Counselor Ethics and Responsibilities

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The general and ethical responsibilities of a counselor do not begin with the acquisition of a new patient, nor do they end when a session or treatment altogether with said patient ends. A counselor always has responsibilities to meet while practicing. These responsibilities, ethical guidelines, and counselor and patient expectations are enshrined in, for example, the American Counseling Associations (ACA) Code of Ethics (2014). A patient receiving psychotherapeutic treatment is entitled to certain rights and protections and documentation communicating those rights (e.g., informed consent). Additionally, practicing counselors have certain expectations to protect those rights and others, including obligations to protect the patient and others from harm throughout treatment, to document informed consent and keep thorough records, to practice self-care, to act as a patient and social advocate, and to adhere to and demonstrate appropriate values.

Client Rights

Five principles of ethical practice can be considered regarding the rights of clients while practicing as a licensed professional counselor. One such right is autonomy; that is, a patient has a right to autonomy and self-determination. Even despite a case of distorted beliefs on the part of the patient, the patient should remain autonomous (Conlin & Boness, 2019). Not only does respect for this right inherently establish a means for the counselor to avoid imposing values, this also provides an avenue for more effective treatment; specifically, a counselor can ask questions of a patient to display his or her curiosity and interest in the patient, the patient can provide appropriate context and convey understanding, and the question itself allows for patient autonomy (Fourie, 2010). Another such right is nonmaleficence. According to the ACA Code of Ethics, a counselor should "… act to avoid harming their clients, trainees, and research participants and to minimize or to remedy unavoidable or unanticipated harm" (2014, p. 4). Indeed, this can more so mean to ensure that any harm is outweighed by any good when conducting treatment. For example, should a literal sense of *first, do no harm* be assumed, a

surgery could never be conducted because an incision is a literal harm brought to a person (Shah, 2012). In other words, as the ACA words it in their code of ethics, nonmaleficence is "…*avoiding* actions that cause harm" (emphasis added) (2014, p. 3).

Yet another patient right that must be considered is beneficence. Beneficence, as well as nonmaleficence, is a component of a consequentialist model of counseling. A counselor may weigh the totality of costs and benefits, the benefits over the harms, to maximize patient happiness and/or reduce patient harm (Hall & van Niekerk, 2017). In either case, the counselor is ethically obligated to work towards the better of the patient. An additional patient right is justice; that is, counselors should be dedicated to equity and patient fairness (ACA, 2014). Research on the lack of counselor competency of privilege and equality should translate into more concrete policy, including the way in which counselors are trained and the way in which patient success is measured (Moleiro, Freire, Pinto, & Roberto, 2018). Lastly, a patient is entitled to fidelity in treatment. Such fidelity of treatment can include evidence-based intervention tactics and established standards of practice (documented throughout treatment) to ensure competent delivery of treatment; this maintains accountability and bolsters confidence on the part of patients, and can demonstrate competency and opportunity for counselors (Lyon, Stanick, & Pullmann, 2018).

These patient rights, as well as additional details regarding expectations and counselor competency, should be covered with a patient before and throughout treatment. This process is known as informed consent, and this consent protects patient rights and reduces provider liability. Informed consent "…is a legal permission to carry out the treatment given after clear understanding" (Sood & Gupta, 2018, p. 44), and is best presented using the interpretive model. This model allows the counselor to provide information and empowers the patient to make informed decisions; the counselor also helps the patient to clarify the implications of certain choices and to measure those implication against the patient's preexisting values (Hall & van

Niekerk, 2017). Clear understanding, as Sood & Gupta (2018) highlight, is essential and should include information on billing, privacy, HIPAA, and credentialing compliance.

Patients have a right to be informed of their billing and fees. The ACA Code of Ethics requires counselors inform patients of procedures upon nonpayment, as well (2014). Informed consent should also include an explanation of privacy expectations, including its limitations (e.g. interdisciplinary treatment and supervisor involvement) (ACA, 2014). The counselor should explain the potential dilemmas of confidentiality; for example, the counselor will be required to maintain confidentiality from a family member, or break confidentiality should the patient insinuate he or she intends to hurt someone. This privacy is enshrined in the Health Insurance Portability and Accountability Act (HIPAA), which aims to protect patient data and treatment details and enforces a punitive code to ensure compliance (Levine, 2013). Under HIPAA, for example, a counselor is unable to discuss details of treatment with family members of patients; there are potential downsides to this, and it is important a patient is made of aware and provided with all of the necessary information. The patient should also be made aware of credentialing board requirements for informed consent, as well. The state board also allows the patient to research a counselor to ensure that the counselor is licensed. This multi-faceted approach to informed consent (i.e., ACA ethics, HIPAA, and state credentialing boards) helps to ensure compliance.

Responsibility to Warn and Protect

As previously mentioned, a counselor has a responsibility to protect his or her patients and to warn appropriate third parties if a patient has expressed interest in harming others. This mandate was established in *Tarasoff v. Regents of the University of California*, which found that psychotherapists are required to inform authorities (thereby breaking confidentiality) if a patient has threatened to harm another person. Many counselors find a preponderance of reasoning to inform patients of *Tarasoff* laws in their respective state; this is not required, but it can safely be

considered a best-practice to inform a patient that such threats will not be kept confidential (Klinka, 2009).

Not every state has *Tarasoff* laws, and not every state has mandatory reporting laws. Oklahoma is one such state in which common law broadly requires a counselor to warn on the basis of specific treatment (Sommers-Flanagan, R., Sommers-Flanagan, J., & Welfel, 2009). In this case, a counselor in Oklahoma should inform every patient of this potential need to breach confidentiality, should the patient threaten harm against themself or others. The ACA Code of Ethics also supports this, stating that confidentiality "…does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed" (2014, p. 7).

Client Record-Keeping

A professional counselor must maintain appropriate records throughout a patient's treatment. It is necessary for a counselor to document informed consent, as well as treatment details and patient expectations, in order to assure the highest levels of treatment. The ACA Code of Ethics refers to documentation as "necessary for rendering professional services" (2014, p. 7) and requires that counselors ensure that the records are protected and kept confidential. In doing so, a patient can be empowered as the decision-maker regarding his or her treatment, and this can be documented; it also helps to ensure that a patient has proper expectations of treatment.

The counselor, therefore, is also more protected. Documentation ensures the best treatment for the patient, *and* it is evidence that such treatment took place and is in line with professional standards (Corey, Corey, Corey, and Callanan, 2014). Should a patient terminate treatment and allege misconduct, the counselor will be able to provide documentation and details of the patient's treatment. This is also a necessary component of informed consent. If patient expectations are not discussed, the patient may believe the counselor is intentionally misleading

or defrauding them; informed consent, and documenting this consent, reduces liability for the counselor.

Self-Care

Ensuring the highest level of patient care requires that counselors proactively care for themselves, as well. Self-care is even enshrined in the ACA Code of Ethics, requiring counselors to "…engage in self-care activities to maintain and promote their own emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities" (2014, p. 8). There are positive effects in incorporating self-care and mindfulness into graduate-level training for counselors; additionally, counselors can learn more about self-care tools that can then be passed onto patients (Dye, Burke, & Wolf, 2020).

Many studies, from those investigated in peer-reviewed journals to those raved about in contemporary journalism, all purport the necessity and benefits of self-care, specifically mindfulness and meditation exercise. These are made more popular largely to the accessibility of applications such as Headspace and Calm; indeed, fitness applications such as FitBit and Peloton also provide a wide variety of meditation classes. Some of these applications have been found to be lacking in evidence-based treatment, but nonetheless provide wider access that may result in a net-benefit (Wasil, Venturo-Conerly, Shingleton, & Weisz, 2019).

In my opinion, these applications are a necessary and beneficial component of my ongoing self-care routine. It also helps that these applications are used in conjunction with ongoing psychotherapy, where evidence-based context can be added. Additionally, exercise is a necessary component of self-care. My exercise of choice is swimming, but walking outside is also of great benefit as the settings themselves in which I exercise have an impact on my mental health (Klaperski, Koch, Hewel, Schempp, & Müller, 2019). One self-care activity recommended by the therapist is gratitude and mindfulness journaling. I have made the effort of

acquiring a journal, but not have started this exercise. I intend on incorporating it into my self-care routine in the future.

As with any human, a counselor is not somehow immune to mental health disorders or mental stress. Given my history and background, it is very important that I work to ensure I am in a position to treat other people. There are no topics that I feel uncomfortable addressing, given that for the last decade I have made it a point to discuss the pressure points and taboo topics in my life. Perhaps my biggest challenge, as it stands now, is my ability to *change* my behavior to better meet the worldview of a patient. By that I mean, cultural sensitivity is not just an awareness, it's an action; given my international travels and diversity of friends, I believe I have the awareness I need to address a culturally diverse patient group. However, I need to allow that awareness force adjustment so that I can better meet the needs of patients, specifically regarding power dynamics.

It is important that a counselor attend counseling as part of a self-care routine. A counselor without appropriate support and self-care activity may develop secondary traumatic stress, placing his or her treatment at serious risk (Everall, & Paulson, 2004). A counselor should seek treatment to ensure the highest levels of treatment for his or her respective patient, and perhaps for similar reason the patient is seeking treatment in the first place. Again, counselors are not immune to mental hardship.

Advocacy

Advocacy is an ethical requirement of counselors. The ACA Code of Ethics (2014) requires counselor to advocate beyond a counselor-to-patient medium by encouraging involvement in institutional and societal change. The ACA provides information on counselors can get involved; for example, the current topic that the ACA is lobbying for is in support of Medicare expansion to cover mental health and marriage counseling services ("Take Action,"

n.d.). Additionally, counselors can look closer to home and get involved in local ballot initiatives that redirect police funding to mental health and addiction services, for example.

Counselor Values

Counselors will face difficult topics and treat patients with whom there may be little to no common worldview. Regardless of these differences, patient choice is a necessity in psychotherapy; a counselor should promote personal choice by building awareness and sense of personal responsibility, and relating these back to the values of the patient (Ryan & Deci, 2008). This process also renders the counselor's values irrelevant, as they should be. The ACA Code of Ethics prohibits a counselor from imposing his or her values onto a patient (2014).

For example, in a case of assisted suicide, an 87-year-old with terminal cancer may wish to end her life and seeks advice on how to communicate her wish to her family. She is adamant and is not interested in discussing her position. The values of the counselor are irrelevant here. Should a counselor disagree, it is not his or her place to say so. However, in order to ensure the patient has implemented thorough reasoning to arrive at this decision, a counselor should ask challenging, non-leading questions; this demonstrates concern and curiosity on the side of the counselor and is a non-threatening means to open communication on the topic (Fourier, 2010). A counselor should then provide evidence-based advice and ensure that this advice aligns with the values of the patient. That is the only value I have in this regard; this is an extremely personal decision to this patient, and it is her decision to make. That is the case with all assisted-suicide, in my opinion.

Another example may involve an extramarital affair. Polyamory is more common than many realize (see Haupert, Gesselman, Moors, Fisher, & Garcia, 2017). Should such a couple, or member of a couple, become patient(s), it is important to continue to suppress my own values. By following advice from Fourie (2010), I can ask probative questions and provide evidence-based reasoning to ensure that this couple is making the best decision for them. Indeed, should I provide

information that discourages polyamory (see Sheff, 2015), I should also be prepared with other scientific writing that may support polyamory (see Ferrer, 2019). Self-determination theory requires that the counselor provide information so that the patient(s) can choose whatever is best for them. I personally abhor polyamory, but that is irrelevant.

In addition to withholding value judgments, it is also necessary for a counselor to empathize. In a Wittgensteinian approach to moral advice and moral judgment, that is often what people need most: validation of their struggle, and a person to struggle with them (De Mesel, 2014).

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