HANDBOOK OF COUNSELING PSYCHOLOGY

FOURTH EDITION

Edited by

Steven D. Brown

Robert W. Lent

John Wiley & Sons, Inc.

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To Linda Heath for years of love, friendship, and good humor; Zachary and Kathryn Brown for their support and myriad ways for keeping life interesting; Elma and Irvin Brown for always believing in me; René Dawis and Lloyd Lofquist for serving as exceptional scholarly role models early in my career; Suzette Speight and Liz Vera for being such professionally stimulating and supportive colleagues; and my students for their invaluable contributions to our work together.

S. D. B.

To Ellen and Jeremy, who taught me that work has its place but, at the end of the day (and all during the day), nothing beats family; Rich Russell, for being my advisor, mentor, "big brother," and friend; Ohio State's counseling psychology program, for being the graduate training powerhouse it was; my colleagues at Maryland, for continually inspiring me with their dedication to scholarship and practice; my advisees, for their infusion of curiosity and energy; and Howie Gresh, my Coney Island pal, for keeping me laughing for 50 years.

R. W. L.

Contents

Preface

This edition of the *Handbook of Counseling Psychology,* like all three prior editions, has three primary objectives: (1) to provide a scholarly review of important areas of counseling psychology inquiry, (2) to elaborate directions for future research, and (3) to draw specific suggestions for practice that derive from the scholarly literature in counseling psychology and related disciplines. Also, as in the third edition, we asked authors, as much as possible, to report effect sizes and to use these, and published meta-analyses, to draw inferences about the current state of knowledge in the field, to suggest questions for future investigation, and to derive practice implications. We are pleased to see that the research literature on topics addressed in this edition had advanced sufficiently so that, in many cases, our authors could use meta-analyses and report effect sizes to summarize their literature and draw implications. We are also pleased that many authors calculated and reported effect sizes when preexisting meta-analyses were not available.

Despite the broad continuities with prior editions, this edition departs from the others in significant ways. First, as readers of past editions will notice, there are more, but shorter, chapters in this edition. Our decision to include shorter chapters on more focused topics was solidified by an email survey we conducted with the membership of the Society of Counseling Psychology. Our goals were to capture advances in a wider range of the field while allowing authors to cover circumscribed topics in reasonable depth. We hope readers find this choice to be a good one. We thank our authors for trying so hard to follow length guidelines (not an easy task) and for their graciousness when difficult decisions had to be made to reduce their text to page limits.

The section topics and their ordering also depart from earlier editions. Part I of this edition, a *Handbook* mainstay, covers important current professional and scientific issues, but many of the topics in this edition are new and reflect important emerging professional trends. The coverage in this section was largely suggested to us by our survey of Division 17 members. Topics that were mentioned frequently included the new APA ethics code; managed care and prescription privileges; the growing use of technology in research, assessment, and counseling; the international growth of counseling psychology; social justice issues; and the growing attention to positive psychology. Each of these topics is covered in Part I.

The subsequent three sections cover important research in the most active areas of counseling psychology inquiry over the past 10 years. Brent Mallinckrodt, in response to our e-mail survey, kindly provided us with a content (key word) analysis of research published in the *Journal of Counseling Psychology* and *The Counseling Psychologist* since the publication of the third edition of this *Handbook*. The results revealed that the most active areas of counseling psychology research in this time frame were, in order, multicultural psychology, counseling and supervision process and outcome, and vocational psychology. These topics, therefore, are covered in Part II (multicultural psychology), Part III (counseling and supervision), and Part IV (vocational psychology) of this edition.

Part V covers topics on development and prevention. Although Brent Mallinckrodt's content analysis did not reveal that prevention per se engages the research attention of large numbers of counseling psychologists, it did show that many in our field are interested in health and disease, suicide, substance abuse,

eating disorders, and school violence. Because we continue to believe that development and prevention are of historic and contemporary significance to counseling psychology, we decided to include chapters on each of the preceding topics, but to ask authors to take a preventive rather than remedial-treatment approach to them. These topics are complemented by two promotion-oriented chapters on resiliency interventions for at-risk youth and interventions to promote positive development and competencies. We hope the chapters in Part V will stimulate readers to give renewed thought to promoting positive development and resiliency and preventing (rather than only treating) psychological and health-related problems.

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We have many people to thank for their help throughout this project. First, we thank the many Division 17 members who responded to our email survey. Their suggestions were invaluable in helping us create a volume that spoke as much as possible to the current interests and concerns of those working in our field. Second, we thank Brent Mallinckrodt for going above and beyond what we had asked for in the survey. His content analysis gave us an excellent picture of contemporary counseling psychology research and provided us with an empirical basis for organizing this edition of the *Handbook*. Third, we are indebted to topic experts who took time out of their busy schedules to help us consider what to include in each Part. After deciding on the main sections and developing a preliminary set of chapter topics in each section, we emailed experts in each area (often multiple times) for input and suggestions about content and possible authors. The ultimate set of topics covered in each Part owes much to the thoughtful suggestions of Consuelo Arbona, Fred Borgen, Jean Carter, Ruth Fassinger, Nadya Fouad, Charlie Gelso, Paul Gore, Puncky Heppner, Clara Hill, Mary Ann Hoffman, Fred Leong, Jim Lichtenberg, Brent Mallinckrodt, Matt Miller, Laurie Mintz, Karen Multon, Karen O'Brien, Joe Ponterotto, Jim Rounds, Mark Savickas, Derald Wing Sue, Terry Tracey, Liz Vera, and Bruce Wampold.

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As always, we thank our families for their patience, support, and inspiration. We could not have completed this edition of the *Handbook* without them. Finally, we thank each other. Although a bit out of the ordinary for an acknowledgment, we've had, and continue to have, a heck of a professional run together based on mutual respect, complementary talents, and a long-lasting friendship—three characteristics that have sustained our professional collaborations and have, for each of us, enhanced our lives in innumerable ways.

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PART I

Professional and Scientific Issues

CHAPTER 1

Legal and Ethical Issues Affecting Counseling Psychologists

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

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

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

RISK MANAGEMENT

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

Informed Consent

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

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

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

Documentation

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

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

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

Consultation

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

Ethical Decision-Making Models

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

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

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

An Example of Risk Management

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

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

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

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

COMPETENCE

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

Movement to Define Competencies

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

Ethics Competence

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

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

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

Multicultural Competence

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

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

Faculty and Supervisor Competence

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

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

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

Persons with Competence Problems

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

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

Graduate Students with Competence Problems

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

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

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

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

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

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

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

Professional Competence

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

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

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

Self-Care

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

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

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

CHALLENGING ETHICAL SITUATIONS

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

Conflicts between Professional Ethics and the Demands of Employers

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

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

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

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

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

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

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

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