

Article 2

Highlights of the 2005 ACA Code of Ethics

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The American Counseling Association recently adopted a new *Code of Ethics*, effective July 1, 2005. For a code of ethics to be useful to a group of professionals, it must be a living document, one that is updated to reflect changes in society and the profession. The process of revising a code affords professional organizations an opportunity to examine current practices and clinical, social, and ethical issues faced by its members. Since ACA, then the American Personnel and Guidance Association, adopted its first *Code of Ethics* in 1963, the *Code* has been revised approximately every 7 to 10 years. The purpose of this article is to provide a brief overview of the revision process and some of the changes that were made to the 1995 *Code of Ethics and Standards of Practice*.

Revision Process

In 2002 David Kaplan, then ACA president, appointed the following members to serve on the ACA Ethics Code Revision Taskforce: John Bloom, Tammy Bringaze, Rocco Cottone, Harriet Glosoff, Barbara Herlihy, Michael Kocet (Chair), Courtland Lee, Judy Miranti, Christine Moll, and Vilia Tarvydas. The taskforce members were assisted by two doctoral students, Anna Harpster and Michael Hartley, who served as note-takers during the process.

The revision process took approximately 3 years, with taskforce members initially meeting for telephone conference calls approximately once a month. The committee communicated regularly between meetings by e-mail and worked in subcommittees to review sections of the *Code* and to draft recommended changes. The entire group discussed all recommendations and made revisions to each section. As they continued in their work, the taskforce members met at least biweekly to create a draft code of ethics that was published in *Counseling Today* and posted on the ACA Web site. ACA provided members with the opportunity to provide feedback to the taskforce. In addition, the taskforce sought guidance from ACA leadership and from outside experts as they worked on sections of the draft. Finally,

ACA sponsored town hall meetings at the 2004 and 2005 national conventions during which ACA members met with the taskforce, discussed highlights of the draft document, and provided feedback.

In comparing the 1995 *Code of Ethics and Standards of Practice* and the 2005 *ACA Code of Ethics*, readers will note many differences. It is beyond the scope of this article to present a comprehensive comparison of the two documents. Instead, we call your attention to a few major differences in the 2005 *ACA Code of Ethics*.

Introduction to the Code of Ethics

The 2005 *ACA Code of Ethics* consists of the same eight main sections as the 1995 document with some changes in the titles. Following are the eight areas with differences in the titles of the 1995 sections, if any, in parentheses:

- A. The Counseling Relationship;
- B. Confidentiality, Privileged Communication, and Privacy (Confidentiality);
- C. Professional Responsibility;
- D. Relationship With Other Professionals;
- E. Evaluation, Assessment, and Interpretation;
- F. Supervision, Training, and Teaching (Teaching, Training, and Supervision);
- G. Research and Publication; and
- H. Resolving Ethical Issues.

Readers of the new *Code* will notice there is no longer a reference to Standards of Practice, which was part of the title of the 1995 document. The intent of the Standards of Practice was to offer a concise outline of minimum expectations for ethical behaviors, more behavioral than aspirational in nature. Rather than finding the Standards helpful, however, individuals found these confusing in terms of using the document in their day-to-day lives and their ethical decision-making processes. Further, people were unclear of how the Standards of Practice were used in adjudication of

accused violations of the *Code of Ethics*. Based on feedback, the Standards of Practice were integrated into the body of the 2005 *Code*.

Preamble and Purposes

The Preamble has been updated to address issues of cultural context and values that inform the development and interpretation of the 2005 *Code*. In addition, another new feature of the *Code* is the section that outlines five main purposes of the *ACA Code of Ethics* as follows: (1) to enable the association to clarify to current and future members, and to those served by members, the nature of the ethical responsibilities held in common by its members; (2) to support the mission of the association; (3) to establish principles that define ethical behavior and best practices; (4) to serve as an ethical guide designed to assist members in constructing a professional course of action that best serves those utilizing counseling services and best promotes the values of the counseling profession; and (5) to serve as the basis for processing of ethical complaints and inquiries initiated against members of the association. In presenting the purposes of the 2005 *Code*, ACA includes a discussion of the new introductions to each section.

The introductions now found at the beginning of each of the eight sections are meant to set a tone for each section. Each introduction “helps set the tone for that particular section and provides a starting point that invites reflection on the ethical mandates contained in each part of the *ACA Code of Ethics*” (ACA, 2005, p. 3). In addition to asking counselors to reflect on ethical mandates presented in the *Code*, the new introduction to the *Code* notes that counselors should recognize that there are reasonable differences of opinion regarding which values, ethical principles, and ethical standards should be applied when faced with ethical dilemmas. Counselors are now expected to be familiar with a credible model of ethical decision making that “can bear public scrutiny and its application” (ACA, 2005, p. 3).

One charge given to the taskforce by the ACA Governing Council was for the members to draft recommended changes to the 1995 *Code* with special (but not exclusive) consideration of cultural and social justice issues faced by counselors in today’s complex world. Before presenting a few highlights of changes in each of the eight sections, we briefly review some ways that cultural issues are infused in the 2005 *Code*.

Multicultural and Diversity Issues

As noted, an important component threaded through the 2005 *ACA Code of Ethics* is an emphasis

on multicultural and diversity issues facing counseling professionals. The majority of introductory statements speak specifically to ethical obligations of counselors to consider cultural contexts related to the standards in the related sections. For example, the introduction to Section G, Research and Publications, ends with “Counselors minimize bias and respect diversity in designing and implementing research programs” (ACA 2005, p. 16).

Following are just a few examples of ways in which issues of culture, diversity, and social justice are addressed in the new *ACA Code of Ethics*. Standard A.1.d. was changed from “Family Involvement” to “Support Network Involvement” and broadens the concept of family to include any person from the perspective of the client who plays a central role in that person’s life. New Standard A.10.e. Receiving Gifts states that “Counselors understand the challenges of accepting gifts from clients and recognize that in some cultures, small gifts are a token of respect and showing gratitude.” The 2005 *Code* also brings attention to the need for counselors to be aware of and sensitive to cultural meanings of confidentiality and privacy as well (see Standard B.1.a. Multicultural/Diversity Considerations). Just one more example of the recognition of how cultural and social issues affect the counseling relationship is the new Standard E.5.c., which directs counselors to “recognize historical and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups and the role of mental health professionals in perpetuating these prejudices through diagnosis and treatment.” We now briefly highlight some other changes and new standards in each of the sections.

Section A

ACA made several additions to this section. The standards related to boundary issues between counselors and clients and counselors and former clients seem to reflect a paradigm shift that is taking place in the counseling profession. Previously, there was an emphasis on the need to avoid any type of nonprofessional relationship with clients with no recognition that not all types of “dual relationships” may be harmful. The 2005 *Code* contains a new standard, A.5.d., which speaks, albeit with cautions, to potentially beneficial interactions between counselors and clients that go beyond the traditional professional counseling relationship. Please consult Standard A.5.d. to learn more about potentially beneficial relationships and factors that should be considered. Another change related to boundary issues is in Standard A.5.b., which changes the prohibition on having sexual or

romantic relationships with former clients from 2 to 5 years while expanding the language to include such relationships with romantic partners or family members of former clients.

A significant addition to the 2005 *ACA Code of Ethics* is Section A.9., which provides guidance to counselors serving clients who are terminally ill. The American Counseling Association is one of the few national mental health organizations to specifically address end-of-life care in its *Code of Ethics*. In doing so, ACA does not endorse one way of approaching this sensitive issue. Rather it directs counselors to take measures that enable clients

1. to obtain high quality end-of-life care....;
2. to exercise the highest degree of self-determination possible;
3. to be given every opportunity to engage in informed decision making regarding their end-of-life care; and
4. to receive complete and adequate assessment regarding their ability to make competent, rational decisions on their own behalf from a mental health professional who is experienced in end-of-life care practice. (A.9.a., p. 5)

Counselors facing end-of-life issues are also ethically responsible for seeking supervision and consultation to help clients receive competent care from a wide range of professionals.

Section A.12. Technology Applications greatly expands on the same section in the 1995 *Code*. ACA integrated the *Ethical Standards for Internet Online Counseling* adopted by ACA in 1999 into the new Section A.12. and broadened the ethical use of technology in research, record keeping, and the provision of services to consumers.

Section B

One major change in Section B is an increased discussion of privacy and confidentiality when working with clients who are minors or adults who cannot give informed consent. Standards B.5.a., B.5.b., and B.5.c. outline the need for counselors to protect the confidentiality of such clients and to include clients in decisions about the disclosure of confidential information while being “sensitive to the cultural diversity of families” and respecting “the inherent rights and responsibilities of parents/guardians over the welfare of their children/charges.” Counselors are expected to “work to establish, as appropriate, collaborative relationships with parents/guardians to best serve clients.”

Although we cannot review all the changes in Section B, there are two that we want to bring to the attention of readers. First, Standard B.3.f., also new to the 2005 *Code of Ethics*, reminds counselors that they are required to protect the confidentiality of deceased clients. Second, there is a significant change related to family counseling. Standard B.2.b. (Family Counseling) of the 1995 *Code* stated that “...information about one family member cannot be disclosed to another member without permission. Counselors protect the privacy rights of each family member.” Standard B.4.b. of the 2005 *ACA Code of Ethics*, now called Couples and Family Counseling, addresses the need of counselors to “clearly define who is considered ‘the client’ and to discuss expectations and limitations of confidentiality” and to “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.”

Section C

More detailed language was added to this section on counselor impairment in Standard C.2.g. In addition to counselors being responsible to seek assistance for problems that reach the level of professional impairment, we are now also ethically obligated to “assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted.” In addition, a section was added that addresses the importance of all counseling professionals, regardless of setting, to create a plan for the transfer of clients and records to an appropriate colleague in the event of a counselor’s incapacitation, death, or termination of practice (Standard C.2.h.).

Another addition to the *ACA Code of Ethics* is Standard C.6.e. Scientific Bases for Treatment Modalities. Although the 1995 *Code* directed counselors to monitor their effectiveness, it did not speak to our responsibility to base techniques and treatment plans on theory and/or empirical or scientific results. Standard C.6.e. further states that “counselors who do not must define the techniques/procedures as ‘unproven’ or ‘developing’ and explain the potential risks and ethical considerations of using such techniques/procedures and take steps to protect clients from possible harm.”

Section D

Counselors across work settings are often part of interdisciplinary teams. There are several new standards that address responsibilities to develop and strengthen relationships with colleagues from other disciplines to

best serve clients (Standard D.1.b.); to keep the focus on the well-being of clients by “drawing on the perspectives, values, and experiences of the counseling profession and those of colleagues from other disciplines” (Standard D.1.c.); and to clarify professional roles, parameters of confidentiality, and ethical obligations of the team and its members (Standards D.1.d., D.1.e.).

Section E

One noteworthy change in this section is the terminology used. For example, the word *tests* used in the 1995 *Code* has been replaced with the word *assessment*, which has a broader, more holistic meaning. There are two other significant changes from the 1995 document. The first is the addition of Standard E.5.c., which we previously discussed. The second is the acknowledgement that over the past 10 years, counselors have increased their presence in legal proceedings including forensic evaluations. This led to the inclusion of new Standards E.13.a. through E.13.d. that address the need for counselors to understand their primary obligations when conducting forensic evaluations, how these obligations differ from those involved in counseling, and their responsibility to explain this to clients. The new standards also prohibit counselors from conducting forensic evaluations with clients they are counseling or have counseled and to “avoid potentially harmful professional or personal relationships with family members, romantic partners, and close friends of individuals they are evaluating or have evaluated in the past” (Standard E.13.d.).

Section F

This section has been reorganized since 1995 and greatly expanded in terms of noting ethical obligations of counselors who supervise counseling students, trainees, and staff. It now includes many of the standards noted in the 1993 *Ethical Guidelines for Counseling Supervisors* published by the Association for Counselor Education and Supervision (a division of ACA). Section F focuses on counselor supervision and client welfare across settings, informed consent in the supervisory relationship, competence of counseling supervisors, supervisor responsibilities, potentially harmful and beneficial relationships between supervisors and supervisees and between faculty members and students, student welfare and orientation, self-growth experiences, impairment of counseling students and supervisees, ethical evaluation of the performance of supervisees and students, and endorsement of supervisees and students. The changes

are too substantial to review in this article, and we encourage counselors, supervisors, supervisees, counselor educators, and counseling students to closely review this section.

Section G

Readers will notice that the term *research subjects* used in the 1995 *Code of Ethics and Standards of Practice* has been replaced with the term *research participants*, meant to be more inclusive and less clinically detached. This section provides guidance to counselors in the appropriate handling of records during the research process, informed consent with research participants, and confidentiality of people involved with research projects. Although research is often conducted by faculty members of counselor education programs, there are counselors practicing in a variety of settings who also engage in research. According to new Standard G.1.c., when these “independent researchers do not have access to an Institutional Review Board (IRB),” they have an ethical obligation “to consult with researchers who are familiar with IRB procedures to provide appropriate safeguards” for research participants. Section G also addresses issues related to publication. There is a new standard specifically stating that counselors do not plagiarize the work of others (Standard G.5.b.). In addition, Standard G.4.e. from the 1995 *Code*, which addressed the professional review of material submitted for publication, has been expanded in the new Standard G.5.h.

Section H

The 2005 *ACA Code of Ethics* provides greater clarity to counselors about ways to address potential conflicts between ethical guidelines and legal requirements. Standard H.1.b. notes that in such situations, counselors “make known their commitment to the *ACA Code of Ethics* and take steps to resolve the conflict. If the conflict cannot be resolved by such means, counselors may adhere to the requirements of law, regulations, or other governing legal authority.” Another change in this section is the expanded list of potential agencies/organizations to which information regarding suspected or documented ethical violations may be reported to include “state or national committees on professional ethics, voluntary national certification bodies, state licensing boards, or . . . the appropriate institutional authorities” (Standard H.2.c.). Finally, there is a new standard (H.2.g.) that protects the rights of ACA members who have made or been the subject of an ethics complaint.

Conclusion

As previously mentioned, our intent in writing this article is to provide a brief overview of the revision process and a general overview of some changes that were made to the 1995 *Code of Ethics and Standards of Practice*. We believe it is critical for counselors, as well as an ethical obligation, to thoroughly review the entire 2005 *ACA Code of Ethics* to understand how to apply the new *Code* to their day-to-day practice. No code of ethics can address any and all situations that counselors may face. Consulting with ethics experts in the field on specific standards, therefore, becomes quite important. One way of doing this is to ask the ACA Ethics Committee for a formal interpretation of the 2005 *ACA Code of Ethics* by submitting a scenario and question(s) about specific standards to the ACA Ethics Committee staff liaison.

References

American Counseling Association. (1995). *Code of ethics and standards of practice*. Alexandria, VA: Author.

American Counseling Association. (2005). *ACA Code of ethics*. Alexandria, VA: Author.