings. In this chapter we have discussed some issues that are related to most groups: How does a leader’s theoretical view of groups influence the way a group is structured? What are some key elements in recruiting, screening, selecting, and preparing group members? What ethical, professional, legal, and practical issues concerning confidentiality are involved in any type of group? To what degree should participants be prepared for a
group before the group begins? What are some ethical issues in the selection and training of group leaders? In what ways can group techniques be used or abused? What responsibility do group leaders have in terms of follow-up and evaluation? With respect to these and other issues, we have stressed the importance of formulating your own views on ethical practice in leading groups, after carefully considering the best practice guidelines and training standards of ASGW.

**Suggested Activities**

1. Replicate the initial session of a group. Two students can volunteer to co-lead and approximately eight other students can become group members. Assume that the group is a personal-growth group that will meet for a predetermined number of weeks. The co-leaders’ job is to orient and prepare the members by describing the group’s purpose, giving an overview of group process concepts, and talking about ground rules for effective group participation. If time allows, members can express any fears and expectations they have about being involved in the group, and they can also raise questions they would like to explore.

2. Practice conducting screening interviews for potential group members. One person volunteers to conduct interviews, and another student can role play a potential group member. Allow about 10 minutes for the interview. Afterward, the prospective client can talk about what it was like to be interviewed, and the group leader can share his or her experience.

3. As part of your job, you are expected to lead a group consisting of involuntary members. How will this fact affect your approach? What might you do differently with this group compared with a group of voluntary members? Have several students play the reluctant members while others practice dealing with them.

4. You are leading a counseling group with high school students. A member comes to the group obviously incoherent and disruptive. How do you deal with him? What might you say or do? Discuss in class how you would deal with this situation, or demonstrate how you might respond by having a fellow student play the part of the adolescent.

5. Again, assume that you are leading a high school counseling group. An angry father who gave written permission for his son’s participation comes to your office and demands to know what is going on in your group. He is convinced that his son’s participation in the group is an invasion of family privacy. As a group leader, how would you deal with his anger? To make the situation more real and interesting, have someone role play the father.

6. Selecting a good co-leader for a group is important, for not all matches of co-leaders are productive. Form dyads and negotiate with your partner to determine whether the two of you would be effective if you were to lead a group together. You might discuss matters such as potential power struggles, competitiveness, compatibility of views and philosophy, your differing styles
and how they might complement or interfere with each other, and other issues that you think would have a bearing on your ability to work as a team.

InfoTrac® College Edition Resources

For additional readings, explore InfoTrac College Edition, our online library. Key words are listed in a form that enables the search engine to locate a wider range of articles in the online university library. Key words should be entered exactly as shown, including asterisks, “W1,” “W2,” “AND,” and other search engine tools. Go to http://www.infotrac-college.com and select these key word searches:

training AND group W1 leader*
supervision AND group W1 leader*
co-leadership AND group w1 work AND (psych????y OR psychotherapy OR couns*)
confidentiality AND group* AND (psych????y OR psychotherapy OR couns*)
values AND (group W1 counseling OR group W1 therapy)
screening AND (group W1 counseling OR group W1 therapy)
Pre-Chapter Self-Inventory

Directions: For each statement, indicate the response that most closely identifies your beliefs and attitudes. Use the following code:

5 = I strongly agree with this statement.
4 = I agree with this statement.
3 = I am undecided about this statement.
2 = I disagree with this statement.
1 = I strongly disagree with this statement.

1. It is important to include people from the client’s environment in his or her treatment.
2. Community workers need to take an active role in seeking solutions to the social and political conditions related to human suffering.
3. Mental health experts need to devote more of their energies to preventing emotional and behavioral disorders rather than just treating them.
4. With increasing attention being paid to the community mental health approach and less funding being provided, the role of the professional needs to expand to include a variety of indirect services to clients as well as direct clinical services.
5. The use of nonlicensed workers is a valuable, cost-effective, and ethical way to deal with the shortage of professional help and budget constraints.
6. Nonlicensed workers who receive adequate training and good supervision are capable of providing many of the direct services that professionals now provide.
7. In working with a variety of client groups in the community, it is essential for community workers to be skilled in out-of-office strategies and roles such as change agent, outreach, consulting, and advocacy.
8. Human-service workers need to understand the community in which they operate, including its needs, assets, and issues.
Ethical Issues in Community Work*

9. It is possible to work within the framework of a system and still be effective.
10. When I think of my experience in working in an agency or an institution, I am convinced of the necessity to initiate significant changes in the organization.
11. I frequently have good ideas and proposals, and I see myself as being willing to do the work necessary to translate these plans into actual programs.
12. Ethical practice requires that we look for ways to involve and mobilize resources in the community for identifying assets and opportunities as well as identifying problems and finding solutions.
13. Although I might be unable to bring about major changes in an institution or system, I am confident that I can make changes within the boundaries of my own position.
14. I can see that I might fall into complacency and rarely question what I am doing or how I could do my work more effectively, which would be unethical.
15. It would be unethical to accept a position with an agency whose central aims I disagreed with.
16. Human-service workers should be able to identify indigenous leaders in the community and work with them to improve conditions in the community.
17. A central role in human services is the development of leadership among community members.
18. As a professional working in the community, one of my main goals is to empower people in the community to become increasingly self-reliant.
19. As a counselor I am part of a system, and I have an ethical responsibility to work toward changing those aspects of the system that I think need changing.
20. I place a special value on meaningful contact with colleagues so as not to become excessively narrow in my thinking.

*We want to acknowledge Mark Homan, instructor of social work at Pima Community College (Tucson, Arizona), for his consultation with us and helpful input in revising this chapter.
Chapter 13

Introduction

Working with people who come for “individual” counseling is one way for professionals to promote mental and emotional health. Working in the community involves different skills, some of which include connecting people, developing leadership, inspiring confidence, and promoting a culture of learning (Mark Homan, personal communication, January 20, 2005). Professional helpers can foster real and lasting changes if they have an impact on the total milieu of people’s lives in a “systems” approach. The aspirations and difficulties of clients intertwine with those of many other people and, ultimately, with those of the community at large. What occurs in one part of the system affects all parts of the system to some degree. In this chapter we focus on the community itself as the target for change.

Systems theories posit that the identified client’s problem might be a symptom of how the family system functions, not just a symptom of the individual’s internal dynamics. When the community mental health movement came into existence, it took the family systems perspective a step further and holds that the entire community is the best focus of treatment. By looking at the whole community, it is possible to discover the strengths within the community and to develop ways to bring these strengths to work for the community. Feminist therapy likewise addresses the need to consider the social and cultural context that contributes to a person’s problems in order to understand that person. It is our contention that individual, family, community, and feminist perspectives all have a special place as each one addresses a specific and complementary need that is not addressed by the others. These theoretical frameworks need not compete with one another; the field is enriched by all approaches.

The foundation of all ethical practice is promoting the welfare of clients. More often than not, ethical practice requires that we look at the community as a whole to identify assets and opportunities as well as to identify problems and find solutions. If community workers ignore community needs because they seem overwhelming, and overlook the abilities, strengths, and resources within the community, this poses an ethical concern. Practitioners can make ripples within segments of the community even in small ways if they are committed to becoming change agents. It is essential that community workers focus on the capabilities and strengths within a community, for doing so empowers people in the community.

We use the term community agency broadly to include any institution—public or private, nonprofit or for-profit—designed to provide a wide range of social and psychological services to the community. Likewise, when we speak of a community counselor, we refer to a diverse pool of human-service workers whose primary duties include serving individuals within the community in a variety of community groups. Community workers include, but are not limited to, social workers, community organizers and developers, psychologists, psychiatrists, nurses, counselors, couples and family therapists, and human-service workers with varying degrees of education and training.
Whether or not you work in a community agency setting, you need to know how to mobilize community resources. Examine your own commitment to working in the community by thinking about these questions:

- What sense do you have of the social and psychological needs in your community and of the assets and resources within the community to deal with them?
- If clients ask what resources are available to them, would you know where to refer them? Could it be unethical if you did not know?
- What forces within your community exacerbate the problems individuals and groups are experiencing?
- What are the main assets available to empower people in your community?
- What factors contribute to the strength and development of your community?
- How do you see your role in improving your community?

Whereas the traditional approach to understanding and treating human problems focuses on resolution of internal conflicts as a pathway to individual change, the community approach focuses on ways of changing the environmental factors causing individual problems. The community mental health perspective is relevant to all communities, but it is particularly relevant to underserved communities. Although there is some question as to whether there are sufficient mental health professionals to meet the mental health needs of all people in the United States, there is agreement that many geographical regions and client populations are underserved (Robiner & Crew, 2000). DeLeon, Giesting, and Kenkel (2003) state that community health centers, and other community agencies, provide opportunities for graduate psychology students to acquire the culturally sensitive competencies required of them to adequately address the needs and abilities of underserved populations.

A community orientation requires practitioners to design interventions that go beyond the office. Counselors trained in individual therapy who work in the community must develop a more expansive notion of who the client is. “Clients” are primarily constituency group members, residents of target communities, and people who have been marginalized (Hardina, 2004). The community orientation is based on the premise that the community itself is the most appropriate focus of attention, rather than the individual, and also the most potent resource for solutions. As Mark Homan stresses in his teaching, “Healthy communities believe more in their abilities than in their problems” (personal communication, January 20, 2005). The ethical imperative is to do what best serves the “community as the client”:

> Just like an individual or a family, a community has resources and limitations. Communities have established coping mechanisms to deal with problems. To promote change in a community, the community must believe in its own ability to change and must take responsibility for its actions or inactions. (Homan, 2004, pp. 24–25)

We also examine an issue of particular importance to the community worker: namely, how the system affects the counselor and how to thrive and
survive while working in the system. In examining the counselor’s relationship to the community, we address the ethical dimensions of practice. If practitioners are limited in their ability to adapt their roles to the needs of the community, they are not likely to be effective in reaching those who most need assistance.

Ethical Practice in Community Work

The ethics codes of professional practice reinforce the practitioner’s responsibility to the community and to society (see the ethics codes box titled Responsibilities to Community and Society). It is left to community workers to identify strategies for becoming more responsive to the community.

Those who engage in community work often encounter ethical dilemmas different from those common to clinical practice. In writing about guidelines for ethical practice in community organization, Hardina (2004) addresses both the contributions and the limitations of the Code of Ethics of the National Association of Social Workers (1999). Hardina notes that the ethical principles for social workers outlined in the code of ethics do not begin to cover many of the practical situations community workers encounter.

Community organizers typically work with community residents, constituency groups, local institutions, and government decision makers. Hardina asserts that most community practice activities occur outside traditional agency settings and involve the use of power and influence to bring about social change. One of the primary objectives of community practice is constituency self-determination. Community organizers must first determine the primary recipient of their interventions. Is the client or constituent an individual, a group of people, or society in general? They also need to acquire adequate tools to deal effectively with the ethical dilemmas they encounter in practice.

The Community Mental Health Orientation

The need for diverse and readily accessible treatment programs has been a key factor in the development of the community mental health orientation, which is based on the premise that problem solving does not take place in a vacuum, isolated from the larger social and political influences of society. Environmental factors cause or contribute to the problems of many groups in society, and a process that considers both the individual and the environment is often most beneficial to clients.

The focus of community work is on preventing rather than curing problems. Additionally, members of the community are encouraged to take control of and master their own problems so that traditional intervention will become less necessary (Trull, 2005). Lewis, Lewis, Daniels, and D’Andrea (2003) define community counseling as “a comprehensive helping framework of intervention strategies and services that promotes the personal development and well-being of all individuals and communities” (p. 6). They describe the activities
Responsibilities to Community and Society


Human service professionals keep informed about current social issues as they affect the client and the community. They share that information with clients, groups and community as part of their work. (Statement 11.)

Human service professionals act as advocates in addressing unmet client and community needs. Human service professionals provide a mechanism for identifying unmet client needs, calling attention to these needs, and assisting in planning and mobilizing to advocate for those needs at the local community level. (Statement 13.)

Human service professionals advocate for the rights of all members of society, particularly those who are members of minorities and groups at which discriminatory practices have historically been directed. (Statement 16.)

Canadian Association of Social Workers (1994)

A social worker shall advocate change: (a) in the best interest of the client, and (b) for the overall benefit of society, the environment and the global community. (10)

A social worker shall identify, document and advocate for the elimination of discrimination. (10.1.)

A social worker shall advocate for the equal distribution of resources to all persons. (10.2.)

A social worker shall advocate for the equal access of all persons to resources, services and opportunities. (10.3.)

A social worker shall advocate for a clean and healthy environment and shall advocate the development of environmental strategies consistent with social work principles. (10.4.)

A social worker shall provide reasonable professional services in a state of emergency. (10.5.)

A social worker shall promote social justice. (10.6.)

American School Counselor Association (2004)

The professional school counselor:

(a) Collaborates with agencies, organizations and individuals in the community in the best interest of students and without regard to personal reward or remuneration.

(b) Extends his/her influence and opportunity to deliver a comprehensive school counseling program to all students by collaborating with community resources for student success. (D.2.)

National Association of Social Workers (1999)

(a) Social workers should engage in social and political action that seeks to ensure that all persons have equal access to the resources, employment, services, and opportunities that they require in order to meet their basic human needs and to develop fully. Social workers should be aware of the impact of the political arena on practice, and should advocate for changes in policy and legislation to improve social conditions in order to meet basic human needs and promote social justice.

(b) Social workers should act to expand choice and opportunity for all persons, with special regard for vulnerable, disadvantaged, oppressed, and exploited persons and groups.

(c) Social workers should promote conditions that encourage respect for cultural and social diversity within the United States and globally. Social workers should promote policies and practices that demonstrate respect for difference, support the expansion of cultural knowledge and resources, advocate for programs and institutions that demonstrate cultural competence, and promote policies that safeguard the rights of and confirm equity and social justice for all people.

continued on next page
that make up a comprehensive community counseling model as having the following four components: (1) direct client services, (2) indirect client services, (3) direct community services, and (4) indirect community services. Let’s examine each of these components separately.

1. **Direct client services** focus on outreach activities to a population that might be at risk for developing mental health problems. Community counselors provide help to clients either facing crises or dealing with ongoing stressors that impair their coping ability. By reaching out to those schools and communities that would be receptive to help, community workers can offer a variety of personal, career, family, and counseling services to at-risk groups (Lewis et al., 2003). This population would also include referrals from the courts, churches, probation departments, and mandated therapy for drug and alcohol abuse.

2. **Indirect client services** consist of client advocacy and consultation, which involves active intervention for and with an individual or a group. These include, but are not limited to, people without jobs, people without homes, people with disabilities, and persons living with AIDS. Community workers need to become advocates, speaking up on their clients’ behalf and actively intervening in their client’s situation (Lewis et al., 2003). Advocacy consists of those focused efforts to change existing policy or to influence proposed policy on behalf of specific underrepresented groups (Ezell, 2001). Mark Homan (personal communication, January 20, 2005) has a different point of view on advocacy. He makes a subtle, but important distinction, of working with groups, rather than for groups. For Homan, advocacy aims at working with groups to build their capacity and power and use it, along with ours, to make change. As much as possible, advocacy involves creating partnerships by working with groups in a collaborative way rather than merely providing services for these groups.

3. **Direct community services** in the form of preventive education are geared to the population at large. Examples of these programs include life planning workshops, value clarification seminars, interpersonal skills training, marriage...
education, and teaching parents about their legal rights and responsibilities. Because the emphasis is on prevention, these programs help people develop a wider range of competencies. The focus of preventive programs is on teaching effective living and problem-solving competencies.

4. **Indirect community services** are attempts to change the social environment to meet the needs of the population as a whole and are carried out by influencing public policy. The focus is on promoting systemic change by working closely with those in the community who develop public policy. The overall goal is the reduction of health problems, both mental and physical.

Community counseling calls for practitioners who (a) are familiar with resources within the community that they can refer clients to, when necessary; (b) have a basic knowledge of the cultural background of their clients; (c) possess skills that can be used as needed by clients; (d) have the ability to balance various roles as professionals; (e) are able to identify nonprofessionals in the community who have the ability to be change agents for their community, and (f) have the willingness to be advocates for policy changes in the community.

**Roles of Helpers Working in the Community**

Ideally, all mental health professionals are committed to promoting change on both individual and community levels; however, they do not all have the same areas of interest and expertise. No matter what setting we choose for our work, we must be aware of the broader context of human problems in order to be effective and therefore ethical. The challenge is to think beyond the needs of the individual to the needs and the strengths of the community at large, in much the same way as practitioners would include the family when addressing the needs of the child.

As we indicated in Chapter 4, to meet the needs of many ethnic and culturally diverse clients, traditional counselors need to have a different vision and master different skills, such as outreach interventions. Delivering services in nontraditional settings may be clinically and ethically indicated and may be beneficial to clients. On this point, Knapp and Slattery (2004) indicate that home-based services are often the only way some people can get services because of transportation problems, mobility issues, or cultural barriers to office-based treatment. Providing home-based services can also lead to ethical challenges in managing professional boundaries. When working in the homes of clients, Knapp and Slattery recommend that therapists emphasize informed consent, especially about therapeutic boundaries.

The outreach approach may include both developmental and educational efforts, such as skills training, stress management, and consultation. Outreach activities also include family preservation services, the goal of which is to develop a treatment plan with a family to maintain children’s safety in their own homes. Community counselors also attempt to change the dysfunctional system that is producing problems for individuals, families, and communities.
The focus is on looking at the problem in context rather than dealing only with the problem within the individual.

**Alternative Counselor Roles**

Rather than operating in a singular role, as is the case with many traditional counselors, the emphasis of the community perspective is on alternative ways of helping clients. Atkinson, Thompson, and Grant (1993) state that the role of psychotherapist is frequently inappropriately applied when working with racial or ethnic minority clients. Atkinson and his colleagues believe the conventional role of psychotherapist is appropriate “only for a client who is highly acculturated and now wants relief from an existing problem that has an internal etiology” (p. 269). Other writers (Sue, Ivey, & Pedersen, 1996; Sue & Sue, 2003) have criticized conventional approaches to therapy because they place undue responsibility on the client for his or her plight. At the extreme, some interventions blame client problems entirely on the individual without regard to contributing environmental factors. Community-oriented counseling emphasizes the necessity for recognizing and dealing with environmental conditions that often create problems for ethnically diverse client groups. This is known as a psychosocial approach or orientation. Atkinson (2004) suggests alternative roles for counselors who work in the community: advocate, change agent, consultant, adviser, facilitator of indigenous support systems, and facilitator of indigenous healing methods.

**Advocate.** Because ethnic minority clients are often oppressed to some degree by the dominant society, they can be helped by counselors who are willing to speak on their behalf. Mental health practitioners especially need to function as advocates for clients who are low in acculturation and who need remediation of a problem that results from discrimination and oppression.

**Change Agent.** Counselors can confront and bring about change within the system that contributes to, if not creates, many of the problems clients face. In the role of change agents, counselors assist clients in recognizing oppressive forces in the community as a source of their problem; they also teach clients strategies for dealing with these environmental problems. A change agent recognizes that healthy communities produce healthy people. The main purpose of community change is fostering healthy communities (Homan, 2004). As a change agent one must sometimes educate organizations to change their culture to meet the needs of the community.

**Consultant.** Operating as consultants, counselors encourage ethnic minority clients to learn skills they can use to interact successfully with various forces within their community. In this role, client and counselor cooperate in addressing unhealthy forces within the system. They work with racial and ethnic minority clients to design preventive programs aimed at eliminating the negative impacts of racism and oppression. The role of consultant can be seen as the role of a teacher. Often the “teacher” is less of a threat and more socially
acceptable to members of non-Western cultures than the “counselor,” even though the same professional may be performing both functions.

**Adviser.** The counselor as adviser initiates discussions with clients about ways to deal with environmental problems that contribute to their personal problems. For example, recent immigrants may need advice on immigration paperwork, coping with problems they will face in the job market, or problems that their children may encounter at school.

**Facilitator of Indigenous Support Systems.** All cultural groups have some form of social support aimed at preventing or remediating psychological and social problems. Many ethnically diverse clients, people in rural environments, and older people would not consider seeking professional help in the traditional sense. However, they may be willing to turn to social support systems within their own communities. Community workers need to be aware of cultural factors that may be instrumental in contributing to a client’s problem or resources that might help alleviate or solve the client’s problem. Counselors can play an important role by encouraging clients to make full use of indigenous support systems within their own communities.

**Facilitator of Indigenous Healing Systems.** Mental health practitioners need to learn what kinds of healing resources exist within a client’s culture. In many cultures individuals with problems are more likely to put their trust in traditional healers. For that reason, counselors need to be aware of indigenous healing systems and be willing to work collaboratively with them when it is to the benefit of the client. Ignoring these indigenous resources can have a negative effect on the client’s welfare, and therefore, has ethical implications. One such example of a conflict between indigenous healing and mainstream medicine is explored in Fadiman’s (1997) book, *The Spirit Catches You and You Fall Down*. This conflict resulted in the death of a child.

Constantine and colleagues (2004) present a comprehensive literature review and discuss the cultural relevance of indigenous healing practices in promoting psychological, physical, and spiritual well-being in people of color. They suggest that counselors exercise due care in making referrals to indigenous helping resources that would not jeopardize clients’ physical and mental health. Constantine and her colleagues encourage counselors to be open to learning about indigenous healing resources, especially with clients from cultures that may mistrust Western mental health approaches. By assuming an open stance, “counselors may be able to recognize potential similarities and differences between indigenous and Western approaches to helping and may begin to bridge the gaps between traditional helping institutions and the cultures of the individuals they serve” (p. 120).

In summary, it is ethically incumbent on practitioners who work in the community to assume some or all of the alternative roles described here when needed to benefit their clients and provide optimal care.
Some Tasks of Community Counseling

The community counseling approach serves people of all ages and backgrounds and with all types and degrees of problems. To effectively serve this variety of client populations, practitioners need to develop culturally diverse competencies (Hogan-Garcia, 2003). In community counseling, practitioners may find themselves performing some or all of these duties:

- Supporting the needs of minority groups in the community
- Assisting client groups to become true partners with professionals in the development and delivery of services with shared decision-making authority
- Promoting community organization and development activities as fundamental agency responsibilities and seeing that this is reflected in agency budgets
- Actively reaching out to people with special needs and initiating programs aimed at preventing problems rather than merely treating them
- Drawing on and improving the skills of community workers and laypeople to help meet the many different needs and discover and use the many abilities of clients
- Developing strategies to deal effectively with poverty, drug and alcohol abuse, child sexual and physical abuse, and domestic violence
- Developing strategies that will empower the disenfranchised in the community
- Consulting with a variety of social agencies about programs in gerontology, welfare, child care, and rehabilitation, and helping community workers apply psychological knowledge in their work
- Evaluating human-service programs to assess agency intervention efforts
- Advocating and assisting with public and private initiatives that promote the total well-being of clients
- Working with members of a particular community to develop and build on community assets to promote communities and instill self-reliance

Educating the Community

There are many reasons people do not make use of available mental health resources. They may not be aware of their existence; they may not be able to afford these services; they may have misconceptions about the nature and purpose of counseling; they may be reluctant to recognize their problems; they may harbor the attitude that they should be able to take charge of their own lives; they may feel a social stigma attached to seeking professional help; or they may perceive that these resources are not intended for them because the services are administered in a culturally insensitive way. One of the major barriers to clients not making use of social and psychological services is that access to these services is confusing and sometimes humiliating.

One goal of the community approach is to educate the public and attempt to change the attitudes of the community about mental health and the attitudes of those who deliver mental health services. Many people still cling to a very narrow definition of mental illness. Widespread misconceptions include the
notion that once people suffer from any kind of emotional disturbance they can never be cured, the idea that people with emotional and behavioral disorders are merely deficient in “willpower,” and the belief that the mentally ill are always dangerous and should be separated from the community lest they “contaminate” or harm others. Professionals face real challenges in combating these misconceptions, for unless this is done many people will not seek professional help. Practitioners are ethically bound to actively work at presenting mental health services in a way that is understandable to and respectful of the community at large.

Influencing Policymakers

The challenges facing community workers are often overwhelming, especially with current constraints on funding and the bureaucratic malaise. How can dedicated community workers continue to develop social programs if they are constantly faced with the likelihood that their programs will be cut back or canceled? Sherman and Wenocur (1983) write, “Thus, the workers are put in a double bind, in that they are now held responsible by their clients for help they feel they should, but cannot in fact, provide adequately.Caught in this bind, workers often cannot cope with clients’ anger. Worse, they cannot justify their inability to help” (p. 376). There is little room for staff members to come up with innovative social programs when the agencies themselves are concerned with mere survival.

One way community workers can initiate change is by organizing within an agency or even several agencies and developing a collective voice. Practitioners can empower a community to organize political action to influence the state and national government to fulfill their responsibilities. This action may involve providing funds, technical assistance, legal protection, or other support a smaller community requires to flourish (Homan, 2004).

The Case of a Nonprofit Agency Designed to Educate the Community. The Coalition for Children, Adolescents and Parents (CCAP) is a community agency aimed at the prevention of adolescent pregnancy. This small grassroots agency in Orange County, California, applies outreach strategies to educate the community as a way to meet a critical need in the community (Hogan-Garcia & Scheinberg, 2000). For the past 20 years, CCAP has served as a model of how to involve the community in a project to enhance the community. From its inception, a high priority has been given to hiring a multiethnic staff that could serve and mirror the community. The staff is committed to understanding each other, rather than allowing their differences to separate them, and staff members meet frequently for cultural sharing as a way to better understand each other and themselves. Those who work at the agency have opportunities to critically examine their ethnocentric assumptions about the world and the community. All the members of the agency staff are committed to clarifying and understanding personal values, beliefs, and behaviors. Because the individuals on the staff believe in the value of understanding cultural diversity, they are able to serve as a bridge between the mainstream and minority communities.
One of the early projects designed by CCAP involved outreach and education in the Latino community to prevent the spread of HIV. A Latina staff member conducted interviews with 30 mothers in the community regarding their understanding of HIV, human sexuality, and teen pregnancy. From this contact with these mothers, a group of leaders (comadres) was formed to educate the community. The women who served as leaders met for monthly meetings, which were held at a neighborhood center. Eventually, the women invited their husbands into the classes. This project was funded by an external source, and the agency was required to report to the funders about the outcomes of the project. Hogan-Garcia and Scheinberg (2000) summarize these outcomes thusly:

By the end of the contract year, the agency had exceeded the expectations of funders with the project and the Comadres Project had spread the word about HIV prevention to friends, neighbors, and family members. The empowerment of disenfranchised women and men continued beyond the contract term. CCAP staff continued to meet with and follow this special group of friends. Three women went back to school, a group of the women formed a Spanish-speaking PTA group, and one went on to become a school board member. (p. 28)

In 2000 the agency served more than 12,000 clients, providing after-school recreational services, tutoring, academic enrichment programs, physical examinations, parenting education, conflict resolution, cultural-diversity training, school-based group counseling, a homeless shelter, drug abuse prevention, and child care training. This agency is an example of an effective collaboration that is committed to ensuring that the members of the community have a full voice in determining the nature of community services.

The projects that are a part of CCAP are based on a set of culturally competent practice principles, which have been described by Hogan-Garcia and Scheinberg (2000) and Hogan-Garcia (2003):

- Be willing to examine your assumptions and personal values.
- In an agency, bring together an ethnically diverse staff and board.
- Develop and maintain positive relationships with key people in the community.
- Ask community members about their perceptions of what is needed in the community.
- Bring community members and agency staff together in genuine dialogue.
- Design a program based on the community’s definition of their needs.
- In implementing a program, be sensitive to the pace of the community.
- Advocate for the needs of the community and serve as a bridge between cultural groups.
- Translate the progress of the community in terms that the funders of the project will understand.

Based on the discussion of the CCAP project, respond to the following questions:

- Are you open to learning first-hand about other cultures?
Would you value this kind of ongoing self-evaluation?

Do you think ethnic diversity of staff members is necessary for a community agency to be successful?

**The Case of Maribel.** Maribel is the director of a community clinic in an inner-city neighborhood. Her agency provides birth control counseling and funding for abortion for low-income women. As the time approaches for her to submit her request for financing to the state government, she is contacted by a local politician who is adamantly opposed to abortion. He informs her that if she requests funding for abortion he will do everything in his power not only to deny the money but also to reduce the overall funding for the agency. Faced with the prospect of radically reduced funds, Maribel omits her request for money for abortion services.

- In light of the threats that were made, did Maribel act in the best interest of her community? Can you see any justification for her action? What ethical concerns are raised by her decision?
- What if Maribel seemed to go along with the politician’s request, but later on, when the funding for the other programs was acquired, she diverted some of the money for abortion services? Would this be ethical? Would Maribel be breaking the law?
- How ethically bound was Maribel to disclose the coercive attempts of the influential politician, even though it was only her word against his?
- What would you have done in her place?

**The Case of Natalie.** Natalie is an intern with a community agency that provides counseling services to local elementary schools. She facilitates a group for children with behavioral problems. On one occasion the principal overheard one of the students reacting angrily. The principal assumed control of the group, got into a verbal exchange with the child, and suspended him from school. When Natalie appealed to her clinical director, he angrily told her: “Back off, and don’t you dare challenge the principal.” He let her know in no uncertain terms that if she were to take action against the principal the contract of providing counseling services to the school would be jeopardized, with the subsequent loss of funding to the clinic.

- What are the possible ethical considerations in this case?
- If you were Natalie, what would you do?
- If you were her supervisor, what would you say to her? What would you feel obligated to do, if anything?

**Promoting Change in the Community**

Homan (personal communication, January 20, 2005) poses a question that has significant implications for community work: Are you willing to honestly examine who owns the project or the change? From Homan’s perspective, if we are
just doing things we think are right for people, rather than the project really being theirs to take charge of, we may just be politely reasserting a form of social control. While some client/constituent groups do not have the immediate skills, or even the time to take care of every aspect of a change project, they can learn skills and receive support for their work, rather than receive a substitution for it. Thus the matter of “who owns” the project is an important ethical concern.

Homan (2004) emphasizes the notion that promoting community change is a broader issue than merely solving the problems of the community. He raises a series of questions that community workers need to address in their change efforts (p. 57):

- Is there an identified community? If so, who has defined it and how is it defined?
- Does the project build skills of community members? Can these skills be identified?
- Does the project produce new leaders and new teachers?
- Who owns the project? How is this seen? Who holds decision-making authority? If ownership is external, what processes are in place to transfer ownership to the members of the community?
- Does the project produce new community resources that can exist apart from the project or after the intended life of the project?
- Do the benefits or resources created by the project in turn create new benefits or resources?
- Which community capacities or assets will the project build upon? How will these be expanded by the project?
- Which community conditions does the project intend to change?

The answers to these questions can provide community workers with a framework for developing the capacity within a community to recognize conditions that need to be changed and the willingness and ability to take action to bring this change about.

Ways to Involve Yourself in the Community

Consider your responsibility to teach constituents to use the resources available to them in their communities. Here is a list of things you might do to link residents to the environment in which they live. Rate each of these activities, using the following code:

A = I would do this routinely.
B = I would do this occasionally.
C = I would do this rarely.

1. I would work with agencies to determine which services need to be offered and how they might best be offered.
2. I would familiarize myself with available community resources so that I could refer people to appropriate sources of further help.
With my clients’ permission, I would enlist people who had a direct influence on their lives.

I would connect my clients to the support systems and resources already available in the community.

I would work actively with groups committed to bringing about change in the community.

I would encourage efforts to make the community’s helping network more responsive.

I would provide training to key people from various cultural groups in peer-counseling skills so that they could work with those people who might not seek professional services from an agency.

I would make it a point to get to know politicians who were actively involved in helping the community.

If you plan on going into one of the mental health professions, you are likely to spend some time working in a community agency setting, and you will be working with many different facets of the community. If you were to work in such a setting at this time, consider the following questions:

- How would you go about learning what it takes to become an effective agent for change in the community?
- What skills do you already have that can be applied to community change?
- What is the most essential skill you need to acquire?
- What fears or concerns do you have of working in the community?
- How would you translate your ideas into a practical set of strategies aimed at community change?
- How aware are you of your beliefs and attitudes toward the people you serve, and how might this affect the way you work?

Making a Difference in the Community

In his article, “Making a Difference,” Rob Waters (2004) profiles the work of five community-oriented therapists who engaged in social activism. These five “citizen-therapists” exemplify people who are deeply connected to their own communities and who are actively working to promote change. Each of these therapists has taken a different path to change the community, yet each of them has been motivated by the question, “How can I make a difference?” As you read about their efforts, imagine yourself engaging in similar community work.

- Ramon Rojano is convinced that the direction the helping profession needs to take is for therapists to become active agents of social change. A psychiatrist who had worked primarily with rich Caucasians, Rojano shifted his focus and began working in a child guidance clinic with Latinos and African Americans. He quickly realized that relying on traditional psychotherapy approaches to deal with a family’s psychological needs was pointless unless he addressed poverty, violence, and the social and economic crises that were part
of the lives of these family members. Referring to his approach as "community family therapy," Rojano has shifted from the traditional role for which he was trained as a psychiatrist to an alternative role of bettering the mental health system for the poor.

- Diane Sollee is a leader in the marriage education movement. Part of her work has involved seminars to train people to become marriage educators, who then have the task of teaching basic communication skills to couples. To avoid becoming identified with any political faction, Sollee has refused to accept funding from anyone. The core of her work is to get couples the information and skills they need to succeed in their marriage and family life.

- Kenneth Hardy is a family therapist who over the years has developed projects in schools, churches, corporations, and the United States military to help groups deal with diversity issues. Hardy’s goal is to help people acknowledge the reality of social injustice and the inequalities of race, gender, and social class in ways that people can develop a true understanding of diversity. In his professional work, Hardy has focused increasingly on those who are disenfranchised and disempowered.

- Jack Saul is the director of New York University’s International Trauma Studies Program, which is committed to helping people survive disaster. In reflecting on the aftermath of 9/11, Saul contends that “collective suffering requires a collective response” (p. 40). In disaster situations, Saul believes that therapists need to think in broader terms and develop models for mobilizing a community’s own resources for healing. He met with officials to set up Project Liberty, which was the commission established to distribute $100 million in mental health funds that Congress provided for recovery from the 9/11 disaster. Currently, Saul is devoting his energies toward developing community resources for healing 6,000 Liberian refugees living on Staten Island. He operates largely behind the scenes to help organize drop-in centers, job-placement programs, and family support programs that bring together various community leaders. Saul says, “The key thing in doing this kind of work is to bring your therapeutic skills to the community in a way that promotes the community’s own capacities, without becoming too central” (p. 41).

- Barbara Lee, a graduate of the School of Social Welfare at the University of California at Berkeley, is now a member of Congress on Capitol Hill. Lee has learned that she is able to have the widest possible impact by exercising political power. Lee brings a clinician’s perspective to bear on the running of her congressional office. She and her staff give major attention to social work in action by advocating for low-income people. Lee co-sponsored a bill that authorized AIDS relief to Africa that passed the House and Senate and was signed into law by President Bush in 2003. This achievement is but one example of what Lee means when she says, “I didn’t go into politics to be part of the system, but to change the system, to shake it up and make things better” (p. 43).

These five social activists give testimony to the power of changing systems and helping communities in discovering their own resources for healing.
Working Within a System

One of the major challenges for counselors who work in the community is to learn how to make the system work for the clients they serve and, secondarily, work for themselves so that in the process they do not lose their ability to be effective with clients. Working in a system can put an added strain on the counselor due to the monumental amount of paperwork required to justify continued funding, high caseloads, and a multitude of policy directives. Another source of strain is the counselor’s relationships with those who administer the agency or institution, who may have long forgotten the practicalities involved in providing direct services to clients. Conversely, practitioners who deal with clients directly may have little appreciation for the intricacies with which administrators must contend in managing and funding their programs. If communication and problem solving are inadequate, as they often are, tension and problems are inevitable. The ultimate challenge is to empower the community to address its own problems. This will be difficult if the system trying to effect change is itself impaired.

Case Management in a Community Setting

The emergence of case management as a dominant force in human-service delivery presents new ethical challenges. Case management involves planning and coordinating approaches to treatment. It is guided by the principles of fairness, accountability, collaboration, advocacy for individuals’ needs, effective and efficient delivery of services, treatment of the whole person, and individual empowerment. True to this holistic stance, the overall goal of case management is to promote, restore, or maintain the independent functioning of clients in the least-restrictive community environment.

Because of the collaborative and holistic nature of case management, both within and between human-service agencies, the interdisciplinary approach plays a pivotal role in the provision of assessment, planning, resource information, monitoring, and evaluation of client services. Depending on the range and complexity of human services offered, interdisciplinary teams include professionals from many disciplines, each representing a service the consumer may need. However, the effectiveness of the interdisciplinary team approach is very much dependent on the professionalism, respect, and cooperation between team members. For instance, a team that is dominated by one discipline or one team member can be detrimental to human-service delivery. When team members lack professional skills and resource knowledge to make appropriate interventions, recommendations, and referrals, clients may be harmed. Time and efficiency considerations can also play a role in the careless exclusion of clients and their families from the interdisciplinary process deliberations, which is a failure to honor the principle of empowering the client. Similarly, in the interest of time and job security, the case manager may ignore client advocacy responsibilities, which raises a serious ethical issue.
Cooperation and collaboration between human-service agencies can be particularly challenging. Typically, each community agency has specific eligibility criteria (often state or federally mandated), a specific range of services, and a limited budget. Depending on the financial health of the agency budget, the eligibility criteria are interpreted in a less or more strict manner, forcing consideration of the principle of fairness as it is applied to agency applicants. The principle of fairness must also be considered with regard to cooperation between agencies in the provision of client services.

Nowhere today is the application of the case management system of human-service delivery more pronounced than in health maintenance organizations (HMOs). Although it is generally accepted that case management has provided accountability and a level of fairness to health care, many criticisms are raised. One criticism is that necessary health services are often denied by a case manager within the HMO organization. Furthermore, the HMO case manager is acting as a gatekeeper for the HMO corporation, rationing medicine to paying clients to promote and protect corporate profits. This also creates an ethical dilemma.

Consider these questions as they pertain to the ethical issues associated with case management as a way to deliver human services in a community agency:

- In delivering services, how does one balance staying within the budget with service to clients?
- Is it ethical to break rules (federal, state, agency) for the welfare of the individual client?
- Should I always consult with agency management when I see the necessity of breaking rules?
- Am I willing to advocate for client needs at the risk of losing my job?
- It can be efficient for client files to be accessible to all agency professional staff on the agency computer network. What risks, if any, are involved in this?
- In what kind of situations might client autonomy be honored more than professional codes or agency policies and procedures?
- Am I ethically bound to resign from my position as an agency worker if my work assignments are beyond my professional capabilities?
- Should I be a “whistle-blower” when agency management or staff engage in unethical or illegal behavior?
- Do I have an ethical obligation to challenge those systems that overload workers, which can result in superficial work?

The Challenge of Maintaining Integrity in an Agency Environment

Many professionals struggle with the issue of how to work within a system while retaining their integrity and vitality. Although working in an organization is oftentimes frustrating, counselors need to examine their attitude, which might be part of the problem. Blaming others does not effect change. Focusing on the things that can be changed fosters a sense of personal power that may allow for progress.
Practitioners need to evaluate the options they have in responding to unacceptable circumstances. Homan (2004) raises some thought-provoking questions in this regard:

- If you respond to the presence of disturbing social conditions within your midst by attempting to mainly soften the pain they cause, does this imply tolerance for these problems in the system?
- If you genuinely believe that your efforts make a difference, should you accept limitations on your efforts?
- To what degree is it your ethical responsibility to work toward shaping the system that shapes your practice?

Homan suggests that simply putting up with problems within a system is rarely gratifying and that workers gain professional satisfaction by actively taking steps to promote positive changes:

I believe that you do have options for challenging the circumstances that lead to the problems you confront. And I believe that you have options for creating conditions that permit you to do effective work. In my experience, workers who have acted thoughtfully and purposefully to confront and resolve systemic problems have produced many positive results. (p. 77)

Recognizing the need for action is the first step toward responding to unacceptable circumstances. Once a problem has been identified, Homan suggests that you have four basic responses to choose from (p. 87):

- You can change your perception by identifying the situation as acceptable.
- You can leave the situation, either by emotionally withdrawing or by physically leaving.
- You can recognize the situation as unacceptable and then decide to adjust to the situation.
- You can identify the situation as unacceptable and do what you can to change it.

Each of these actions has consequences for both you and your clients. If you recognize that you do have choices in how you respond to unacceptable situations, you may be challenged to take action to change these circumstances. From an ethical perspective, you are expected to alert your employer to circumstances that may impair your ability to reach clients.

We support Homan's ideas of how to respond to problems in a system. We also need to recognize that sometimes a worker's physical and mental health may be at risk in a dysfunctional system. In such a case, the only viable option might be to withdraw from the system to prevent serious health problems or burnout.

By creating and participating in support groups, those who work in an agency might find ways to collectively address problems in the system of which they are a part. Sherman and Wenocur (1983) make a strong case for the value of support groups in agency settings. These groups create an internal subculture that provides some support in dealing with bureaucratic pressure. Workers alone would have difficulty changing large organizations, but when they unite, they have a greater opportunity for effecting change.
The Case of Toni. For 19 years Toni has worked with women in recovery in a community agency that is funded by a grant. To prevent burnout, she and her co-workers organized a support group among the community workers in the agency. Her group consists of about 15 people, some of whom are case managers, treatment counselors, nurses, social workers, and supervisors. They meet at the agency during work hours twice a month for up to 2 hours. During these sessions the workers have opportunities to talk about difficult clients or stressful situations they are facing on the job or in their personal lives. Personal concerns sometimes have an impact on workers’ abilities to function professionally, and members are able to use the support within the group as a way to deal with personal issues.

Unfortunately, because of cuts in many of the nonprofit grants, many of the benefits they previously had have been cut. Toni says,

I have recently been hard hit by these cuts. The grant on which I have been working for the past 19 years was recently cut by 10%. To make ends meet in the organization, many employees have been laid off, which has resulted in greater workloads for those remaining. These cutbacks were especially felt in the counseling area. We have lost a treatment counselor as well as two social workers, one based at the intensive day treatment program and the other at a hospital-based clinic. All of us are feeling the increased stress resulting from these losses. We have been forced to let go of our bi-monthly stress reduction meetings that over the years have been so valuable to us. This has left me alone in the clinic and hospital area without backup. Being unable to have someone to consult with on a daily basis has greatly increased my stress level. I am quickly realizing how important our meetings were to the welfare of the organization, as well as to the clients. Exploring new ways to manage our work-related stress is a top priority for our agency now. (Toni Wallace, personal communication, December 23, 2004)

- If you worked for this agency, would you want to join this group?
- Do you think members of this group might have more power within the agency than workers who are not in the group?
- How would you cope with the cutbacks and the loss of a program you valued?
- How might you deal with the demands of an increased workload due to the layoffs?

Relationships Between Community Worker and Agency

The ethical violations in a community agency are more complex and difficult to resolve than violations pertaining to individual counseling. If a worker is not motivated, the system may tolerate this lack of motivation. If the system violates the rights of the client (community), then this is a real challenge to address. There is no easy solution to the problem of a system abusing clients, but clearly the people seeking help are vulnerable and need to be protected. Correcting such an abuse that may be systemwide demands the willingness of those involved in the system to practice aspirational ethics and take action.
To be an effective community helper, human service workers need to have the knowledge and skills necessary to effectively work in bureaucratic organizations before they assume professional employment (Sherman & Wenocur, 1983). In addition to their degrees, training, and professional competencies, they need to learn how to best deal with the rules and regulations of their agency. Typically they have little say in the formulation of agency policies, and furthermore, they are limited in what they can do by the agency’s rules and regulations. The system may be so cumbersome and difficult for clients to work with that practitioners must assist clients in obtaining resources through lobbying, advocacy, referrals, and networking.

As a mental health practitioner, you need to decide how you will work within the system and how you can be most effective. Study an agency’s philosophy before you accept a position, and determine whether the agency’s norms, values, and expectations coincide with what you expect from the position. If you are not able to support the philosophy and policies of that agency, you are almost certain to experience conflicts, if not failure. It will be up to you to find your own answers to questions such as these:

- To what degree is my philosophy of helping compatible with the agency where I work?
- How can I meet the requirements of an institution and at the same time do what I most believe in?
- What can I do to bring about change in a particular system?
- Would I consider mobilizing clients to promote changes in the community? in my own agency?
- At what point does the price of attempting to work within an organized structure become too high?
- What special ethical obligations am I likely to face in working in a system?

**Moving Toward Empowerment.** We suggest you respond to the following questions to clarify your position on ways in which you could increase your chances of assuming power within the system:

- What would you do if the organization for which you worked instituted a policy to which you were opposed?
- What would you do if you believed strongly that certain changes needed to be made in your institution but your colleagues disagreed?
- How would you attempt to make contact with your colleagues if members of the staff seemed to work largely in isolation from one another?
- If the staff seemed to be divided by jealousies, hostilities, or unspoken conflicts, how would you intervene?
- What do you consider to be the ethics involved in staying with a job after you have done everything you can to bring about change, but to no avail?

Now let’s look at some examples that illustrate issues discussed in this chapter. Try to imagine yourself in each of these situations, and ask yourself how you would deal with them.
The Case of Ronnie. Ronnie, an African American student, moved with his family into a mostly White community and attends high school there. Almost immediately he becomes the butt of racial jokes and experiences social isolation. A teacher notices his isolation and sends him to the school counselor. It is evident to the counselor that Ronnie is being discriminated against, not only by many of the students but also by some of the faculty. The counselor has no reason to doubt the information provided by Ronnie because she is aware of racism in the school and in the community. She determines that it would be much more practical to help Ronnie learn to ignore the prejudice than to try to change the racist attitudes of the school and the community.

- How do you evaluate this counselor’s decision? What are its ethical ramifications? Does she have an obligation to work to change community attitudes?
- What would you do in this situation?
- Does a school system have an ethical obligation to attempt to change attitudes of a community that discriminates against some of its citizens?
- What are the risks of not addressing the problem of racism?

Commentary. In this case, the counselor may be experiencing a conflict of values and may fear reprisals if she acts on values that are not shared by many in the community. She may want to do what is needed to promote the well-being of her client, yet she may be struggling with self-doubts and with anxiety about not being accepted by the faculty. If you were consulting with this counselor, what might you say to her?

The Case of Adriana. Adriana works in a community mental health clinic, and most of her time is devoted to dealing with immediate crises. The more she works with people in crisis, the more she is convinced that the focus of her work should be on preventive programs designed to educate the public. Adriana comes to believe strongly that there would be far fewer clients in distress if people were effectively contacted and motivated to participate in growth-oriented educational programs. She develops detailed, logical, and convincing proposals for programs she would like to implement in the community, but they are consistently rejected by the director of her center. Because the clinic is partially funded by the government for the express purpose of crisis intervention, the director feels uneasy about approving any program that does not relate directly to this objective.

If you were in Adriana’s place, what would you do? Which of the following courses of action would you be likely to take?

- I would do what the director expected and complain that the bureaucratic structure inhibited imaginative programs.
- I would continue to work toward a compromise and try to find some way to make room for my special project. I would work with the director until I convinced her to permit me to launch my program in some form.
3. If I could not do what I deemed important, I would look for another job.
4. I would involve clients in setting the direction for the proposal and providing the necessary support to secure approval.
5. I would examine the director’s responses and try to incorporate them into my approach.
6. I would get several other staff members together, pool our resources, and look for ways to implement the program as a group.
7. With my director’s approval, I would try to obtain a grant for a pilot program in the community.

Chapter Summary

The primary focus of this chapter has been on the importance of working in the community as a change agent. The community mental health orientation is one way to meet the increasing demand for a variety of services. Too often mental health professionals have been denied the opportunity to devise programs that address the diverse needs of the community. Over the past few years some alternatives to conventional therapy have arisen, creating new roles for counselors who work in a community agency setting. It is our position that it is ethically incumbent on the counselor to be aware of community resources as a way to more effectively address the client’s needs.

You may be seeking a full-time career in a system. We think it is essential to consider how to make the system work for you and your clients rather than against you and your clients. As Homan (1999) puts it: “If you treat people as if they are allies, they are more likely to become allies; if you treat them as enemies, they are more likely to become enemies” (p. 141).

We challenge you to think of ways to accept the responsibility of working effectively in an organization and thus increasing your effectiveness as a professional. Finally, we ask you to reflect on the major causes of disillusionment that often accompany working in a system and to find creative ways to retain your vitality.

Authors’ Concluding Commentary

We have raised some of the ethical and professional issues that are likely to be encountered in your counseling practice and have tried to stimulate you to think about your own guidelines for professional practice. If one fundamental question can serve to tie together all the issues we have discussed, it is this: “Who has the right to counsel another person?” This question can be the basis for self-examination whenever you have concerns about clients. At times you may be troubled and believe that you have no right to counsel others, perhaps because you are not doing in your own life what you are challenging your clients to do. Yet occasional self-doubt is far less damaging, in our view, than
a failure to question. Complacency will stifle your growth as a practitioner; honest self-examination, although sometimes difficult, will make you a more effective helper.

Developing a sense of professional and ethical responsibility is a task that is never really finished. There are no final or universal answers to many of the questions we have posed. For ourselves, we hope we never reach the point where we think we have figured it all out and no longer need to reexamine our assumptions and practices. The issues raised in this book demand periodic reflection and an openness to change. We hope you will continue to give careful thought to your own values and ethics and that you will be willing to rethink your positions as you gain more experience. An interest in what you do and in the people you serve will most likely make you not only an ethical practitioner, but also an interesting one.

Suggested Activities

1. Retake the self-assessment at the end of Chapter 1, which surveys your attitudes about ethical and professional issues. Cover your initial answers when you complete the self-assessment, and compare your responses now to see whether your thinking has changed. In addition, circle the 10 questions that are most significant to you or that you are most interested in pursuing further. Bring these to class and discuss them in small groups. Write down a few of the most important things you have learned in this course and from this book. You might also write down some questions that remain unanswered for you. Exchange your ideas with other students.

2. In small groups explore specific ways of becoming involved in the community or using community resources to assist you in working with your clients.

3. Reflect on and discuss alternative roles human-service professionals might play when working in the community. Which of the following roles do you think you could assume as a community worker: (a) advocate, (b) change agent, (c) consultant, (d) adviser, (e) facilitator of indigenous support systems, or (f) facilitator of indigenous healing systems. In small groups discuss in which of these roles you would feel least comfortable functioning, and why. How could you learn to carry out professional roles in the community different from those in which you were trained?

4. An issue you may well face in your practice is how to get through the hesitation people have toward asking for professional assistance. Ask yourself how you should respond to clients who have questions such as these: “What will people think if they find out that I am coming for professional help?” “Shouldn’t I really be able to solve my problems on my own? Isn’t it a sign of weakness that I need others to help me?” “Will I really be able to resolve my problems by consulting you?” After you have thought through your own responses, share them in dyads or in small groups.

5. How aware are you of the resources that exist in your community? Would you know where to refer clients for special needs? Investigate a community
mental health center in your area and find the answers to questions such as these:

- Where would you send a family who needed help?
- Where would you send a family who has a child with a learning or developmental disability?
- What website resources would you recommend?
- What facilities are available to treat drug and alcohol abuse?
- Is crisis intervention available?
- Are health and medical services available at the center?
- What groups are offered?
- Where would you refer a couple seeking couples counseling?
- Are hot-line services available?
- What provisions are there for emergency situations?
- What do people have to do to qualify for help at the center?

6. Several students can interview a variety of professionals in the mental health field about the major problems they encounter in their institution. What barriers do they meet when they attempt to implement programs? How do they deal with obstacles? Compare the responses of experienced and inexperienced personnel without revealing the identities of the persons interviewed.

7. After recognizing that a problem exists within the organization for which you work, identify skills you would need to make the desired changes. How might you go about developing strategies for getting support from coworkers if you were interested in changing an agency?

8. Consider asking professionals how they view workers who organize and mobilize clients, particularly toward making changes in the agency in which the professional works.

9. Interview clients in an agency and get their perceptions of how community workers have involved them in changing the conditions they face.

10. Some websites offer useful information pertaining to topics addressed in this chapter. Choose several topics that interest you and check these resources to see what information is available.

- Welfare Information Network: www.welfareinfo.org
- The Web Counseling Site: http://home.nww.net/willcars/index.html
- Addiction: www.jointogether.org or www.atforum.com
- Multicultural Services: www.mc-memhr.org
- Child Welfare League of America: www.handsmt.org/cwla
- Substance Abuse and Mental Health Services Administration: www.samhsa.gov
- Mental Retardation: www.thearc.org
- National Coalition for the Homeless: www.ari.net/hone/nch
- Homeless Population Resources: www.homeless.org
- Psychosocial Rehabilitation: www.ucpsychrehab.org
- Posttraumatic Stress Disorder: www.ncptsd.org
- Program for Assertive Community Treatment: www.nami.org/about/pactfact.html
- Crisis Counseling: www.crisiscounseling.com
- Suicide Crisis Intervention: www.mhsantuary.com
- Prevention: www.prevention.org
- Advocacy Institute: www.advocacy.com
- Law and Social Policy: www.clasp.org

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For additional readings, explore InfoTrac College Edition, our online library. Key words are listed in a form that enables the search engine to locate a wider range of articles in the online university library. Key words should be entered exactly as shown, including asterisks, “W1,” “W2,” “AND,” and other search engine tools. Go to http://www.infotrac-college.com and select these key word searches:

community W1 counsel*
community W1 mental W1 health
mental W1 health AND paraprofessional*
community W1 agency AND ethic*
direct W1 client W1 service*
direct W1 community W1 service*
change W1 agent AND community AND ethic*
case W1 management AND community AND ethic*
*Books and articles marked with an asterisk are suggested for further study.


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