

**Counseling Students: Perceptions of Problematic Behaviors,  
Self-Care and Related Training**

by

Amanda Marie Thomas

A dissertation submitted to the Graduate Faculty of  
Auburn University  
in partial fulfillment of the  
requirements for the Degree of  
Doctor of Philosophy

Auburn, Alabama  
August 9, 2010

Keywords: problematic behaviors, self-care, duty to warn

Copyright 2010 by Amanda Marie Thomas

Approved by

Jamie Carney, Chair, Professor of  
Special Education, Rehabilitation, Counseling/School Psychology  
David Shannon, Professor of  
Educational Psychology Program  
Karen Rabren, Associate Professor of  
Special Education, Rehabilitation, & Counseling/School Psychology

## Abstract

The purpose of this study was to examine student awareness and frequency of self-reported problematic behaviors, self-care practices, and related training experiences. Participants were randomly selected from regionally represented community and school counseling programs through a faculty representative. Eighty-four subjects from CACREP and Non-CACREP accredited programs completed the Awareness of Problematic Behavior survey, created by Dr. Jamie Carney. The survey focused on counseling students self-report related to issues including problematic behaviors, self-care practices, and related training experiences. Responses were analyzed and subjected to reliability assessment, correlation analysis, and descriptive review to determine significance. Although no significant differences resulted related to problematic behaviors and self-care or problematic behaviors and exposure to training programs, there was a relationship in reported self-care training and problematic training experiences suggesting that subjects who received self-care training, likely received problematic behavior training. All subjects reported practicing self-care. Qualitative responses obtained in this study offers information related to self-reported behavioral indicators. Findings from this study provide new and current information related to problematic behaviors, self-care practices, and academic training program trends.

## Acknowledgments

If I am part of all that I have met, then I would like to take this opportunity to thank the people who have contributed. First and foremost, thanks to my soul-mate and soon-to-be husband, Chad who reminds me to follow God's plan, think before I speak, and to be grateful for what I have. To my parents, Fred and Marilyn, who nourished and encouraged my potential before I ever knew it even existed. Thank you for helping me to reach for the stars!

I also want to express my gratitude and deep appreciation to Dr. Jamie Carney who is my advisor, professor and most importantly my mentor. Dr. Carney has showed me how to be the kind of professional woman that I aspire to be. Thank you also to Dr. David Shannon and Dr. Karen Rabren who offered help and support in every step of this dissertation process. I could not have asked for a better or more knowledgeable team of advisors. From the bottom of my heart - thank you.

## Table of Contents

Abstract .....	ii
Acknowledgments.....	iii
List of Tables .....	v
I. Introduction .....	1
Rationale .....	1
Significance of Study.....	2
Purpose of Study.....	3
Research Questions.....	4
Operational Definition .....	4
Summary.....	5
II. Literature Review .....	6
Introduction.....	6
Problematic Behaviors in the Profession .....	9
Problematic Behaviors in Academia.....	15
Self-Care and Academia .....	22
Summary .....	26
III. Methodology .....	27
Introduction.....	27
Research Questions.....	27

Participants.....	27
Instruments.....	28
Procedures.....	30
Data Analysis .....	31
Summary .....	32
IV. Results.....	33
Introduction.....	33
Participants.....	34
Reliabilities .....	36
Results.....	36
Summary .....	50
V. Discussion .....	51
Introduction.....	51
Quantitative Analysis.....	52
Qualitative Analysis.....	53
Limitations .....	54
Recommendations for Future Research.....	55
Implications.....	56
Summary .....	60
References .....	61
Appendix A    Hippocratic Oath .....	70
Appendix B    American Counseling Association Code of Ethics .....	72

Appendix C	Published Studies on Common Factors Associated with Student Unsuitability in Social Science Programs.....	92
Appendix D	American Personnel and Guidance Association Code of Ethics.....	95
Appendix E	Awareness of Problematic Behavior Survey .....	101
Appendix F	Information Sheet.....	108
Appendix G	Auburn University Institutional Review Board Approval to Conduct Study Email.....	110
Appendix H	Lenoir-Rhyne Institutional Review Board Approval to Conduct Study Email .....	112
Appendix I	Recruitment Email .....	114

## List of Tables

Table 1	Demographic Information Overall.....	35
Table 2	Descriptive Information Self-Care Practices .....	37
Table 3	Descriptive Information Experienced Problematic Behavior .....	40
Table 4	Coded Behavioral Indicators Associated with Problematic Behaviors .....	42
Table 5	Descriptive Information on Received Self-Care Training .....	46
Table 6	Descriptive Information on Received Problematic Training.....	47
Table 7	Bivariate Correlations between Self-Care Practices, Self-Care Training, Problematic Behavior Training and Problematic Behaviors.....	48
Table 8	Regression Analysis of Predictors Self-Care, Self-Care Training and Problematic Training with Criterion Problematic Behavior .....	49
Table 9	Correlation Coefficients of Self-Care, Self-Care Training and Problematic Training.....	49

## CHAPTER I. INTRODUCTION

This study explored student self reports of problematic behaviors, self-care practices and training experiences. Analysis was conducted to assess masters-level graduate student's ability to identify problematic behaviors within themselves. The purpose was to explore whether counselors-in-training possess the knowledge and training to demonstrate self-awareness in an effort to prevent problematic behaviors. Individual self-care is a skill necessary in preventing harm to oneself, clients, and society-at-large. Assessing graduate students' ability to demonstrate self-care and self-awareness of problematic behaviors will be helpful in program development and advocacy initiatives.

### **Rationale**

The Hippocratic Oath (see Appendix A), "above all, do no harm," has been adopted by the counseling profession and may be found in the American Counseling Association's (ACA) *Code of Ethics* (see Appendix B). In adherence to this concept of nonmaleficence, one of the five moral principles to ethical counseling practice (Kitchener, 1986), several ethical guidelines have been developed to identify and promote the avoidance of harm within the profession (ACA, 2005). This no harm concept, in many cases, is first introduced to students during graduate instruction as counselors-in-training become more acquainted with the counseling profession. Oftentimes, graduate students are advised to avoid legal infractions by becoming aware of their responsibility to attend to a client who poses a threat to one self or others as this is an ethical



concern whereby the practitioner is bound by a duty to warn the appropriate authorities (Gross & Robinson, 1987).

This duty to avoid harm also extends personally to the counselor who is ethically obligated to monitor their own and their peers behaviors and report if needed (ACA, 2005). All professionals within the counseling community are required by ethical standards to identify and intervene when problematic behaviors arise whether these behaviors are presented by the individual themselves or a colleague. Counselors-in-training and professionals alike may struggle with their role as a gatekeeper and can be resistant to report a problematic peer because of the potential for negative repercussions. In response to this pressure, Kitchener (1986) advised educators to model appropriate behaviors so that students can observe the difficult choices associated with behaving ethically. Demonstration of ethical decision-making and related behaviors, allows students to increase their understanding of the gatekeeper role. Additionally, course content that exposes students to healthy and appropriate self-care practices may function as a preventive measure to reduce the persistence of problematic behaviors during academic enrollment. “The need is not for more unethical behavior charges brought up for punishment, but for an awareness and a willingness to support ways to treat early signs” (Emerson & Markos, 1996, p. 110).

### **Significance of Study**

Currently there is a dearth of research on self-reported problematic behaviors; however, there is some research available that considers faculty and supervisor evaluations of said behaviors. Previous research has indicated that problematic behaviors have been noted in graduate students, practitioners, supervisors and educators by colleagues and peers (Burgess, 1995; Lamb & Swerdlik, 2003; Mearns & Allen, 1991). In regard to self-perceived deficiencies,

student perception of problematic behaviors related to the self has not been considered.

Although there is some evidence of research applicable to the study of problematic students from the perspective of educator and peers, many of these significant findings were published between five and ten years ago suggesting that this specific topic would benefit from more recent research (see Appendix C). In response to the absence of current research, this study focused on student self-reports of problematic behaviors, self-care practices, and related training experiences.

This study obtained data in an effort to explore individual self-reports related to problematic behaviors. This topic is especially significant when considering program development and advocacy initiatives. As counselors-in-training are learning to become clinical practitioners, it only seems natural that students are introduced to problematic behaviors and the ethically sanctioned regulations to prevent harm. This study assessed student knowledge and current academic training practices. Upon analysis of the data, all subjects reported practicing self-care behaviors to some degree. Results indicated that there is not a significant relationship between the practice of self-care and the presence of problematic behaviors. However, there is a significant relationship between problematic behavior training as a predictor variable on self-reported problematic behaviors. The data did report a significant relationship between self-care training and problematic behavior training suggesting that students who received training on one of the topics likely received training on the other. It is believed that the outcome data obtained in this study will provide additional information regarding indicators associated with problematic behaviors, the frequency of experienced problematic behaviors, and current training practices.

### **Purpose of Study**

The purpose of this study was to: (1) examine counselors-in-training self-reported experiences related to problematic behaviors; (2) consider the frequency of self-care practices

utilized by counselors-in-training; and (3) explore whether graduate students are receiving training related to self-care and problematic behaviors.

### **Research Questions**

In an attempt to explore counseling students' awareness of problematic behaviors, self-care practices, and related training experiences, the following questions will be investigated.

1. What self-care behaviors do counselors-in-training use?
2. What is the nature of problematic behaviors that counselors-in-training identify personally?
3. What behavioral indicators do counselors-in-training identify as experiencing problematic behavior?
4. What training have counselors-in-training received on self-care?
5. What is the relationship between self-care practices, self-care training and problematic behavior training with the number of reported problematic behaviors?

### **Operational Definitions**

To facilitate general comprehension, the specific terminology used within this study will be defined. These terms are consistent with generally accepted definitions within the scholarly literature available.

*Problematic behavior:* when a practitioner is functioning at a below acceptable standard influenced by either deficient clinical skills or psychological limitations potentially causing damage to clients, students, supervisees, colleagues or society-at-large (Kress & Protivnak, 2009).

*Self-monitoring*: the realistic awareness of one's own abilities. A higher level of competence implies that the individual makes more accurate assessments of oneself (Snyder, 1974).

*Self-care*: "a holistic approach toward preserving and maintaining our own wellness across domains" (ACA, 2004, [http://www.counseling.org/wellness\\_taskforce/tf\\_wellness\\_strategies.htm](http://www.counseling.org/wellness_taskforce/tf_wellness_strategies.htm)).

### **Summary**

In closing, this study explored problematic behaviors using masters-level counselor-in-training student self-reports. Counseling students were prompted to disclose information regarding personal experiences of problematic behaviors, self-care practices utilized, and if they had received training on identifying problematic behaviors. Ultimately assessing graduate students' ability to demonstrate self-care and self-awareness of problematic behaviors can assist in initiatives to train and evaluate students.

## CHAPTER II. LITERATURE REVIEW

### **Introduction**

The Hippocratic Oath, “above all, do no harm,” has been adopted by the counseling profession as a basic tenant to ethical therapeutic practice (ACA, 2005B; NBCC, 2005) and academic instruction (CACREP, 2009; ACES, 1991). This concept, in many cases, is first introduced during graduate instruction as students become more acquainted with the counseling profession. Due to prior litigation, a client who poses a threat to one self or others is an especially serious liability, as the practitioner is bound by a duty to warn the appropriate person(s) (Gross & Robinson, 1987). This duty to warn concept also extends to the counselor who is ethically obligated to report and monitor their own and peers behaviors (ACA, 2005).

Researchers have transitioned from using the term impaired to problematic. The term problematic is preferred because it suggests that the individual is functioning at a below acceptable standard potentially causing damage to clients, students, supervisees, colleagues or society-at-large (Kaslow, Mitnick, & Baker, 2002; Kress & Protivnak, 2009; Rosenberg, Getzelman, Arcinue, & Oren, 2005). Previously, research employed the term impaired which seemed to imply that the individual-in-question could be remediated (Kaslow, et al., 2002; Lawson & Vernart, 2005; Rosenburg, Getzelman, Arcinue, & Oren, 2005; Sheffield, 1996; Wilkinson, 2006). Not all problematic behavior can be eliminated and there are times when a counselor is ill-advised in providing continued counseling services (Frame & Stevens-Smith, 1995, Lamb, Presser, Pfof, Baum, Jackson, & Jarvis, 1987). Thus, the use of the word impaired

seemed to misrepresent a sample of individuals. Not to mention, the term impaired may also suggest that the individual has a disability. According to the Americans with Disabilities Act, (ADA, 1990) individuals who are impaired should receive the necessary accommodations in order to provide competent care. Overlooking a counselor's negative professional behavior or excusing problematic behavior as a disability could potentially lead to harm, thereby causing a serious ethical violation. Thus, the term problematic has been selected in an effort to delineate from the concept of impairment that was previously confusing. In this context, the presence of a problematic behavior proposes that the individual functions as a liability and is thereby not a suitable candidate for the counseling profession.

Harm may be conceptualized as damage to the client or society-at-large. For example, a counselor-in-training who refuses to work with a specific client population because the group represents a non-preferred client demographic may choose to not offer services based on their individual, moral convictions. This action could potentially cause harm through abandonment (4.11.a), personal values (A.4.b), and appreciation of diversity (B.1.a.) (ACA, 200b). Huprich and Rudd (2004) noted that problematic behaviors in clinicians are an increasing concern as the profession continues to develop because a formalized method to evaluate negative behaviors is not readily available. One especially challenging issue regarding this topic is that the terms self-monitor or evaluate can be perceived as ambiguous because a consensually accepted definition is not yet available (Hermon & Hazler, 1999; Welfel, 2005). As researchers continue to identify and address problematic behaviors that can interfere with the counseling process, valuable information can be gleaned that could lead to the provision of improved counseling services. Furthermore, it seems that the counseling professions relationship with problematic behaviors at this time is more rehabilitative than preventative in function (Frame & Stevens-Smith, 1995;

Olsheski & Leech, 1996; Emerson & Markos, 1996; Young & Lambie, 2007). This suggests that action in response to a problematic behavior takes place once the damage has occurred and been disclosed to regulating bodies which seems counterproductive to the basic tenants of the counseling profession of avoiding harm. Examining these empirical findings encourages more professionally supported ethical-decision making practices, advocacy initiatives and preventative measures to assure that the Hippocratic Oath is upheld on the front end.

Some problematic behaviors are more damaging than others. For example, a counselor who engages in a sexual relationship with a client is considered to have violated the ethical standards and would likely receive legal and professional consequences for their inappropriate behavior (ACA, 2005). Despite severity, some behaviors may be considered problematic but are not as damaging as the previously described sexual/dual relationship. Such examples of a less serious ethical infraction may be when a counselor discusses with a non-counseling friend information regarding a client (i.e., presenting problem, personal experiences) in the absence of a collaborative/consultative relationship (Welfel, 2005).

Research conducted by Sherry, Teschendorf, Anderson and Guzman (1991) found that the majority of polled mental health professionals admitted to committing an ethical infraction either deliberately or unknowingly. Although these negative behaviors may interfere with the counseling process, a standardized method to prevent their occurrence is not available. "It is the subtle, but nonetheless damaging impairments that puzzle us, make us wonder when to speak up, when to confront, and when to mind our own business" (Emerson & Markos, 1996, p. 109).

Counselors are to self-monitor against problematic behaviors despite the degree of client harm (ACA, 2005). In this context, self-monitoring will be described using Synder's (1974) definition and considers the awareness of one's own knowing. The capacity to self-monitor

connotes a high level of competence and suggests that the individual is able to make accurate assessments of their own abilities. Thus, an individual who does not engage in self-monitoring practices exhibits a lower level of proficiency and lacks the requisite knowledge to assess their skills (Synder, 1974). In consideration of the knowledge associated with self-monitoring, it seems ideal for counselors to practice techniques associated with regulating and identifying problematic behaviors.

### **Problematic Behaviors in the Profession**

First examined in the 1970s, impairment within the field of psychology was identified as difficulties exhibited by the practitioner that compromised clinical abilities causing legal and ethical intervention (Olsheski & Leech, 1996). Over the past thirty years, several professional organizations have expressed an interest in remediating impaired clinicians within the mental health field and include social workers, the American Counseling Association (ACA), the American Psychological Association (APA) and the American Medical Association (AMA) (Farber, Gilibert, Aboff, Collier, Weiner & Boyer, 1989). Consistency amongst professions as identified by Tarvydas, Leahy, and Saunders (2004) indicate that both Rehabilitation Counselors and Nationally Certified Counselors (NCC) agree that behaviors associated with professional competency warrant unethical practices. Behaviors commonly associated with professional incompetence include providing therapeutic services when not prepared, practicing while intoxicated, or not sharing the limits of confidentiality with the client. Although the discussed organizations have all worked independently to explore clinician deficiencies within the mental health field in an effort to avoid harm, there appears to be some general similarities between the recognition of professionally ethical and unethical behaviors.



The American Counseling Association, previously known as the American Association for Counseling and Development (AACD) and the American Personnel and Guidance Association (APGA); developed a committee concerned with providing ethical support within its first year of conception in 1952 and disseminated its first published APGA Ethical Code in 1961 (Gibson & Pope, 1993; Ponton & Duba, 2009) (see Appendix D). As evidenced in ACA's historical origins, the counseling profession has adopted an active position in ethical advocacy and guidance. Olshenski and Leech (1996) noted that ACA (nationally) and related state credentialing programs historically had a unique relationship because they worked together to improve their knowledge and awareness of problematic behaviors in the profession. This is noted by the preparation and consensually distributed ACA Code of Ethics, (2005) which identifies specific criteria related to ethical practice including professional responsibility to self-monitor and avoid harm. "Without a code of established ethics, a group of people with similar interests cannot be considered a professional organization" (Allen, 1986, p. 293).

More specifically, the ACA Code of Ethics addresses impairment in a variety of ways. First, the professional is reminded that they are to avoid harm (A.4.a; A.8.b). This means that counselors should not intentionally or negligently make their clients vulnerable to personal, emotional or psychological damage. Also, counselors should be aware of the symptoms associated with impairment and are to regulate their own and others behaviors if it is damaging (C.2.g). Clinicians, educators, students, and researchers all serve as gatekeepers to the profession and must uphold the ethical standards (F.1,a.; F.6.a). Additionally counselors are to monitor their own effectiveness and seek intervention as needed (C.2.d.; F.7.b.; F.8.b.). During academic matriculation, counselor educators are to inform and remind counselors-in-training of the ethical standards which include continual evaluation both academically and interpersonally

(F.9.a.). Throughout this continual evaluation, students who are unable to exhibit counseling skill competency must be remediated as indicated in the code (F.9.b.).

ACA developed this ethical code to serve as a guideline for professional behavior; however, critics report that the wording at times appears ambiguous or confusing. Thoroughly understanding these guidelines can make ethical decision-making difficult because practitioners may only be able to rely upon individual interpretation. A professional who is presenting with problematic behaviors might experience compromised judgment in regard to self-regulation as their skewed perception can lead to distorted interpretations and ethical disobedience.

Before merging ethical guidelines with ACA, the Association for Counselor Education and Supervision (ACES, 1991) advised supervisors to protect the welfare of clients by providing counselors-in-training with a knowledge of ethical codes when monitoring supervisee performance (1:01; 1:06; 2.a). Additionally, supervisors were to remind counselors of the ethical and legal implications associated with the profession (2.03). When faced with a student/supervisee with deficient skills, ACES recommended that the supervisor suggest professional development activities to promote growth (3.18); however, these activities to encourage self-awareness for the counselor-in-training were not to be provided by the supervisor so that they were able to continually evaluate student progress. In this system, the role of the supervisor is one of accountability for the counselors-in-training's decision making can be a liability to the supervisor.

The national board of certified counselors (NBCC), a credentialing agency that certifies professional counselors, has also developed an ethical code that strives to promote ethical behavior within the counseling profession. In these guidelines, certified counselors are reminded that they are to monitor peer behavior in accordance with the ethical standards (NBCC, 2005,

A:3). Thus, if a colleague is not acting in an ethical manner, the peer is to make the appropriate arrangements to protect the client's welfare. Section A:13 reports that counselors are to act in morally and legally appropriate manners in an effort to protect the profession. Furthermore, these guidelines stipulate that NBCC certified counselors are not to provide counseling services if they are not emotionally or mentally able to uphold a professional relationship or if they have breached an ethical infraction (NBCC, 2005, A:15). One particularly noteworthy ethical violation in the NBCC code occurs when the client's welfare is not protected as both the counselor (B:1) and/or supervisor (C:i) can be held responsible. In summary, it appears that NBCC endorses practitioner promotion of client welfare and requests that problematic clinicians discontinue providing services — whether that be self or peer regulated.

Despite the presence of several codes of ethics for counselors, the guidelines continue to appear vague and require additional interpretation. Although these guidelines were developed to assist in decision making, it appears that interpreting the code into realistic situations does not increase practitioner confidence (Gibson & Pope, 1993). Supporting this claim, research conducted by Walden, Herlihy, and Ashton (2003) of 15 former ACA Ethics Committee chairs found that, “respondents reported a sense of awe at the pervasiveness and complexity of ethical issues in the areas of ethical issues in counseling practice. They made frequent references to the constant blending of moral, value, and legal issues in the area of ethics” (Walden et al., 2003, p. 108). The ambiguous nature of the counseling code(s) of conduct can be quite challenging to new or inexperienced counselors-in-training who are attempting to navigate through the professional realm. Not to mention, ethical decision making may be further compromised if the counselor-in-training is unable to manage their own needs through continued self-monitoring. Complicating this matter is that ACA requires clinicians to monitor themselves against

impairment, however, protocol for managing a problematic counselor are not available (Sheffield, 1996).

Within the field of psychology, 39% of polled practitioners reported knowing of a fellow psychologist who suffered from substance addiction and 63%, of that same sample, stated that they knew a colleague who was presently experiencing symptoms associated with burnout (Wood, Klein, Cross, Lammers, & Elliott, 1985). Of polled practicing psychologists, 90% reported experiencing emotional distress related to their occupation (Guy & Liaboe, 1986). In psychology training programs, Vacha-Haase, Davenport, and Kerewsky (2004) found that the most frequently reported occurrences of problematic behaviors in students included deficient clinical skills (65%), resistance toward supervision feedback (52%), and interpersonal aversiveness (42%). Huprich and Rudd (2004) found that problematic students in clinical psychology are more frequently reported and dismissed in doctoral programs than internship. In consideration of substance use, of 158 polled faculty 25% reported knowing of a student who had, or currently has a substance abuse addiction (Scott & Stevens, 1998). These research studies seem to suggest that problematic behaviors in the profession and classroom are prevalent and a real concern to practitioners. Although undesirable professional have been identified, interventions to reduce these occurrences are less available.

In 1996, researchers projected that approximately 6,000 mental health counselors within the United States experienced impairment either mentally or emotionally (Kotler & Hazler, 1996). To further explore this phenomena within the profession, in 2003 ACA appointed a task force that focused on problematic behaviors in an effort to identify critical issues related to this ethical concern. Research participants were randomly selected ACA members (Lawson & Vernart, 2005). Survey responses indicated that 64% of participants had personal experience

with an impaired colleague (ACA, 2004). The study's results indicated that there is a need for a growing awareness of impairment within the profession; thereby three general categories were developed to address problematic behaviors within the profession (Lawson & Vernart, 2005). These three categories are (1) impairment prevention and resiliency education, (2) resources, interventions, and treatment for impaired counselors and (3) advocacy (Lawson & Vernart, 2005).

Research suggests that professionals are hesitant to confront a problematic peer (Scott & Stevens, 1998) due to a variety of reasons including the fear for negative repercussions, differing sensitivities amongst professionals making problematic behaviors more detectable to some, or difficulties interpreting one's role in the ethical guidelines (Kitchener, 1986). "Most colleagues in any profession are hesitant to report behavior that seems to be unethical or the result of impairment for fear of retribution or for the simple reason that they may be wrong" (Sheffield, 1996, p. 100). This aversion to monitoring problematic behaviors can be quite damaging to the profession as noted by 76% of polled professional counselors who reported an unwillingness to report a peer. Additionally, 83% of those studied were unaware of available, state-wide professional development activities to provide awareness of problematic behaviors (ACA, 2004).

These findings seem to suggest that problematic counselor may not be able to regulate him or herself and intervene to avoid causing harm. Consequently the impaired practitioner's colleagues may be resistant to address the problematic behavior due to fear of negative consequences. This chaotic cycle seems further aggravated by unavailable professional support and unclear, despite numerous, ethical guidelines.

## **Problematic Behaviors in Academia**

While counselor education faculty are not ethically permitted to perceive their students as clients, they do maintain a significant responsibility in monitoring student problematic behaviors and related gatekeeping concerns (Gaubatz & Vera, 2002; Gizara & Forrest, 2004). In the counseling profession, the appropriate governing bodies (ACA, 2005; CACREP, 2009) suggest that college and university faculty are to educate and demonstrate appropriate professional behaviors while consistently evaluating students. “Counselor education is an academic discipline that focuses on promoting the training of competent professional counselors. Counselors and counselor educators have a philosophical commitment to promoting the growth, development, and holistic experiences of themselves, clients, and students” (Hill, 2004, p. 135). In essence, students must be well suited for the profession by being both willing and able (Owen, 1993).

Students should be evaluated on both academic and interpersonal paradigms. This implies that successful academic work alone does not indicate student success within the counseling profession. In a study conducted by Gaubatz and Vera (2002) of 118 surveyed counselor education faculty members, approximately 10.4% of enrolled masters’ students were ill-suited for the profession. Contrary to these findings, Forest, Elman, Gizara and Vacha-Haase (1995), found that an estimated 5% of graduate students are remediated or dismissed each year and Burgess (1995) estimated that 3–4% of counseling students within a five year period are problematic. These differences in figures suggest that although 10.4% of students are ill-suited, only 5% receive remediation or dismissal from masters-level programs implying that academia lacks formal gatekeeping procedures and allows unsuitable counseling students successful candidacy despite negative presentation.

There is not a general consensus of what constitutes problematic behaviors (Burgess, 1995; Huprich & Rudd, 2004; Woodyard, 1997). This lack of agreement may cause difficulties when attempting to study the significance of problematic behaviors in counseling graduate students, and also leads to confusion as when it is appropriate to confront problematic behaviors. Moreover, it is important to note that problematic behaviors exhibited by a student does not mean that the student has violated an ethical code; however, the violation of an ethical code indicates the presence of a problematic behavior.

In an effort to identify specific problematic student critical indicators, a study conducted by Li, Trusty, Lampe, and Lin (2007) polled 35 CACREP accredited faculty and discussed 86 different cases of problematic peers. Through the administration of the Behavioral Indicators of Student Impairment Survey, problematic behaviors identified were lying, addiction, refusal to participate in counseling, inappropriate boundaries, acting seductively toward clients, inability to demonstrate multicultural sensitivity, psychological impairment, engagement in sexual relationships with clients, harassing peers, and interpersonal deficiencies (Li, et al., 2007). These constructs are some of the most recent contributions to the field of impairment and suggest that the profession continues to identify the presence of these destructive behaviors. Out of 10 identified behavioral indicators of problematic students, six of these were considered psychological issues by students (Hill, 2005). This suggests that the terminology associated with problematic behaviors is unclear and differs between academic and student opinion.

Kaslow et al. (2002), suggested that students may exhibit personal factors that increase their vulnerability toward experiencing problematic behaviors and include: (a) experienced abuse as a child, (b) have a persistent substance addiction, (c) are diagnosed with an axis I or II disorder, (d) feel the need to present a false sense of self, (e) is a “wounded healer” (Goldberg,

1986), and/or (f) experiences attachment difficulties. Additionally, Kaslow et al., identified a continuum of student behaviors ranging from model (motivated, reliable), to less than desirable (resistant to graduate school time commitments, unreliable), and finally to disruptive (verbally combative within the classroom, demonstrating deceptiveness toward other students, frequently unprepared for class activities) for use within the counseling profession. This range provides professionals more substantial indicators when attempting to determine problematic student behaviors by rating the severity. Academic institutions are encouraged to develop evaluation measures based on these behavioral markers. In consideration of the Kaslow et al., continuum of student behaviors, greater consistency throughout the profession can be promoted and attained through a standardized evaluation method.

“Counselor educators who are concerned about the fitness of a particular trainee are faced with navigating a formidable maze of student, institutional, and client rights” (Gaubatz & Vera, 2002, p. 295). Counselor educators are confronted with the reality that the demands of pursuing a graduate counseling degree can be quite stressful leading to the presence of problematic behaviors (Lamb & Swerdlik, 2003). In consideration of these issues, defining and identifying problematic behaviors when working with institutional policies and student dynamics can be complicated. It is not surprising that some students with problematic behaviors are not addressed. More specifically, there is much speculation that a portion of students who demonstrate problematic behaviors while attending graduate school may not be confronted by faculty despite the evidence of problematic behaviors. These students are termed “gate slippers” as the gatekeeping process was not implemented in an effort to remediate the student. One cause for the lack of confronting problematic behaviors may be the difficulties associated with



remediating and dismissing students as it can be quite litigious causing faculty to ‘heed with caution’ (Cole & Lewis, 1993; McAdams III, Foster, & Ward, 2007; Lamb, et al., 1987).

Problematic peers can be an especially frustrating experience for counseling students. As found by Mearns and Allen (1991), approximately 95% of 73 polled graduate students reported experience with a problematic peer. Graduate students stated a desire to uphold the ACA ethics and wished to intervene when confronted with an unethical peer (Mearns & Allen, 1991) but lack the knowledge to do so. A survey of clinical psychology students regarding impaired peers found that students reported the topic of problematic peers was not discussed during course enrollment (Oliver, Bernstein, Anderson, Blashfield & Roberts, 2004). Additionally, the number one behavioral indicator associated with problematic behaviors that students felt compelled to inform faculty was related to interpersonal issues as opposed to academic or ethical deficiencies (Oliver, et al., 2004).

Students function in a different role with peers as opposed to faculty and the persistence of problematic behaviors may be more noticeable through the frequency of student interactions. Not to mention, a problematic student may mask or maintain “impression management” in the classroom to avoid remediation services although these behaviors may not be upheld amongst the student body (Bradley & Post, 1991; Myers, Mobely, & Booth, 2003; Rosenberg, et al., 2005). Despite the presence of problematic behaviors in a peer, students are not likely to confront the individual. Rather students are more likely to avoid interactions with the problematic peer and this can potentially cause decreased motivation within the classroom impacting the non-problematic student academic and emotional functioning (Rosenberg, et al., 2005). Rosenberg et al. found in their study of counseling psychology students, that a majority reported having a negative experience with a problematic peer during course enrollment. Of 129

polled students in this study, only 5% reported experiencing no impact on the persistence of a problematic student within their graduate program. Furthermore, 95% of reported disturbances with a problematic peer included (a) disruption of class time, (b) difficulties applying the cohort model during supervision, (c) challenges related to individual student learning (Oliver, et al., 2005). Research indicates that non-problematic students are impacted by a problematic student in the following areas: experienced negative feelings emotionally, encountered difficulties within the classroom environment, decreased confidence in the mental-health profession, and decreased confidence in faculty (Oliver et al., 2004, Mearns & Allen, 1991).

Rosenberg et al., (2005) found that students believed that they were more aware of problematic peers than faculty. Furthermore, students stated that they were unsure if faculty would be responsive if they approached them regarding a deficient fellow student (Mearns & Allen, 1991; Rosenberg, et al., 2005). The educational climate can be negatively affected if a problematic student is present within a program. Some of the most commonly reported student responses to a problematic student was gossiping about the peer or withdrawing from the student (Mearns & Allen, 1991; Rosenberg, et al., 2005).

These studies represent the available literature regarding student responses to problematic peers and seem to suggest that students are unsure of appropriate gatekeeping procedures or their role within academia to prevent the practice of deficient practitioners. As previously noted, academia holds a large responsibility in preparing counselors to function in an ethical and effective manner. However, academia must also serve as a gatekeeper, in an effort to prevent problematic students from practicing as a counselor. As faculty identify and attempt to implement remediation plans, it is mandatory that the student's confidentiality be upheld causing fellow graduate students to be unaware of faculty intervention. Since students are unaware of

faculty actions, it can be frustrating for both staff and student morale. Not to mention, a student may demonstrate problematic behaviors while maintaining a high academic performance, thereby seeming contradictory as the student must be remediated despite classroom success.

Student motivation to enroll in counseling graduate programs includes a variety of stimuli, for example, exhibiting a willingness to help others, demonstrating a desire to become more acquainted with the human psyche, et cetera. Not all motives to join the counseling profession are well-intentioned though, one potentially disturbing cause is to enroll in a counseling program is to remedy one's own personal problems (Lumadue & Duffey, 1999). Of studied counselors-in-training, White and Franzoni (1990) found that a large number of counseling graduate students experienced adjustment or personality difficulties at a higher rate than the average population, which may suggest that problematic students may be attracted to the mental health profession to address personal issues.

The process of evaluating students begins as early as the admissions process (Koerin & Miller, 1995). At this time, students are prompted to provide letters of reference, grade point averages, and (depending of the university) may engage in formal interviews. In an effort to monitor student progress, continual evaluation seems to be the recommendation to prevent harm (Wilkerson, 2006; Witmer & Young, 1996). Levy (1983) suggested incorporating a variety of evaluative methods in course curriculum including both formative and summative measures in an effort to provide continual feedback in a variety of formats. The utilization of several types of evaluation methods allows educators to assess past performance and identify future objectives in an effort to remediate questionable student behaviors. Similar to treatment planning, evaluation measures can support professionals during documentation procedures and may assist in the development of measureable goals. Bradley and Post (1991) found that out of 113 polled

counseling programs only 65% reported continued student evaluation during graduate matriculation. Despite the best of intentions to introduce evaluative measures when monitoring student progress, if programs are not adhering to a continual appraisal process — then the best measure will not be effective.

If, despite intervention, the student continues to demonstrate problematic behaviors, a remediation plan can be prepared. Interventions may include: additional coursework, recommendation to participate in therapy, requests to receive additional supervision, advisement to attend professional development activities, and more significantly a suggestion to remove oneself from the program (Biaggio, Gasparikova-Krasnes & Bauer, 1983; Kutz, 1986; Olkin & Gaughen, 1991). Huprich and Rudd (2004) found that faculty who encountered a personal experience with a problematic clinical psychology student who required remediation procedures, reported that students complied to the remediation plan at a rate of 67% consistently, 26% partially, and 7% not at all. Currently, there is not a professionally accepted remediation procedure, thus formal practices are not yet available (Huprich & Rudd, 2004). One consideration recommended by Wilkerson (2006) is that the remediation process should be executed with specific thoughtfulness on time limitations, documentation, and the students' ability to successfully achieve the desired goal.

Students who have successfully navigated through the admission selection process are increasingly difficult to terminate because due process and documentation procedures are not consistently upheld throughout academic institutions. This makes a formal procedure for remediation unavailable. A mistake in documenting the student's problematic behavior can cause the student to remain in the program despite the evidence of a problem. Thus, it is extremely important for staff and students to be knowledgeable on the ethical and academic

guidelines related to problematic behaviors. Research suggests that student's who receive ethics training infused within the graduate program, are less likely to commit an ethical infraction (Butler & Williams, 1985). An approach as identified by ACA and ACES, focuses on students who show interpersonal aversiveness, substance abuse/chemical dependency, mental health illnesses, and other pervasive difficulties (Lawson & Vernart, 2005; Mearns & Allen, 1991) whereby the individual is encouraged to maintain a remediation plan in an effort to unlearn the problematic issue(s); however, this is a professional recommendation and not a requirement meaning that the student corrects the behaviors not from a personal standpoint, but rather a professional one. Burgess (1995) found that remediation over termination was the preferred intervention when confronted with an impaired peer at 77%. As faculty are ethically bound to provide support services to problematic students, remediation plans appear to be a tool that can assist during this sensitive time (Enouchs & Eitzbach, 2004).

Students, who are personally experiencing problematic behaviors, are encouraged by the code of ethics to monitor themselves in an effort to avoid causing harm to clients (ACA, 2005). As experiencing weaknesses toward a preferred profession or deficiencies can be disheartening, the academic climate is encouraged to provide students with support (O'Connor, 2001). This willingness to provide assistance to an impaired peer does not mean that the student remains in the program despite the persistence of behaviors not suitable for the counseling profession, but rather peers and faculty are aware of the difficulties associated with being identified as a problematic peer. This willingness to provide support toward a peer can be achieved by educating students and through faculty modeling of appropriate professional behaviors (Rosenberg, et al., 2005).

### **Self-Care and Academia**

As the potential for negative consequences in relation to counseling and problematic behaviors has been highlighted in the professional literature, it seems very practical that self-care has garnered increasing attention (Kaslow, et al., Kress & Protivnak, 2009; Lawson & Vernart, 2005; Roach & Young, 2007; Rosenburg, et al., 2005; Sheffield, 1996; Wilkinson, 2006; Yager & Tovar-Blank, 2007). For this study, self-care will be defined, “as a holistic approach toward preserving and maintaining our own wellness across domains” (ACA, 2004). According to the Task Force (2004), self-care activities should be maintained by counselors to achieve wellness. Self-care strategies as identified by the Task Force include; meditation, journaling, reading for pleasure, hobbies, volunteering, going to the movies, visiting with friends, laughing, going to see a counselor, crying, exercising, drinking plenty of water, sleeping enough, eating regular meals, yoga, et cetera (ACA, 2004). Task Force committee members noted that it is not of importance what specific self-care activity(s) were selected rather it is more important that the counselor has participated in appropriate self-care practices.

The specific concept of wellness was first introduced by a physician named Dr. Halbert Dunn in 1961 who believed that a combination of personal accountability and understanding of the environment promoted the attainment of psychological and physical health (E-AWR, 2006). This suggests that despite physical sickness, an individual can remain well if they maintain a general satisfaction, achieved through self-care practices. This understanding has been hypothesized by the counseling profession to mean that wellness and self-care reduces ethical violations and the persistence of problematic behaviors (Kaslow, et al., Kress & Protivnak, 2009; Lawson & Vernart, 2005; Roach & Young, 2007; Rosenburg, Getzelman, et al., 1996; Wilkinson, 2006; Yager & Tovar-Blank, 2007).

ACA, ACES, and CACREP endorses self-care and encourages academic programs to educate students on wellness and self-care (Roach & Young, 2007). “The continued healthiness of the profession depends on individual awareness of personal wellness” (Olsheski & Leech, 1996, p. 135). At this time, there is not a consensually standardized professional training practice for counseling programs on self-care and wellness. Bradley and Post (1991) suggested that the absence of standardization may be an accidental professional endorsement to promote problematic behaviors.

Despite the self-care methods utilized, it appears that wellness (if achieved) saturates all components of one’s lifestyle (Roach & Young, 2007). Thus, the counseling profession stresses the need for counselors to be able to balance personal and professional stressors when needed. Once students begin to experience stress, they may exhibit a range of symptoms including anxiety, fatigue, and decreased motivation (Hill, 2009; Theriault & Gazzola, 2005). These feelings appear to compromise an individual’s motivation and potentially lead to problematic behaviors. It seems that masters-level students are especially vulnerable to stress and report lower levels of wellness than their doctoral counterparts (Myers, et al., 2003). These results suggest that matriculation through counseling programs may promote greater levels of wellness although the cause for this is not known (Myers, et al.).

“One of the most important skills counselors can learn in guarding against impairment is the regular practice of self monitoring and self care activities” (Lawson & Vernart, 2005, p. 6). Oftentimes, self-care and wellness training are first introduced during graduate enrollment. Suggestions to introduce and incorporate wellness and self-care training in counseling programs might include (1) initiate wellness discussions (2) link professional development practices to wellness (3) faculty modeling of appropriate behaviors (4) shatter the concept of the perfect

counselor (5) remind students of the holistic nature of wellness (6) promote student participation in personal counseling (7) educate using the ACA Code of Ethics standards (8) infuse self-care practices into all courses (9) creatively remind students of wellness and self-care (10) endorse positive relations with society (Yager & Tovar Blank, 2007). The theme in these ideas considers the importance of introducing and reintroducing the many opportunities to utilize resources to maintain self-care for graduate students.

Interestingly, counselors reported that they do not seek counseling as a self-care resource (Kottler, 1993). Despite research that indicates individuals who sought personal counseling reported decreased feelings associated with burnout and increased personal growth, the majority of clinicians are not seeking counseling services (Linley & Joseph, 2007).

Periodically, students should be evaluated during graduate study for problematic behavior and self-care practices (ACA, 2005; CACREP, 2009; Roach & Young, 2007). At this time consensually agreed methods to assess, evaluate, and promote student accountability are not available (Myers, et al., 2003).

Academic faculty maintain an important responsibility when evaluating students. Based on their role, it is proposed that faculty should contribute to the adoption of wellness practices for counseling students (Hill, 2004). Austin and Rice (1990) believed that faculty who practice self-care as evidenced in the academic milieu, modeled and supported student growth toward wellness.

In response to the literature on problematic behaviors and impairment, the counseling profession endorsed self-care and wellness practices (ACA, 2004). Although self-care is supported by the professional bodies, there is not yet a consensually supported evaluation or training approach to monitor wellness and self-care. Researchers suggest that academic



programs implement training considerations that promote self-care and utilize faculty as models of appropriate behaviors.

### **Summary**

All professionals within the counseling community are required by ethical standards to identify and intervene when problematic behaviors arise whether that occurs within oneself or a colleague. Counselors-in-training, and professionals alike, struggle with their role as a gatekeeper and may be resistant to report a problematic peer because of the potential for negative repercussions. In response to the literature on problematic behaviors, the counseling profession has endorsed self-care practices to achieve wellness. Kitchener (1986) indicated that educators should model appropriate behaviors so that students can observe the difficult choices associated with acting ethically. This demonstration of ethical behaviors, allows students to increase their knowledge of problematic behaviors, gatekeeping, self-monitoring, and self-care. Additionally, course content and training that exposes students to acceptable, professional practices may serve as an intervention to reduce the presence of problematic behaviors during academic matriculation.

## CHAPTER III. METHODOLOGY

### **Introduction**

This section addresses the procedures and methodology related to this specific research as the study was developed to empirically investigate student self-perceptions related to problematic behaviors. Included within this chapter is the study's research questions, instrument description, the process for which the data was collected and selected data analysis methods.

### **Research Questions**

In an attempt to explore counseling students' perceptions of problematic behaviors, self-care and related training experiences the following questions were investigated.

1. What self-care behaviors do counselors-in-training use?
2. What is the nature of problematic behaviors that counselors-in-training identify personally?
3. What behavioral indicators do counselors-in-training identify as experiencing problematic behavior?
4. What training have counselors-in-training received on self-care?
5. What is the relationship between self-care practices, self-care training and problematic behavior training with the number of reported problematic behaviors?

### **Participants**

Participants in this study were recruited from masters-level counselor training programs and included a regional representation of schools throughout the United States. Programs

solicited included CACREP and non-CACREP Community and/or School Counseling degree seeking candidates. Participation was restricted to students who were currently enrolled in a graduate program. Subjects were randomly selected. Participants received a survey package which included the Awareness of Problematic Behavior Survey (see appendix E) and Information Sheet (see appendix F). In accordance to research related to statistical power analysis, the projected participant pool was 75 (Cohen, 1988).

### **Instruments**

The Awareness of Problematic Behavior survey was developed by Dr. Jamie Carney. At the beginning of the survey, participants were prompted to answer a series of demographic questions such as gender, degree program enrolled in, and number of credit hours completed. Participants were then asked questions related to self-care practices, recognition of problematic behaviors as evidenced within oneself, and whether the individual had received training related to identifying problematic behaviors. The Awareness of Problematic Behavior survey was first used for this study and is based on research disseminated by Li, et al. (2007) and Rosenberg, et al. (2005) who have attempted to identify behavioral indicators associated with problematic behaviors.

According to Li et al., (2007) individuals who exhibit non-academic behavioral indicators of impairment may include:

- 1) lies
- 2) exhibits addictive behavior
- 3) refuses to consider personal counseling when recommended
- 4) touches clients inappropriately
- 5) has inappropriate boundaries

- 6) is seductive toward clients
- 7) displays anger toward a specific gender, race, sexual orientation, etc
- 8) displays psychotic symptoms
- 9) misrepresents his or her skill level
- 10) engages in sexual contact with a client
- 11) is doing therapy/ attending classes under the influence of drugs or alcohol
- 12) is sexually harassing clients/other students
- 13) has suicidal attempts/ideation
- 14) has a personality disorder
- 15) has deficient interpersonal skills
- 16) has difficulty receiving supervision
- 17) displays academic dishonesty.

The behavioral indicators as developed by Li et al., assisted in the development of the ‘have you experienced any of the following problematic behaviors,’ checklist. Although in this case, students were prompted to self-report as opposed to CACREP academic unit leaders reporting whether they had observed the behavior in others as in the Li et al. study.

Although Rosenthal et al. (2005) was noted as a contributor to the survey design, the specific questions designed from the research was not used for this study. Rosenthal studied the impact of problematic peers and this concept was beyond this study’s scope.

The survey consisted of 12 questions. The first five questions focused on the subjects personal experiences with problematic behaviors and self-care practices. The final seven questions asked subjects about the persistence of problematic behaviors within peers. For this study, only the first five questions were used as the objective to gather information on self-

reported problematic behaviors. For question one, participants were prompted to check the self-care behaviors that they practiced. Questions two and three inquired whether the student had received training on self-care and assessing personal problematic behaviors. Question four was an open-ended question that asked subjects to identify behavioral indicators that they would use to determine if they were experiencing problematic behaviors. Question number five was another checklist that asked the subject if they had experienced any of the problematic behaviors listed. These constructs were obtained from the research disseminated by Li, et al. Finally, question number six asked the subject whether they had ever received remediation and if so, would they please describe their experiences.

### **Procedures**

The data collected for this research study was facilitated through one researcher-designed survey on student self-reports. After approval from Auburn University's Institutional Review Board (IRB) was received (see Appendix G), 104 Community and/or School Counseling Faculty were contacted (one from each institution) via email requesting their assistance in disseminating the research (see Appendix I). From the 104 faculty contacted, twelve faculty representatives agreed to disseminate the surveys to their graduate students. Of the twelve faculty, five faculty representatives were from the Council for Accreditation of Counseling and Related Education Programs (CACREP) and seven faculty represented Non-CACREP programs. A total of 292 surveys were sent through standard mail with an accompanying mailing envelope and information sheet. Evaluation packets consisted of the IRB letter of approval to conduct research and the Awareness of Problematic Behaviors Survey. Both items were individually attached to a self-addressed stamped envelope.

Potential subjects were made aware that their willingness to participate was noted through the completion of the included measure. All participants were instructed that they were to return the measure in the provided envelope, and to seal the envelope. All responses received were anonymous, as identifiable information was not collected.

### **Data Analysis**

Generally, the scope of this study was to collect information on problematic behaviors, self-care and training experiences. More specifically, masters-level student's self-report of personal experiences with problematic behaviors. This study also aimed to explore counseling students' self-care practices and training experiences in relation to problematic behaviors and self-care. Participants were also polled to provide personal behavioral indicators as associated with problematic behaviors.

Collected data was analyzed using the Statistical Package for Social Services (SPSS) version 17.0 computer software. In order to address research questions 1, 2 and 4, descriptive statistics were calculated. A qualitative analysis was considered for question number 3 as it was an open-ended question which related to the behavioral indicators counselors-in-training identify if they had ever experienced any problematic behaviors. This question can provide useful information related to student self-monitoring and awareness of problematic behaviors based on the participants responses. Statements were coded for emergent themes, content analysis support and qualitative support of the quantitative analysis. Researcher bias and predisposition of the data were coded based on a key word identification with the groupings including (1) academic, (2) anger, (3) avoidant, (4) eating, (5) emotional, (6) interactions, (7) personality, (8) professional responsibility, and (9) physical which are consistent with the primary topics identified from the Li et al., research and the informational organization of this study. Finally,

question number 5 was addressed using bivariate correlations and multiple linear regression. For the bivariate correlation, all variables were considered to determine if a relationship existed. Furthermore, for the multiple linear regression the independent variables of “self-care”, “self-care training”, and “problematic training” were used to predict the dependent variable of problematic behaviors.

### **Summary**

In this chapter, an overview of the research study was provided with a focus on participant recruitment, instrument selection, assessment distribution practices, and data analysis procedures. In summary, graduate students who were currently enrolled in Counselor Education programs were encouraged to participate. The instrument utilized for this student is entitled the Awareness of Problematic Behavior Survey developed by Dr. Jamie Carney. The surveys were disseminated by a faculty representative and sampled student bodies were regionally comprised within the United States. Collected data was analyzed using various statistical methods including bivariate correlation, multiple linear regression, descriptive and qualitative analysis.

## CHAPTER IV. RESULTS

### **Introduction**

The purpose of this research study was to explore masters-level counseling graduate student's awareness of problematic behaviors. To conduct this research, 104 regionally representative universities were contacted throughout the United States and twelve School and Community programs agreed to participate in the study. One survey was disseminated to all participating programs to collect data. The survey evaluated student reports of self-care, problematic behaviors and if program services were available. The survey was developed due to a dearth in available research on problematic students. This chapter will present the results of the data analysis collected with an emphasis on demographic considerations, self-care practices, and the presence of reported problematic behaviors. Additionally, the study's methodology will be considered including a focus on the statistical analyses selected and data trends. Information in this section will be offered according to the research questions examined.

The research questions developed for this study were:

1. What self-care behaviors do counselors-in-training use?
2. What is the nature of problematic behaviors that counselors-in-training identify personally?
3. What behavioral indicators do counselors-in-training identify as experiencing problematic behavior?



4. What training have counselors-in-training received on self-care?
5. What is the relationship between self-care practices, self-care training and problematic behavior training with the number of reported problematic behaviors?

As these questions examined problematic behaviors, self-care practices and training experiences for counselors-in-training, the sample of participants captured represented this specific population. All participants for this study were adult students who were currently enrolled in counseling masters granting programs.

### **Participants**

Demographic information collected for this study was obtained from community and school counseling masters-level students. Information related to demographics included (1) gender, (2) degree program enrolled in e.g., masters or doctoral, (3) credit hours completed in the program, and (4) specialty area.

All 84 subjects who participated in this study completed the demographics questions found at the top of the survey (see Appendix E) and the demographic results are presented in Table 1. The subjects in this study consisted of 14 male students and 70 female students. All 84 participants were enrolled in master-level degree seeking programs. Twenty-one percent (21%) reported that they had completed 0–12 credit hours, 33% stated that they had completed 13–24 credit hours, 26% said that they completed 25–40 credits and 19% reported 41+ credit hours. Of the 84 subjects, 52 identified their specialty area as Community Counseling with 22 students reporting that were on the School Counseling track.

Table 1

*Demographic Description Overall*

Descriptor	Variable	Overall N (n %)
Gender	Male	14 (16.7%)
	Female	70 (83.3%)
Degree Program	Masters	84 (100%)
	Doctoral	0
Credit Hours Completed	0–12	18 (21.4%)
	13–24	28 (33.3%)
	25–40	22 (26.2%)
	41+	15 (19%)
Specialty Area	Community	10 (11.9%)
	School	22 (26.2%)
Accreditation	CACREP	44 (52.4%)
	Non-CACREP	40 (47.6%)

In conjunction with the demographic data, subjects were placed in groups as to whether they had national accreditation with the Council for Accreditation of Counseling & Related Educational Program (CACREP). CACREP is the nationally recognized special accrediting body for counseling programs whose curriculum is in compliance with professionally supported standards (CACREP, 2009). If the program was not accredited, they were identified as Non-CACREP. Of the 84 subjects, 44 reported attending a CACREP program. Inversely, 40 subjects reported that they attended a Non-CACREP program. These demographic constructs set the

basis for analysis of how the demographic factors impact student's ability to assess and monitor problematic behaviors.

### **Reliabilities**

Using Cronbach's Alpha, an internal consistency analysis was utilized to assess reliability coefficients and determine consistency within the survey questions or how well the construct survey questions measured for intended outcomes. Reliability coefficients for the four construct questions ranged from a low -.482 to .618. For this study self-care practices resulted in a coefficient of .233, self-care training resulted in a -.482, problematic training .601 and problematic behavior at .618.

### **Results**

#### **Research Question 1**

Research Question 1 focused on the procedures used to identify which self-care behaviors counselors-in-training use. Based on the participants' responses overall, 100% masters-level students utilize self-care practices. This indicates that all subjects from CACREP and Non-CACREP programs equally use self-care.

Upon further consideration, specific self-care practices appeared to be utilized more frequently. Table 2 provides a closer examination of the frequency of self-care practices. Respondents reported a high frequency of spending time with friends (97.1%), discussing concerns with peers (79.8%), exercising (67.9%) and spending time with hobbies (66.7%).

Table 2

*Descriptive Information Self-Care Practices*

Self Care Behaviors Engaged	Overall	CACREP	Non-CACREP
	n (%)	n(%)	n(%)
Exercise	57 (67.9%)	32 (72.7%)	25 (62.5%)
Meditation	17 (20.2%)	7 (15.9%)	10 (25%)
Spending time with friends	77 (91.7%)	40 (90.9%)	37 (92.5%)
Seeking consultation	21 (25%)	10 (22.7%)	11 (27.5%)
Discussing concerns with supervisors	24 (28.6%)	14 (31.8%)	10 (25%)
Spending time with hobbies	56 (66.7%)	30 (68.2%)	26 (65%)
Discussing concerns with peers	64 (76.2 %)	34 (77.3%)	30 (75%)
Relaxation exercises	17 (20.2%)	10 (22.7%)	7 (17.5%)
Listening to music	67 (79.8%)	37 (84.1%)	30 (75%)
Seeing a counselor for personal issues	14 (16.7%)	8 (18.2%)	6 (15%)
Other	13 (15.5%)	8 (18.2%)	5 (12.5%)
Journaling	1 (1.19%)		1 (2.5%)
Spending time with family	1 (1.19%)	1 (2.27%)	
Pray	1 (1.19%)	1 (2.27%)	1 (2.5%)
Dog park with dogs	1 (1.19%)	1 (2.27%)	
Spending time with bible	1 (1.19%)	1 (2.27%)	
Pampering	2 (2.38%)	1 (2.27 %)	
Yoga	1 (1.19%)		1 (2.5%)

(table continues)

Table 2 (continued)

Self Care Behaviors Engaged	Overall	CACREP	Non-CACREP
	n (%)	n(%)	n(%)
Watching television	1 (1.19%)	1 (2.27%)	
Reading	1 (1.19%)	1 (2.27%)	
Cooking/eating healthy	1 (1.19%)	1 (2.27%)	
Surfing the net	1 (1.19%)		1 (2.5%)
Dinner and a movie with the spouse	1 (1.19%)		1 (2.5%)
M	5	5.2	4.92
SD	1.5	1.61	1.36

## Research Question 2

Research Question 2 examined the nature of problematic behaviors that counselors-in-training personally experienced. Of the 84 subjects, 50 (59.5%) reported having experienced problematic behaviors on the survey's checklist. The most commonly reported problematic behavior was emotional problems or concerns at 34 (40.5%). Table 2 further explores the frequency of reported problematic behaviors.

Upon a closer look at the descriptive statistics, there appears to be some disparaging differences between CACREP and Non-CACREP programs. One interesting discrepancy between the programs was the 20% of respondents from CACREP programs who reported academic limitations, while 5% of Non-CACREP students reported this as a difficulty. Another interesting difference is the spread between CACREP respondents at 38.6% of students who

reported experiencing avoidant or withdrawal behaviors in comparison to 25% of Non-CACREP students. Finally, 27.3% of CACREP subjects who experienced problematic behaviors reported experience with inappropriate dual relationship, whereas Non-CACREP students reported 2.5%.

A follow-up question to the problematic behavior checklist was an inquiry if the subject had ever experienced remediation and if so, what the remediation included. Of the 84 subjects, 8 (9.5%) reported receiving remediation. Of the 44 CACREP subjects, 2 (4.5%) reported receiving remediation. In these cases the participants reported “I met with key faculty members to disclose items outside of school that was affecting my academic performance. I tried to, with the help of faculty develop a strategic plan for overcoming pressing obstacles,” and “supervision,” as remediation received. For the 40 Non-CACREP students, 6 (15%) reported receiving remediation. Examples of remediation received included, “Able to share issues with faculty member”, “discuss problems with professor – I was having reactions to classmates that concerned me (in regards to their professional behavior”, “discussions”, “encouraged to make personal art and see campus counselor”, “professor noticed disengaged behavior in class; peer noticed behavior and told professors”, and “within class”.

Table 3

*Descriptive Information Experienced Problematic Behaviors*

	Overall	CACREP	Non-CACREP
	n (%)	n (%)	n (%)
Engagement in unprofessional behavior	4 (4.8%)	2 (4.5%)	2 (5%)
Emotional problems or concerns	34 (40.5%)	20 (45.5%)	14 (35%)
Academic limitations or deficiencies	11 (13.1%)	9 (20.5%)	2 (5%)
Eating disordered behavior	16 (19%)	7 (15.9%)	9 (22.5%)
Counseling skill limitations or deficiencies	7 (8.3%)	6 (13.6%)	1 (2.5%)
Substance abuse	2 (2.4%)	2 (4.5%)	0 (0%)
Difficulties maintaining appropriate and professional boundaries	2 (2.4%)	1 (2.3%)	1 (2.5%)
Personality problems or concerns	9 (10.7%)	6 (13.6%)	3 (7.5%)
Unprofessional behavior	3 (3.6%)	1 (2.3%)	2 (5%)
Avoidant or withdrawal behavior	27 (32.1%)	17 (38.6%)	10 (25%)
Anger or aggressive behavior	14 (16.7%)	9 (20.5%)	5 (12.5%)
Problems in interactions with peers	9 (10.7%)	6 (13.6%)	3 (7.5%)
Inappropriate dual relationships	1 (1.2%)	12 (27.3%)	1 (2.5%)
Problems in using or responding to supervision	2 (2.4%)	1 (2.3%)	1 (2.5%)
Inappropriate sexual behavior	2 (2.4%)	2 (4.5%)	0 (0%)
M	1.28	1.18	1.36
SD	.605	.529	6.58

### **Research Question 3**

In addition to the quantitative items on the Awareness of Problematic Behavior Survey, the survey also asked the participants to offer their personal report related to behavioral indicators if they were experiencing problematic behaviors. Responses were coded based on several general themes including (1) Academic limitations, (2) Anger, (3) Avoidant, (4) Eating, (5) Emotional, (6) Interactions, (7) Personality, (8) Professional Responsibility, and (9) Physical. The academic components include performance related to academic limitations or deficiencies. The anger component, similar to the anger or aggressive behavior construct on the survey, noted behavioral indicators consistent with feeling angry. The avoidant component included those statements which were avoidant or withdrawal related. The eating component was reserved for statements that either reported decreased or increased eating habits and or weight gain/loss. The emotional component included statements linked to feeling and emotional problems/concerns. The interactions component was extended beyond friendships and included statements that mentioned any notice of change in relationships or interactions as a behavioral indicator. The personality component included statements that mentioned mood changes or more pervasive attitudinal changes. The professional responsibility component, although not included on the survey checklist, included statements where the participant reported their problematic behavior interfering with the provision of counseling services. The final component, physical, which was also not included in the survey's checklist, included statements with physical references either to sleep, sickness, and headaches. Table 4 lists the theme coded response to question number three which asked what behavioral indicators do counselors-in-training identify who were experiencing problematic behaviors.



Table 4

*Behavioral Indicators Coding*

Behavioral Indicators	Participants' Responses
Theme: Academic Limitations	Academic limitations Academic limitations or deficiencies Decline in academic functioning Decrease in grades Difficulty keeping up with assignments Late assignments Poor attendance in class Poor school performance
Theme: Anger	Anger Frustration Irritable Mild anger Short tempered Snapping at loved ones Tension Unreasonable resentment
Theme: Avoidant	Ability to complete assignments Allowing my living space to get noticeably messy Avoidance Concentration problems Decrease in time spent on religious observance Disengaging in class Disengagement from work Distractibility Feeling procrastinating If I stop doing my "normal" activities such as going to the gym, gardening, or cooking Lack of desire to complete activities I normally enjoy doing Lack of interest in social activities or things I typically enjoy doing Lack of social interests Losing motivation Losing interest in hobbies Not happy with daily routine No motivation to do enjoyable activities Problem focusing Time management Withdrawal

Table 4 (continued)

Behavioral Indicators	Participants' Responses
Theme: Eating	Changes in appetite Eating more or less Not eating correctly Overeating Unhealthy eating Weight gain
Theme: Emotional	Anxiety Anxious Anxious feelings Anxiety and stress become a huge factor Depression Depressed Dwelling on problems Emotional distress Emotional Excessive stress Feelings out of balance Feelings of anxiety more often than normal Feeling burnout Feeling burned out Feeling down Feeling uncomfortable Feeling uncomfortable with actions Feeling of worthlessness Feel stress General level of anxiety Helplessness Lack of motivation Lowered confidence Overwhelmed Overwhelmed with smallest tasks Sadness Stress levels Stress Stressed all the time Suicidal ideation and/or intent Uneasy feelings

Table 4 (continued)

Behavioral Indicators	Participants' Responses
Theme: Interactions	Behaviors negatively influencing my relationship with friends and family Discussing issues with a colleague or supervisor Feedback from friends in the program and instructors Feedback from significant other Feedback from others Friends notice change in behavior Interacting with peers Other people's reactions toward me Talking with supervisor or advisor Wife would tell me Withdrawal from friends and family
Theme: Personality	Abnormal mood swings Attitude change Changes in mood Changes in demeanor Feeling out of control Mood swings Negative attitude Mood swings, crying for an extended period of time (more than 2 days)
Theme: Professional Responsibility	Lack of effectiveness in meeting needs of my clients Minor boundary violations Not being able to focus on my clients issues, not able to be present The amount of time spent thinking about circumstances outside of the session
Theme: Physical	Being tearful Body aches Cannot get out of bed Changes in body health (headache, tired, etc) Changes in physical experience Changes in sleep Changes in sleep pattern Crying easily Fatigue Feel tired Frequently crying

Headaches

Table 4 (continued)

Behavioral Indicators	Participants' Responses
Theme: Physical (cont'd)	Illness Insomnia Lack of sleep Level of physical discomfort Loss of sleep Low energy Not being able to sleep Physical sensations Physically sick Restlessness Skin problems Sleep disturbances Sleeping hours a night When I am smoking

**Research Question 4**

Research Question 4 explored the training counselor-in-training students received on self-care (see Table 5). Of 84 subjects, 46 (54.8%) confirmed that they had received self-care training. Of the 46 subjects, 42 (50%) stated that their training was integrated into a course, 12 (14.3%) reported receiving the training during supervision, and 2 (2.4%) of respondents marked academic advising as the vehicle for which they received training in self-care. Finally, 2 (2.4%) of subjects indicated that they had received self-care training in the form of a wellness workshop. In consideration of CACREP programs, of the 44 participants, 22 (50 %) stated that they had received self-care training. Respondents reported receiving the training at 20 (45.5%) integrated into course, 7 (15.9%) supervision, 2 (4.5%) advisement and 2 (4.5%) from a wellness workshop. For Non-CACREP programs, of the 40 participants, 24 (60%) indicated that they had received training on self-care. 22 (55%) reported the training was received through course integration, 5 (12.5%) supervision, and 4 (10%) received the training during advisement.

Table 5

*Demographic Information Self-Care Training*

Self-Care Training	Overall	CACREP	Non-CACREP
	n (%)	n (%)	n (%)
Have Received	46 (54.8%)	22 (50%)	24 (60%)
Integrated in Course	42 (50%)	10 (45.5%)	22 (55%)
Supervision	12 (14.3%)	7 (15.9%)	5 (12.5%)
Advising	6 (7.1%)	2 (4.5%)	4 (10%)
Other	2 (2.4%)	2 (4.5%)	0
<i>M</i>	1.35	5.23	4.92
<i>SD</i>	.566	1.612	1.457

Although not a specific question, subjects were also polled as to whether they had received training on identifying self problematic behavior (see Table 6). Out of 84 respondents, 39 (46.4%) indicated that they had indeed received training on this construct. Thirty-four (40.5%) stated they experienced the training as integrated into their course(s), 11 (13.1%) indicated they had received the training during supervision and 5 (6%) during advisement. Subjects representing CACREP programs stated 17 (38.6%) received training on self-identifying problematic behaviors. Subjects indicated that 14 (31.8%) received the training integrated into course(s), 5 (11.4%) during supervision, and 1 (2.3%) during advisement. Finally, Non-CACREP students reported 22 (55%) reported training of indentifying self problematic behaviors. 20 (50%) indicated that they had received the training within a course, 6 (15%) in supervision, and 4 (10%) in advisement.

Table 6

*Demographic Information Problematic Training*

Problematic Behavior Training	Overall	CACREP	Non-CACREP
	n(%)	n(%)	n(%)
Training Received	39 (46.4%)	17 (38.6%)	22 (55%)
Integrated into Course	34 (40.5%)	14 (31.8%)	20 (50%)
Supervision	11 (13.1%)	5 (11.4%)	6 (15%)
Advising	5 (6%)	1 (2.3%)	4 (10%)
<i>M</i>	1.28	1.41	1.29
<i>SD</i>	.605	.503	.624

**Research Question 5**

Research Question 5 investigated the relationship between self-care practices, self-care training and problematic training with the number of reported problematic behaviors. A bivariate correlation was conducted between the three independent variables; self-care practices, self-care training and problematic behavior training. A *p* value less than .05 was required to indicate a statistically significant relationship. Results of the bivariate correlation are presented in Table 7. Results of the bivariate indicates that out of four correlations there are three correlations that are not statistically significant. There does appear to be one statistically significant relationship with self-care training and problematic behavior training suggesting that subjects who received the one training may likely receive the other ( $r(82) = .754, p < .01$ ); likewise, if the subject did not receive one of the trainings, there was a possibility that they would not receive the other.

Table 7

*Bivariate Correlations between Self-Care Practices, Self-Care Training, Problematic Behavior Training, and Problematic Behaviors*

Measure	Self-Care	Train Score	Prob Train Score	Prob Score
Self Care	—	.201	.273	-.136
Train Score	.201	—	.754**	-.044
Prob Train Score	.273	.754**	—	-.248
Prob Score	-.136	-.044	-.248	—

\*\* Correlation is significant at the 0.01 level (2-tailed).

A multiple regression analysis was conducted to evaluate how well self-care practices, self-care training, problematic training predict problematic behavior. The predictor variables were entered into a simultaneous regression model predicting problematic behavior. The three constructs self-care, self-care training, and problematic training were the predictor variables. The results, shown in Table 8, indicate that the model was significant. The linear combination of measures was significantly related to problematic behaviors  $R^2 = .461$ ,  $F(3, 12) = 3.426$ ,  $p < .01$ . The sample multiple correlation coefficient .68, indicating that approximately 46% of the variance of problematic behavior index in the sample can be accounted for by the linear combination of criterion measures. At the 5% significance level, the model is useful for predicting the response at  $p = .52$ . There exists enough evidence to conclude that at least one of the predictors is useful for predicting problematic behaviors, thus the model is useful.

Table 8

*Regression Analysis of Predictors Self-Care, Self-Care Training and Problematic Training with Criterion Problematic Behavior*

Predictor variable	Beta	<i>p</i>
Self-Care	-.125	.511
Self-Care Training	-.541	.406
Problematic Training	-1.933	.049

Table 9 shows the indices to demonstrate the strength of the individual predictors. The bivariate correlations represented negative and positive correlations. Three indices were statistically significant ( $p < .05$ ). The predictor variable problematic training was significant as it was negatively correlated with problematic behavior. This may suggest that fewer problematic behaviors were reported if the participant reported receiving problematic training. The other predictor variables were not statistically significantly. There seemed to be a positive correlation between self-care and problematic behavior. This implies that the more self-care practices identified the more problematic behaviors were equally reported.

Table 9

*Correlation Coefficients of Self-Care, Self-Care Training and Problematic Training*

Predictors	Correlation Predictor/Criterion	Correlation
Self-Care	.090	-.144
Self-Care Training	-.490	-.182
Problematic Training	-.628	-.465



## **Summary**

This section analyzed the data collected through dissemination of the Awareness of Problematic Behavior survey. Demographic information in the form of gender, credits in program, and specialty area were noted. Descriptive analysis presented information as related to self-care practices as reported by subjects, problematic behaviors experienced by participants and experiences with training programs in self-care and problematic behaviors. Some qualitative information was presented in consideration of specific behavioral indicators as recorded by subjects. Finally, a bivariate correlation and multiple regression considered the possible influence of self-care practices, self-care training, and problematic behavior training on reported problematic behaviors.

## CHAPTER V. DISCUSSION

### **Introduction**

Counselors are to “do no harm,” as outlined in the ACA Code of Ethics (2005). Additionally noted is the mention that counselors are to monitor their effectiveness (C.2.d.) and are to be aware of their own signs of impairment (C.2.g.). As cited in ACA (2005), counselors-in-training are equally responsible in warding against signs associated with impairment (F.8.b). Typically the ACA Code of Ethics are first introduced to graduate students during their academic matriculation as infused in classroom instructions, supervision opportunities, and experiential activities (Bowman, Bowman, & DeLucia, 1990). This begs the question, are counseling students aware of problematic behaviors as related to the self?

As previously noted, there is a dearth of research on self-reported problematic students; although there is some research available that considers educators and supervisors responses to the persistence of problematic students published years ago. When deliberating over self-perceived deficiencies, student perception’s of individual problematic behaviors has not yet been considered. In response to the absence of research, this study focused on student self-reports of problematic behaviors and self-monitoring techniques. In consideration of the study’s purpose, a survey research design was identified as an appropriate assessment method (Heppner, Wampold, & Kivlighan, 2008). In an effort to explore the frequency of identified variables including self-care practices and presence of problematic behaviors within the field of counseling a survey,

developed by Dr. Jamie Carney, was selected. The goal of this study was to explore a previously unexamined phenomena within the counseling profession as related to counselors-in-training.

In the previous chapter, data collected from regionally represented counselor-in-training graduate students were presented and analyzed. This chapter will provide a more thorough discussion of the results as related to the obtained data, limitations of this specific research study and implications for the counseling profession as gleaned from the noted findings.

### **Quantitative Analysis**

Upon review of the data, it appears that the most significant finding is that participants who receive training on self-care frequently also receive training on problematic behaviors. As all subjects reported self-care practices, this variable became a constant in this study and the most frequently reported activities were spending time with friends, discussing concerns with peers and exercising. Sixty percent of respondents indicated that they had experienced problematic behaviors and the most frequently reported problematic behavior was emotional concerns at 41%. Finally, there was not a statistically significant relationship between self-care practices, self-care training, and problematic training. Upon a closer examination through a multiple regression analysis of the predictor variables, the predictor variable of problematic training was negatively correlated with problematic behaviors and suggests that the respondents who received problematic training reported experiencing less problematic behaviors. The other predictor variables did not yield significant results. As training and self-care have traditionally been recommended to combat the pervasiveness of problematic behaviors, the study's absence of significance in regard to these variables is notable.

## Qualitative Analysis

The descriptive analysis identified no differences between CACREP and Non-CACREP programs between surveyed groups. A review of the means does indicate a general agreement that both sub-groups practice self-care, experienced problematic behaviors and received training on self-care and problematic behaviors.

Qualitative responses obtained from the participants were consistent with the professional research. The themes that emerged from the coding included (1) academic, (2) anger, (3) avoidant, (4) eating, (5) emotional, (6) interactions, (7) personality, (8) professional responsibility, and (9) physical. Subjects reported behavioral indicators that included a range of problematic behaviors from academic deficiencies, angry outbursts, avoidant behaviors, emotional disturbances, interruption in social interactions, personality changes, deficiencies in professional responsibility and physical limitations. These codes overlap previously disseminated research (Emerson & Markos, 1996; Huprich & Rudd, 2004; Li, et al, 2007; Koerin & Miller, 1995; Oliver, et al., 2004; Theriault & Gazzola, 2005). The respondents listed a number of behaviors consistent with problematic behaviors suggesting an understanding of problematic behaviors.

Participants reported that the components presented in this question are behavioral indicators when experiencing problematic behaviors. This translates into a more global issue related to a counselor's ability to practice self-monitoring skills and awareness of personal deficiencies. Whatever the case, counselors-in-training are aware of problematic behaviors and have identified behavioral indicators associated with this potentially damaging construct. This suggests that despite an awareness of problematic behaviors, counselors-in-training continue to remain in counseling programs. Generally, the information obtained through this question is

critical for the counseling profession and academia as students are self-reporting problematic behaviors. As evidence of a professionally supported definition to self-monitoring responsibilities is not available, the themes as found within this study although not ethically condemning – are concerning.

### **Limitations**

As with all studies, this study has several limitations. Information collected from this study was obtained via student self-report thereby suggesting that the data is more subjective in nature. The use of self-report measures may be influenced by social desirability, thus respondents may have inflated the correlations amongst variables (Graham, McDaniel, Douglas, & Snell, 2002). Furthermore, in consideration of the Superiority and Goal Instability Scales (Robbins, 1989), it is important to be careful when interpreting research findings when using one instrument.

The survey's design was prepared in consideration of the noted problematic behaviors in previous research (Li et al., 2007; Rosenberg et al., 2005). The Awareness of Problematic Behavior Survey was developed primarily for this study and has not previously been used to collect data thus there is insufficient information available regarding the survey's validity. The constructs identified as problematic and self-care are by no means exhaustive and reflect factors commonly associated in popular society. This is a limitation because other factors identified as problematic and self-care have unknowingly been omitted.

The sample of counseling students captured for this study represented Community Counseling and School Counseling programs. As many CACREP schools are beginning to transition toward Mental Health Counseling Programs to meet the 2009 objectives, it may have been advantageous to sample from these programs as well. Additionally, sampling from

counseling programs that offered degrees in Additions Counseling, Student Affairs, College Counseling, and other related programs may have made the sample size more robust.

For this study, faculty representatives were contacted as the spring semester was in its final weeks thereby potentially limiting the availability of subjects. Some faculty representatives reported that they were unable to disseminate surveys as the semester had already ended or that they would not be teaching a summer counseling course load. This limited the study's ability to increase the number of participants as well as number of faculty representatives willing to disseminate surveys. Additionally, the surveys collected data on problematic behaviors, as students were preparing for the end of the spring semester or beginning of the summer semester. These times within the semester could impact student responses as they may have experienced increased stress and workload demands based on the time of the semester or condensed summer scheduling.

### **Recommendations for Future Research**

While discussing the study's limitations, specific considerations for future research became evident. A future study of this nature should consider including additional objective methods to measure problematic behaviors and self-monitoring skills of students to reduce subjective bias. Pairing counselor-educator and/or supervisor reports with graduate student reports is one example. Also when contacting faculty representatives and disseminating surveys to graduate students a different time in the semester when subjects may not be directly impacted by final semester preparations or condensed summer schedules is recommended. Another consideration is to offer the survey to licensed counselors, counselor educators and supervisors to capture a more thorough conceptualization of problematic behaviors within the counseling

profession at different levels. Additionally, disseminating surveys to counselors from various counseling disciplines is recommended.

Future research should also focus on a larger sample of counseling graduate students. This study included 84 counselors-in-training, 14 males and 70 females. In consideration of the large number of both CACREP and Non-CACREP counseling graduate programs within the United States, a larger sample size to explore trends may also be beneficial.

### **Implications**

This is one of the first studies that examined student's report on self-identified problematic behaviors. Previously, researchers have examined behavioral indicators associated with problematic students (Lamb, et al., 1991; Li, et al., 2007; Rosenberg, et al., 2005; Scott & Stevens, 1998) educators identification of the persistence of problematic behaviors in graduate students (Mearns & Allen, 1991), clinical programs reported frequency of impaired students (Frame & Stevens, 1995; Lumadue & Duffy, 1999; Vacha-Haase, 1995) and impaired colleagues (Olsheski & Leech, 1996; Rosenberg, et al., 2005). In consideration of the variety of noted topics, Wilkerson (2006) suggested that academia, predominately faculty, conceptualize graduate students with a therapeutic lens. This would allow professionals to work with students in a capacity whereby the student's progress, limitations, and consent would be up for discussion; however, this approach, much like the previous literature, depends upon gatekeepers to assist in remediating the individuals' deficiencies.

For this particular study, data indicated that there is a relationship between self-care training received and problematic behavior training. Furthermore, 100% of respondents reported practicing self-care and 60% consequently reported problematic behaviors. This implies that counselors-in-training possess self-awareness and suggests the possibility of personal

responsibility when regulating problematic behaviors. The themes associated with this study are comparable to similar implications as noted by the ACA Task Force in 2003 when they studied impaired counselors. In their study, the ACA Task Force found that counselors may be more vulnerable to impairment than the average American population and have highlighted three main objectives in an effort to reduce the persistence of problematic behaviors: (1) preventative/educational measures, (2) providing necessary resources if a problematic behavior occurs, and (3) promoting advocacy based initiatives at the state and national levels (Lawson & Venart, 2005). According to the Task Force, clinicians could be conceptualized across a spectrum from “well-balanced” to “problematic” (ACA, 2004). These constructs are fluid in nature and can be experienced by counselors throughout their career, thus a discussion that considers prevention, support and advocacy seems essential. “It would be useful for counselors to know what places them at risk for progressing along the spectrum and to better equip them with activities and strategies that promote health” (Lawson & Vernart, 2005, p. 3).

The Task Force noted that preventative measures with an emphasis on self-monitoring is an important skill (ACA, 2004). In response to these findings, ACA prepared an online web resource for counselors to assess their own self-care. This website includes self-scoring instruments to determine care practices, factors associated with impairment, and other resources that may assist in self-monitoring. It is important to keep in the mind that the website has not been updated since 2005, so some previously available resources have become outdated. Nonetheless, clinicians are able to access the self-assessment measures.

Research that evaluates training experiences and counselor knowledge is necessary in an effort to promote self-monitoring skills. “Education efforts build on counselors’ strengths, help counselors identify areas of vulnerability, and provide strategies to promote wellness” (Lawson



& Vernart, 2005, p. 2). If a problematic behavior arises, research indicates that supporting the clinician is needed (ACA, 2004; Welfel, 2005). From a pedagogy perspective, it seems valuable to introduce practitioners early in their stages of counselor development to ethical decision-making models that simulate real life occurrences and experiential learning as a support for future ethical dilemmas (Bernard & Goodyear, 2004; Choate & Granello, 2006; Cottone, 2001; Garcia, Cartwright, Winston, Borzuchowska, 2003; Rest, 1984). If counselors fit between a fluid continuum of well-balanced and problematic, educational opportunities that promote the identification and clarification of problematic behaviors is ideal. This toolbox, if you will, of a more concrete understanding of both the ACA Ethics Code (2005) and counselor expectations may assist in the decreased need for peer gatekeeping as well as increase personal responsibility. Considering this format, training should include educating counselors-in-training in becoming acquainted with professional mistakes, personal concerns related to ethical slip-ups (i.e., regret, remorse), and assessing possible rehabilitative measures (Reynolds-Welfel, 2005).

A method to support supervisees is through self-monitoring techniques and appropriate professional relationships. Within the literature, supportive relationships are noted as an intervention that reduces impairment and stress (Lamb, et al., 1987). Thus, an encouraging supervisor could introduce self-reflection skills to further develop the practitioner's own abilities including personal strengths and limitations relevant to professional counseling (Bernard & Goodyear, 2004). As most counselors perceive themselves as highly competent, the awareness of a personal ethical infraction can be quite difficult (Welfel, 2005). By introducing methods that can assist clinicians without minimizing the action would be beneficial. Welfel (2005) identified a four element model that may be relevant when a professional encounters an ethical infraction. This model includes: (1) recognition of the error, (2) experience of regret or remorse,

(3) evaluation of the possibilities of restitution, (4) rehabilitation to prevent recurrence. In the final stage of rehabilitation, the counselor is asked to reexamine the ethical misstep and consider available resources in an effort to prevent the infraction's occurrence in the future. Preventative measures may include counseling, becoming aware of one's own responses to stress, and continuing education opportunities. Most notably is the freedom for the counselor to tailor the rehabilitation to their specific needs. Theriault and Gazzola (2005) suggest that a life-long model for clinicians throughout their careers to increase practitioner coping skills as well as assist in feelings of incompetence would improve therapist self-care initiatives. Approaches like these found in within counseling literature help to increase professional awareness of problematic behaviors and encourages responsible behavior.

One objective as identified by the Task Force is advocacy at the state and national levels to assist professionals in defining problematic behaviors, clarifying the ACA Code of Ethics (2005) and increasing professional confidence in managing the presence of problematic behaviors. Lawson and Vernart (2005) noted that one common misconception in the professional field of counseling is that counselors are highly self-actualized and must therefore be mentally healthy in order to provide competent care. The reality is the counselors are vulnerable to difficulties and may present with problematic behaviors. One method to decrease the persistence of problematic behaviors that lead to ethical infractions is by lessening the stigma associated with counselor impairment. A climate that promotes counselor accountability, personal care and minimization to honestly report a personal ethical misdeed is one such consideration (Welfel, 2005). Most recently related to this topic, the ACA Ethics Committee prepared an article that presented tips on self-identifying problematic behaviors and available resources for professional counselors (Thomas & Levitt, 2010). This is one step toward

decreasing the stigma associated with problematic behaviors in an effort to promote honest dialogue within the counseling profession and reduce harm.

### **Summary**

The purpose of this research study was to explore whether counselors-in-training possess the knowledge and training to demonstrate self-awareness in an effort to prevent problematic behaviors. Of the variables studied, significant findings implied that oftentimes students who receive training in self-care, likely receive training in identifying problematic behaviors. Additionally, the predictor variable of problematic training is negatively correlated with the frequency of reported problematic behaviors. Results from this study are novel for the counseling profession as previous research has not considered individual self-reports of problematic behaviors. The presence of problematic behaviors does not imply that a counselor has committed an ethical violation, thus increased opportunities for counselors to increase their understanding of this construct is essential. It is believed that the outcome data obtained in this study will provide additional information regarding indicators associated with problematic behaviors, the frequency of experienced problematic behaviors, and current training practices.

## REFERENCES

- Allen, V. B. (1986). A historical perspective of the AACD ethics committee. *Journal of Counseling and Development, 64*, 293.
- American Counseling Association. (2004). ACA's Taskforce on Counselor Wellness and Impairment: Resources. Retrieved July 17, 2009 from [http://www.counseling.org/wellness\\_taskforce/index.htm](http://www.counseling.org/wellness_taskforce/index.htm).
- American Counseling Association. (2005). *ACA code of ethics*. Alexandria, VA: Author.
- Association for Counselor Education and Supervision. (1991). *Ethical guidelines for counseling supervision*.
- Americans With Disabilities Act of 1990, 42, U.S.C.A. 12101 *et seq.* (West 1993).
- Austin, A. E., & Rice, R. E. (1998). Making tenure viable: Listening to early career faculty. *American Behavioral Scientist, 41*, 736–755.
- Bernard, J. M., & Goodyear, R. K. (2004). *Fundamentals of clinical supervision*. Boston, MA: Pearson.
- Biaggio, M. K., Gasparikova-Krasnec, M., & Bauer, L. (1983). Evaluation of clinical psychology graduate students: The problem of the unsuitable student. *Professional Practice of Psychology, 4*, 9–20.
- Bowman, R. L., Bowman, V. E., & DeLucia, J. L. (1990). Mentoring in a graduate counseling program: Students helping students. *Counselor Education and Supervision, 30*, 58–65.

- Bradley, J., & Post, P. (1991). Impaired students: Do we eliminate them from counselor education programs? *Counselor Education and Supervision, 31*, 100–109.
- Breiar, P. (2008). Preparing our future counselling professionals: Gatekeeping and the implications for research. *Counselling & Psychotherapy Research, 8*(2), 93-101.
- Burgess, S. L. (1995). The impaired clinical and counseling psychology doctoral student. (Doctoral dissertation, California School of Professional Psychology, Berkeley/Alameda, 1995). Dissertation Abstracts International, 56, 02-B.
- Butler, R. W., & Williams, D. A. (1985). Description of Ohio State Board of Psychology hearing on ethical violations: From 1972 to the present. *Professional Psychology: Research and Practice, 16*, 502–511.
- Choate, L. H., & Granello, D. H. (2006). Promoting student cognitive development in counselor preparation: A proposed expanded role for faculty advisors. *Counselor Education & Supervision, 46*, 116–130.
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (3<sup>rd</sup> ed.). New York: Academic Press.
- Cole, B. S., & Lewis, R. G. (1993). Gatekeeping through termination of unsuitable social work students: Legal issues and guidelines. *Journal of Social Work Education, 29*(2), 150–159.
- Cottone, R. R. (2001). A social constructivism model of ethical decision making in counseling. *Journal of Counseling & Development, 79*, 39–45.
- Council for the Accreditation of Counseling and Related Educational Programs. (2009). *Accreditation manual and application*. Alexandria, VA: Author.

- Electronic Ardell Wellness Report. (2006). *What is wellness, anyway?* Academic Search Premier, 339–441.
- Emerson, S., & Markos, P. A. (1996). Signs and symptoms of the impaired counselor. *The Journal of Humanistic Education and Development, 34*, 108–117.
- Farber, N. J., Gilibert, S. G., Aboff, B. M., Collier, V. U., Weiner, J., & Boyer, E. G. (1989). Physicians willingness to report impaired colleagues. *Social Science Medicine, 61*, 1772–1775.
- Forrest, L., Elman, N., Gizara, S., & Vacha-Haase, T. (1999). Trainee impairment: A review of identification, remediation, dismissal, and legal issues. *The Counseling Psychologist, 27*, 627–686.
- Frame, M. W., & Stevens-Smith, P. (1995). Out of harm's way: Enhancing monitoring and dismissal processes in counselor education programs. *Counselor Education and Supervision, 35*, 118–129.
- Garcia, J. G., Cartwright, B., Winston, S. M., & Borzuchowska, B. (2003). A transcultural integrative model for ethical decision making in counseling. *Journal of Counseling & Development, 81*, 268–277.
- Gaubatz, M. D., & Vera, E. M. (2002). Do formalized gatekeeping procedures increase programs' follow-up with deficient trainees? *Counselor Education & Supervision, 41*, 294–305.
- Gibson, W. T., & Pope, K. S. (1993). The ethics of counseling: A national survey of certified counselors. *Journal of Counseling and Development, 71*, 330–336.

- Gizara, S. S., & Forrest, L. (2004). Supervisors' experiences of trainee impairment and incompetence at APA-accredited internship sites. *Professional Psychology: Research and Practice, 35*, 131–140.
- Goldberg, C. (1986). Understanding the impaired practitioner. *Psychotherapy in Private Practice, 4*, 25–34.
- Graham, K. E., McDaniel, M. A., Douglas, E. F., & Snell, A. F. (2002). Biodata validity decay and score inflation with faking: Do item attributes explain variance across items? *Journal of Business and Psychology, 16*, 573–592.
- Gross, D. R., & Robinson, S. E. (1987). Ethics, violence, and counseling: Hear no evil, see no evil, speak no evil? *Journal of Counseling and Development, 65*, 340–344.
- Guy, J., & Liaboe, G. (1986). The impact of conducting psychotherapy of psychotherapists' interpersonal functioning. *Professional Psychology: Research & Practice, 17*, 111–114.
- Heppner, P. P., Wampold, B. E., & Kivlighan, D. M. (2008). *Research design in counseling*. Belmont, CA: Thomson Brooks/Cole.
- Hermon, D. A., & Hazler, R. J. (1999). Adherence to a wellness model and perceptions of psychological well-being. *Journal of Counseling & Development, 77*, 339–343.
- Hill, N. R. (2004). The challenges experienced by pretenured faculty members in counselor education: A wellness perspective. *Counselor Education & Supervision, 44*, 135–146.
- Huprich, S. K., & Rudd, M. R. (2004). A national survey of trainee impairment in clinical counseling and school psychology doctoral programs and internships. *Journal of Clinical Psychology, 60*, 43–52.

- Kaslow, N., Mitnick, M. K., & Baker, J. (2002). Difficult interns and postdoctoral residents: Identification, assessment, and interventions. *Association of Psychology and Postdoctoral Internship Centers*, Pre-Conference Workshop.
- Kitchener, K. S. (1986). Teaching applied ethics in counselor education: An integration of psychological processes and philosophical analysis. *Journal of Counseling and Development*, 64, 306–309.
- Koerin, B., & Miller, J. (1995). Gatekeeping policies: Terminating students for nonacademic reasons. *Journal of Social Work Education*, 31, 247–260.
- Kottler, J. (1993). *On being a therapist*. San Francisco: Jossey-Bass.
- Kottler, J., & Hazler, R. J. (1996). Impaired counselors: The dark side brought into light. *The Journal of Humanistic Education and Development*, 34, 98–107.
- Kress, V. E., & Protivnak, J. J. (2009). Professional development plans to remedy problematic counseling student behaviors. *Counselor Education & Supervision*, 48, 154–166.
- Kutz, S. L. (1986). Defining “impaired psychologist.” *American Psychologist*, 41, 220.
- Lamb, D. H., & Swerdlik, M. E. (2003). Identifying and responding to problematic school psychology supervisees: The evaluation process and issues of impairment. *Clinical Supervisor*, 22, 87–110.
- Lamb, D. H., Preser, N. R., Pfof, K. S., Baum, M. C., Jackson, V. R., & Jarvis, P. A. (1987). Confronting professional impairment during the internship: Identification, due process, and remediation. *Professional Psychology: Research and Practice*, 18, 597–603.
- Lawson, G. (2007). Counselor wellness and impairment: A national survey. *Journal of Humanistic Counseling, Education, and Development*, 46, 20–34.



- Lawson, G., & Venart, B. (2005). Preventing counselor impairment: Vulnerability, wellness and resilience. In G. R. Waltz & R. K. Yep (Eds.), *VISTAS: Compelling perspectives on counseling 2005* (pp. 243–246). Alexandria, VA: American Counseling Association.
- Levy, L. (1983). Evaluation of students in clinical psychology programs: A program evaluation perspective. *Professional Psychology: Research and Practice*, 14, 497–503.
- Li, C. S., Trusty, J., Lampe, R., & Lin, Y. F. (2007). Remediation and termination of impaired students in CACREP-Accredited Counseling Programs. *Journal of Education and Human Development*, 1–12.
- Linley, P. A., & Joseph, S. (2007). Therapy work and therapists' positive and negative well-being. *Journal of Science and Clinical Psychology*, 26(3), 385–403.
- Lumadue, C. A., & Duffey, T. H. (1999). The role of graduate programs as gatekeepers: A model for evaluating student counselor competence. *Counselor Education and Supervision*, 39, 101–109.
- McAdams III, C. R., Foster, V. A., & Ward, T. J. (2007). Remediation and dismissal policies in counselor education: Lessons learned from a challenged in federal court. *Counselor Education & Supervision*, 46, 212–229.
- Mearns, J., & Allen, G. J. (1991). Graduate students' experiences in dealing with impaired peers, compared with faculty predictions: An exploratory study. *Ethics & Behavior*, 191–202.
- Myers, J. E., Mobley, A. K., & Booth, C. S. (2003). Wellness of counseling students: Practicing what we preach. *Counselor Education and Supervision*, 42, 264–274.
- National Board of Certified Counselors. (2005). *NBCC Code of ethics*. Greensboro, NC: Author.

- O'Connor, M. F. (2001). On the etiology and effective management of professional distress and impairment among psychologists. *Professional Psychology: Research and Practice, 32*, 345–350.
- Oliver, M. N. I., Bernstein, J. H., Anderson, K. G., Blashfield, R. K., & Roberts, M. C. (2004). An exploratory examination of student attitudes toward impaired peers in clinical psychology training programs. *Professional Psychology: Research and Practice, 35*(2), 141–147.
- Olkin, R., & Gaughen, S. (1991). Evaluation and dismissal of students in master's level clinical programs: Legal parameters and survey results. *Counselor Education and Supervision, 30*, 276–288.
- Olsheski, J., & Leech, L. L. (1996). Programmatic interventions and treatment of impaired professionals. *Journal of Humanistic Education and Development, 34*(3), 128–141.
- Owen, I. (1993). On 'the private life of the psychotherapist' and the psychology of caring. *The Counseling Psychologist Quarterly, 6*(3), 251–165.
- Ponton, R. F., & Duba, J. D. (2009). The ACA code of ethics: Articulating counseling professional covenant. *Journal of Counseling & Development, 87*, 117–121.
- Rest, J. (1984). Research on moral development: Implications for training counseling psychologists. *The Counseling Psychologist, 12*, 19–29.
- Reynolds-Welfel, E. (2005). Accepting fallibility: A model for personal responsibility for nonegregious ethics infractions. *Counseling and Values, 49*, 120–131.
- Roach, L. F., & Young, M. E. (2007). Do counselor education programs promote wellness in their students? *Counselor Education & Supervision, 47*, 29–45.

- Robbins, S. B., & Patton, M. J. (1989). Validity of the superiority and goal instability scales as measures of defects in the self. *Journal of Personality Assessment, 53*, 122–132.
- Rosenberg, J. I., Getzeman, M. A., Arcinue, F., & Oren, C. Z. (2005). An exploratory look at students' experiences of problematic peers in academic psychology programs. *Professional Psychology: Research and Practice, 36*, 665–673.
- Scott, K. J., & Stevens, G. D. (1998). Faculty impairment: An exploration of peer involvement. *Alcohol and Drug Education, 1–14*.
- Sheffield, D. S. (1998). Counselor impairment: Moving toward a concise definition and protocol. *Journal of Humanistic Education & Development, 37*, 96–117.
- Sherry, P., Teschendorf, R., Anderson, S., & Guzman, F. (1991). Ethical beliefs and behaviors of counseling center professionals. *Journal of College Student Development, 32*, 350–358.
- Snyder, M. (1974). Self-monitoring of expressive behavior. *Journal of Personality and Social Psychology, 30*, 526–537.
- Sweeney, T. J., & Witmer, J. M. (1991). Beyond social interest: Striving toward optimum health and wellness. *Individual Psychology, 47*, 527–554.
- Tarvydas, V. M., Leahy, M. J., & Saunders, J. L. (2004). A comparison of the ethical beliefs of certified rehabilitation counselors and national certified counselors. *Rehabilitation Counseling Bulletin, 47*(4), 234–246.
- Therriault, A., & Gazzola, N. (2005). Feelings of inadequacy, insecurity, and incompetence among experience therapists. *Counselling and Psychotherapy Research, 5*, 11–18.
- Thomas, A. M., & Levitt, D. (in press). Self-care: An ethical obligation and preventative tool. *Counseling Today*.

- Vacha-Haase, T. (1995). Impaired graduate students in APA-accredited clinical, counseling, and school psychology programs.
- Vacha-Haase, T., Davenport, D. S., & Kerewsky, S. D. (2004). Problematic students: Gatekeeping practices of academic professional psychology programs. *Professional Psychology: Research & Practice, 35*, 115–122.
- Walden, S. L., Herlihy, B., & Ashton, L. (2003). The evolution of ethics: Personal perspectives of ACA ethics committee chairs, *Journal of Counseling & Development, 81*, 106–110.
- Welfel, E. R. (2005). Accepting fallibility: A model for personal responsibility for nonegregious ethics infractions. *Counseling and Values, 49*, 120–131.
- White, P. E., & Franzoni, J. B. (1990). A multidimensional analysis of the mental health of graduate counselors in training. *Counselor Education and Supervision, 29*, 258–267.
- Wilkerson, K. (2006). Impaired students: Applying the therapeutic process model to graduate training programs. *Counselor Education & Supervision, 45*, 207–217.
- Witmer, J. M., & Young, M. E. (1996). Preventing counselor impairment: A wellness approach. *Journal of Humanistic Education and Development, 34*, 141–155.
- Wood, B. J., Klein, S., Cross, H. J., Lammers, C. J., & Elliott, J. K. (1985). Impaired practitioners: Psychologists opinions and prevalence, and proposals for intervention. *Professional Psychology: Research and Practice, 16*, 843–850.
- Yager, G. G., & Tovar-Blank, Z. G. (2007). Wellness and counselor education. *Journal of Humanistic Counseling, Education and Development, 46*, 142–153.

APPENDIX A  
HIPPOCRATIC OATH

### The Hippocratic Oath (Original; Translated to English)

I swear by Apollo, the healer, Asclepius, Hugiaia, and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgment, the following oath and agreement:

To consider dear to me, as my parents, him who taught me this art; to live in common with him and, if necessary, to share my goods with him; To look upon his children as my own brothers, to teach them this art.

I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone.

I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan; and similarly I will not give a woman a pessary to cause an abortion..

But I will preserve the purity of my life and my arts.

I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners, specialists in this art.

In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction and especially from the pleasures of love with women or with men, be they free or slaves.

All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal.

If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot.

\*Since its original inception, the Hippocratic Oath, has encountered several modifications including the exclusion of the previously forbidden practices of abortion, euthanasia, other surgery practices.

APPENDIX B  
AMERICAN COUNSELING ASSOCIATION  
CODE OF ETHICS

# ACA Code of Ethics

As approved by the ACA Governing Council

2005



AMERICAN COUNSELING ASSOCIATION  
[www.counseling.org](http://www.counseling.org)



## ACA Code of Ethics Preamble

The American Counseling Association is an educational, scientific, and professional organization whose members work in a variety of settings and serve in multiple capacities. ACA members are dedicated to the enhancement of human development throughout the life span. Association members recognize diversity and embrace a cross-cultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts.

Professional values are an important way of living out an ethical commitment. Values inform principles. Inherently held values that guide our behaviors or exceed prescribed behaviors are deeply ingrained in the counselor and developed out of personal dedication, rather than the mandatory requirement of an external organization.

## ACA Code of Ethics Purpose

The *ACA Code of Ethics* serves five main purposes:

1. The *Code* enables 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. The *Code* helps support the mission of the association.
3. The *Code* establishes principles that define ethical behavior and best practices of association members.
4. The *Code* serves 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.
5. The *Code* serves as the basis for processing of ethical complaints and inquiries initiated against members of the association.

The *ACA Code of Ethics* contains eight main sections that address the following areas:

Section A: The Counseling Relationship

Section B: Confidentiality, Privileged Communication, and Privacy

Section C: Professional Responsibility

Section D: Relationships With Other Professionals

Section E: Evaluation, Assessment, and Interpretation

Section F: Supervision, Training, and Teaching

Section G: Research and Publication

Section H: Resolving Ethical Issues

Each section of the *ACA Code of Ethics* begins with an Introduction. The introductions to each section discuss what counselors should aspire to with regard to ethical behavior and responsibility. The 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*.

When counselors are faced with ethical dilemmas that are difficult to resolve, they are expected to engage in a carefully considered ethical decision-making process. Reasonable differences of opinion can and do exist among counselors with respect to the ways in which values, ethical principles, and ethical standards would be applied when they conflict. While there is no specific ethical decision-making model that is most effective, counselors are expected to be familiar with a credible model of decision making that can bear public scrutiny and its application.

Through a chosen ethical decision-making process and evaluation of the context of the situation, counselors are empowered to make decisions that help expand the capacity of people to grow and develop.

A brief glossary is given to provide readers with a concise description of some of the terms used in the *ACA Code of Ethics*.

# Section A

## The Counseling Relationship

### Introduction

Counselors encourage client growth and development in ways that foster the interest and welfare of clients and promote formation of healthy relationships. Counselors actively attempt to understand the diverse cultural backgrounds of the clients they serve. Counselors also explore their own cultural identities and how these affect their values and beliefs about the counseling process.

Counselors are encouraged to contribute to society by devoting a portion of their professional activity to services for which there is little or no financial return (pro bono publico).

### A.1. Welfare of Those Served by Counselors

#### A.1.a. Primary Responsibility

The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients.

#### A.1.b. Records

Counselors maintain records necessary for rendering professional services to their clients and as required by laws, regulations, or agency or institution procedures. Counselors include sufficient and timely documentation in their client records to facilitate the delivery and continuity of needed services. Counselors take reasonable steps to ensure that documentation in records accurately reflects client progress and services provided. If errors are made in client records, counselors take steps to properly note the correction of such errors according to agency or institutional policies. (See A.12.g.7., B.6., B.6.g., G.2.j.)

#### A.1.c. Counseling Plans

Counselors and their clients work jointly in devising integrated counseling plans that offer reasonable promise of success and are consistent with abilities and circumstances of clients. Counselors and clients regularly review counseling plans to assess their continued viability and effectiveness, respecting the freedom of choice of clients. (See A.2.a., A.2.d., A.12.g.)

#### A.1.d. Support Network Involvement

Counselors recognize that support

networks hold various meanings in the lives of clients and consider enlisting the support, understanding, and involvement of others (e.g., religious/spiritual/community leaders, family members, friends) as positive resources, when appropriate, with client consent.

#### A.1.e. Employment Needs

Counselors work with their clients considering employment in jobs that are consistent with the overall abilities, vocational limitations, physical restrictions, general temperament, interest and aptitude patterns, social skills, education, general qualifications, and other relevant characteristics and needs of clients. When appropriate, counselors appropriately trained in career development will assist in the placement of clients in positions that are consistent with the interest, culture, and the welfare of clients, employers, and/or the public.

### A.2. Informed Consent in the Counseling Relationship

(See A.12.g., B.5., B.6.b., E.3., E.13.b., F.1.c., G.2.a.)

#### A.2.a. Informed Consent

Clients have the freedom to choose whether to enter into or remain in a counseling relationship and need adequate information about the counseling process and the counselor. Counselors have an obligation to review in writing and verbally with clients the rights and responsibilities of both the counselor and the client. Informed consent is an ongoing part of the counseling process, and counselors appropriately document discussions of informed consent throughout the counseling relationship.

#### A.2.b. Types of Information Needed

Counselors explicitly explain to clients the nature of all services provided. They inform clients about issues such as, but not limited to, the following: the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the counselor's qualifications, credentials, and relevant experience; continuation of services upon the incapacitation or death of a counselor; and other pertinent information. Counselors take steps to ensure that clients understand the implications of diagnosis, the intended use of tests and reports, fees, and billing arrangements.

Clients have the right to confidentiality and to be provided with an explanation of its limitations (including how supervisors and/or treatment team professionals are involved); to obtain clear information about their records; to participate in the ongoing counseling plans; and to refuse any services or modality change and to be advised of the consequences of such refusal.

#### A.2.c. Developmental and Cultural Sensitivity

Counselors communicate information in ways that are both developmentally and culturally appropriate. Counselors use clear and understandable language when discussing issues related to informed consent. When clients have difficulty understanding the language used by counselors, they provide necessary services (e.g., arranging for a qualified interpreter or translator) to ensure comprehension by clients. In collaboration with clients, counselors consider cultural implications of informed consent procedures and, where possible, counselors adjust their practices accordingly.

#### A.2.d. Inability to Give Consent

When counseling minors or persons unable to give voluntary consent, counselors seek the assent of clients to services, and include them in decision making as appropriate. Counselors recognize the need to balance the ethical rights of clients to make choices, their capacity to give consent or assent to receive services, and parental or familial legal rights and responsibilities to protect these clients and make decisions on their behalf.

### A.3. Clients Served by Others

When counselors learn that their clients are in a professional relationship with another mental health professional, they request release from clients to inform the other professionals and strive to establish positive and collaborative professional relationships.

### A.4. Avoiding Harm and Imposing Values

#### A.4.a. Avoiding Harm

Counselors act to avoid harming their clients, trainees, and research participants and to minimize or to remedy unavoidable or unanticipated harm.

#### A.4.b. Personal Values

Counselors are aware of their own values, attitudes, beliefs, and behaviors and avoid imposing values that

are inconsistent with counseling goals. Counselors respect the diversity of clients, trainees, and research participants.

## **A.5. Roles and Relationships**

### **With Clients**

*(See F.3., F.10., G.3.)*

#### **A.5.a. Current Clients**

Sexual or romantic counselor–client interactions or relationships with current clients, their romantic partners, or their family members are prohibited.

#### **A.5.b. Former Clients**

Sexual or romantic counselor–client interactions or relationships with former clients, their romantic partners, or their family members are prohibited for a period of 5 years following the last professional contact. Counselors, before engaging in sexual or romantic interactions or relationships with clients, their romantic partners, or client family members after 5 years following the last professional contact, demonstrate forethought and document (in written form) whether the interactions or relationship can be viewed as exploitive in some way and/or whether there is still potential to harm the former client; in cases of potential exploitation and/or harm, the counselor avoids entering such an interaction or relationship.

#### **A.5.c. Nonprofessional Interactions or Relationships (Other Than Sexual or Romantic Interactions or Relationships)**

Counselor–client nonprofessional relationships with clients, former clients, their romantic partners, or their family members should be avoided, except when the interaction is potentially beneficial to the client. *(See A.5.d.)*

#### **A.5.d. Potentially Beneficial Interactions**

When a counselor–client nonprofessional interaction with a client or former client may be potentially beneficial to the client or former client, the counselor must document in case records, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the client or former client and other individuals significantly involved with the client or former client. Such interactions should be initiated with appropriate client consent. Where

unintentional harm occurs to the client or former client, or to an individual significantly involved with the client or former client, due to the nonprofessional interaction, the counselor must show evidence of an attempt to remedy such harm. Examples of potentially beneficial interactions include, but are not limited to, attending a formal ceremony (e.g., a wedding/commitment ceremony or graduation); purchasing a service or product provided by a client or former client (excepting unrestricted bartering); hospital visits to an ill family member; mutual membership in a professional association, organization, or community. *(See A.5.c.)*

#### **A.5.e. Role Changes in the Professional Relationship**

When a counselor changes a role from the original or most recent contracted relationship, he or she obtains informed consent from the client and explains the right of the client to refuse services related to the change. Examples of role changes include

1. changing from individual to relationship or family counseling, or vice versa;
2. changing from a nonforensic evaluative role to a therapeutic role, or vice versa;
3. changing from a counselor to a researcher role (i.e., enlisting clients as research participants), or vice versa; and
4. changing from a counselor to a mediator role, or vice versa.

Clients must be fully informed of any anticipated consequences (e.g., financial, legal, personal, or therapeutic) of counselor role changes.

## **A.6. Roles and Relationships at Individual, Group, Institutional, and Societal Levels**

### **A.6.a. Advocacy**

When appropriate, counselors advocate at individual, group, institutional, and societal levels to examine potential barriers and obstacles that inhibit access and/or the growth and development of clients.

**A.6.b. Confidentiality and Advocacy** Counselors obtain client consent prior to engaging in advocacy efforts on behalf of an identifiable client to

improve the provision of services and to work toward removal of systemic barriers or obstacles that inhibit client access, growth, and development.

## **A.7. Multiple Clients**

When a counselor agrees to provide counseling services to two or more persons who have a relationship, the counselor clarifies at the outset which person or persons are clients and the nature of the relationships the counselor will have with each involved person. If it becomes apparent that the counselor may be called upon to perform potentially conflicting roles, the counselor will clarify, adjust, or withdraw from roles appropriately. *(See A.8.a., B.4.)*

## **A.8. Group Work**

*(See B.4.a.)*

### **A.8.a. Screening**

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.b. Protecting Clients**

In a group setting, counselors take reasonable precautions to protect clients from physical, emotional, or psychological trauma.

## **A.9. End-of-Life Care for Terminally Ill Clients**

### **A.9.a. Quality of Care**

Counselors strive to take measures that enable clients

1. to obtain high quality end-of-life care for their physical, emotional, social, and spiritual needs;
2. to exercise the highest degree of self-determination possible;
3. to be given every opportunity possible 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.b. Counselor Competence, Choice, and Referral**

Recognizing the personal, moral, and competence issues related to

end-of-life decisions, counselors may choose to work or not work with terminally ill clients who wish to explore their end-of-life options. Counselors provide appropriate referral information to ensure that clients receive the necessary help.

#### **A.9.c. Confidentiality**

Counselors who provide services to terminally ill individuals who are considering hastening their own deaths have the option of breaking or not breaking confidentiality, depending on applicable laws and the specific circumstances of the situation and after seeking consultation or supervision from appropriate professional and legal parties. (*See B.5.c., B.7.c.*)

### **A.10. Fees and Bartering**

#### **A.10.a. Accepting Fees From Agency Clients**

Counselors refuse a private fee or other remuneration for rendering services to persons who are entitled to such services through the counselor's employing agency or institution. The policies of a particular agency may make explicit provisions for agency clients to receive counseling services from members of its staff in private practice. In such instances, the clients must be informed of other options open to them should they seek private counseling services.

#### **A.10.b. Establishing Fees**

In establishing fees for professional counseling services, counselors consider the financial status of clients and locality. In the event that the established fee structure is inappropriate for a client, counselors assist clients in attempting to find comparable services of acceptable cost.

#### **A.10.c. Nonpayment of Fees**

If counselors intend to use collection agencies or take legal measures to collect fees from clients who do not pay for services as agreed upon, they first inform clients of intended actions and offer clients the opportunity to make payment.

#### **A.10.d. Bartering**

Counselors may barter only if the relationship is not exploitive or harmful and does not place the counselor in an unfair advantage, if the client requests it, and if such arrangements are an accepted practice among professionals in the community. Counselors consider the cultural implications

of bartering and discuss relevant concerns with clients and document such agreements in a clear written contract.

#### **A.10.e. Receiving Gifts**

Counselors understand the challenges of accepting gifts from clients and recognize that in some cultures, small gifts are a token of respect and showing gratitude. When determining whether or not to accept a gift from clients, counselors take into account the therapeutic relationship, the monetary value of the gift, a client's motivation for giving the gift, and the counselor's motivation for wanting or declining the gift.

### **A.11. Termination and Referral**

#### **A.11.a. Abandonment Prohibited**

Counselors do not abandon or neglect clients in counseling. Counselors assist in making appropriate arrangements for the continuation of treatment, when necessary, during interruptions such as vacations, illness, and following termination.

#### **A.11.b. Inability to Assist Clients**

If counselors determine an inability to be of professional assistance to clients, they avoid entering or continuing counseling relationships. Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives. If clients decline the suggested referrals, counselors should discontinue the relationship.

#### **A.11.c. Appropriate Termination**

Counselors terminate a counseling relationship when it becomes reasonably apparent that the client no longer needs assistance, is not likely to benefit, or is being harmed by continued counseling. Counselors may terminate counseling when in jeopardy of harm by the client, or another person with whom the client has a relationship, or when clients do not pay fees as agreed upon. Counselors provide pretermination counseling and recommend other service providers when necessary.

#### **A.11.d. Appropriate Transfer of Services**

When counselors transfer or refer clients to other practitioners, they ensure that appropriate clinical and administrative processes are completed and open communication is maintained with both clients and practitioners.

### **A.12. Technology Applications**

#### **A.12.a. Benefits and Limitations**

Counselors inform clients of the benefits and limitations of using information technology applications in the counseling process and in business/billing procedures. Such technologies include but are not limited to computer hardware and software, telephones, the World Wide Web, the Internet, online assessment instruments and other communication devices.

#### **A.12.b. Technology-Assisted Services**

When providing technology-assisted distance counseling services, counselors determine that clients are intellectually, emotionally, and physically capable of using the application and that the application is appropriate for the needs of clients.

#### **A.12.c. Inappropriate Services**

When technology-assisted distance counseling services are deemed inappropriate by the counselor or client, counselors consider delivering services face to face.

#### **A.12.d. Access**

Counselors provide reasonable access to computer applications when providing technology-assisted distance counseling services.

#### **A.12.e. Laws and Statutes**

Counselors ensure that the use of technology does not violate the laws of any local, state, national, or international entity and observe all relevant statutes.

#### **A.12.f. Assistance**

Counselors seek business, legal, and technical assistance when using technology applications, particularly when the use of such applications crosses state or national boundaries.

#### **A.12.g. Technology and Informed Consent**

As part of the process of establishing informed consent, counselors do the following:

1. Address issues related to the difficulty of maintaining the confidentiality of electronically transmitted communications.
2. Inform clients of all colleagues, supervisors, and employees, such as Informational Technology (IT) administrators, who might have authorized or unauthorized access to electronic transmissions.
3. Urge clients to be aware of all authorized or unauthorized users

- including family members and fellow employees who have access to any technology clients may use in the counseling process.
4. Inform clients of pertinent legal rights and limitations governing the practice of a profession over state lines or international boundaries.
  5. Use encrypted Web sites and e-mail communications to help ensure confidentiality when possible.
  6. When the use of encryption is not possible, counselors notify clients of this fact and limit electronic transmissions to general communications that are not client specific.
  7. Inform clients if and for how long archival storage of transaction records are maintained.
  8. Discuss the possibility of technology failure and alternate methods of service delivery.
  9. Inform clients of emergency procedures, such as calling 911 or a local crisis hotline, when the counselor is not available.
  10. Discuss time zone differences, local customs, and cultural or language differences that might impact service delivery.
  11. Inform clients when technology-assisted distance counseling services are not covered by insurance. *(See A.2.)*

**A.12.h. Sites on the World Wide Web**

Counselors maintaining sites on the World Wide Web (the Internet) do the following:

1. Regularly check that electronic links are working and professionally appropriate.
2. Establish ways clients can contact the counselor in case of technology failure.
3. Provide electronic links to relevant state licensure and professional certification boards to protect consumer rights and facilitate addressing ethical concerns.
4. Establish a method for verifying client identity.
5. Obtain the written consent of the legal guardian or other authorized legal representative prior to rendering services in the event the client is a minor child, an adult who is legally incompetent, or an adult incapable of giving informed consent.
6. Strive to provide a site that is accessible to persons with disabilities.

7. Strive to provide translation capabilities for clients who have a different primary language while also addressing the imperfect nature of such translations.
8. Assist clients in determining the validity and reliability of information found on the World Wide Web and other technology applications.

## Section B

### Confidentiality, Privileged Communication, and Privacy

**Introduction**

Counselors recognize that trust is a cornerstone of the counseling relationship. Counselors aspire to earn the trust of clients by creating an ongoing partnership, establishing and upholding appropriate boundaries, and maintaining confidentiality. Counselors communicate the parameters of confidentiality in a culturally competent manner.

**B.1. Respecting Client Rights**

**B.1.a. Multicultural/Diversity Considerations**

Counselors maintain awareness and sensitivity regarding cultural meanings of confidentiality and privacy. Counselors respect differing views toward disclosure of information. Counselors hold ongoing discussions with clients as to how, when, and with whom information is to be shared.

**B.1.b. Respect for Privacy**

Counselors respect client rights to privacy. Counselors solicit private information from clients only when it is beneficial to the counseling process.

**B.1.c. Respect for Confidentiality**

Counselors do not share confidential information without client consent or without sound legal or ethical justification.

**B.1.d. Explanation of Limitations**

At initiation and throughout the counseling process, counselors inform clients of the limitations of confidentiality and seek to identify foreseeable situations in which confidentiality must be breached. *(See A.2.b.)*

**B.2. Exceptions**

**B.2.a. Danger and Legal Requirements**

The general requirement that counselors keep information confidential 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. Counselors consult with other professionals when in doubt as to the validity of an exception. Additional considerations apply when addressing end-of-life issues. *(See A.9.c.)*

**B.2.b. Contagious, Life-Threatening Diseases**

When clients disclose that they have a disease commonly known to be both communicable and life threatening, counselors may be justified in disclosing information to identifiable third parties, if they are known to be at demonstrable and high risk of contracting the disease. Prior to making a disclosure, counselors confirm that there is such a diagnosis and assess the intent of clients to inform the third parties about their disease or to engage in any behaviors that may be harmful to an identifiable third party.

**B.2.c. Court-Ordered Disclosure**

When subpoenaed to release confidential or privileged information without a client's permission, counselors obtain written, informed consent from the client or take steps to prohibit the disclosure or have it limited as narrowly as possible due to potential harm to the client or counseling relationship.

**B.2.d. Minimal Disclosure**

To the extent possible, clients are informed before confidential information is disclosed and are involved in the disclosure decision-making process. When circumstances require the disclosure of confidential information, only essential information is revealed.

**B.3. Information Shared With Others**

**B.3.a. Subordinates**

Counselors make every effort to ensure that privacy and confidentiality of clients are maintained by subordinates, including employees, supervisees, students, clerical assistants, and volunteers. *(See F.1.c.)*

### **B.3.b. Treatment Teams**

When client treatment involves a continued review or participation by a treatment team, the client will be informed of the team's existence and composition, information being shared, and the purposes of sharing such information.

### **B.3.c. Confidential Settings**

Counselors disclose confidential information only in settings in which they can reasonably ensure client privacy.

### **B.3.d. Third-Party Payers**

Counselors disclose information to third-party payers only when clients have authorized such disclosure.

### **B.3.e. Transmitting Confidential Information**

Counselors take precautions to ensure the confidentiality of information transmitted through the use of computers, electronic mail, facsimile machines, telephones, voicemail, answering machines, and other electronic or computer technology. (*See A.12.g.*)

### **B.3.f. Deceased Clients**

Counselors protect the confidentiality of deceased clients, consistent with legal requirements and agency or setting policies.

## **B.4. Groups and Families**

### **B.4.a. Group Work**

In group work, counselors clearly explain the importance and parameters of confidentiality for the specific group being entered.

### **B.4.b. Couples and Family Counseling**

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.5. Clients Lacking Capacity to Give Informed Consent**

### **B.5.a. Responsibility to Clients**

When counseling minor clients or adult clients who lack the capacity to give voluntary, informed consent, counselors protect the confidentiality of information received in the counseling relationship as specified by federal and state laws, written policies, and applicable ethical standards.

### **B.5.b. Responsibility to Parents and Legal Guardians**

Counselors inform parents and legal guardians about the role of counselors and the confidential nature of the counseling relationship. Counselors are sensitive to the cultural diversity of families and respect the inherent rights and responsibilities of parents/guardians over the welfare of their children/charges according to law. Counselors work to establish, as appropriate, collaborative relationships with parents/guardians to best serve clients.

### **B.5.c. Release of Confidential Information**

When counseling minor clients or adult clients who lack the capacity to give voluntary consent to release confidential information, counselors seek permission from an appropriate third party to disclose information. In such instances, counselors inform clients consistent with their level of understanding and take culturally appropriate measures to safeguard client confidentiality.

## **B.6. Records**

### **B.6.a. Confidentiality of Records**

Counselors ensure that records are kept in a secure location and that only authorized persons have access to records.

### **B.6.b. Permission to Record**

Counselors obtain permission from clients prior to recording sessions through electronic or other means.

### **B.6.c. Permission to Observe**

Counselors obtain permission from clients prior to observing counseling sessions, reviewing session transcripts, or viewing recordings of sessions with supervisors, faculty, peers, or others within the training environment.

### **B.6.d. Client Access**

Counselors provide reasonable access to records and copies of records when requested by competent clients. Counselors limit the access of clients to their records, or portions of their records, only when there is compelling evidence that such access would cause harm to the client. Counselors document the request of clients and the rationale for withholding some or all of the record in the files of clients. In situations involving multiple clients, counselors provide individual clients with only those parts of records that related

directly to them and do not include confidential information related to any other client.

### **B.6.e. Assistance With Records**

When clients request access to their records, counselors provide assistance and consultation in interpreting counseling records.

### **B.6.f. Disclosure or Transfer**

Unless exceptions to confidentiality exist, counselors obtain written permission from clients to disclose or transfer records to legitimate third parties. Steps are taken to ensure that receivers of counseling records are sensitive to their confidential nature. (*See A.3., E.4.*)

### **B.6.g. Storage and Disposal After Termination**

Counselors store records following termination of services to ensure reasonable future access, maintain records in accordance with state and federal statutes governing records, and dispose of client records and other sensitive materials in a manner that protects client confidentiality. When records are of an artistic nature, counselors obtain client (or guardian) consent with regards to handling of such records or documents. (*See A.1.b.*)

### **B.6.h. Reasonable Precautions**

Counselors take reasonable precautions to protect client confidentiality in the event of the counselor's termination of practice, incapacity, or death. (*See C.2.h.*)

## **B.7. Research and Training**

### **B.7.a. Institutional Approval**

When institutional approval is required, counselors provide accurate information about their research proposals and obtain approval prior to conducting their research. They conduct research in accordance with the approved research protocol.

### **B.7.b. Adherence to Guidelines**

Counselors are responsible for understanding and adhering to state, federal, agency, or institutional policies or applicable guidelines regarding confidentiality in their research practices.

### **B.7.c. Confidentiality of Information Obtained in Research**

Violations of participant privacy and confidentiality are risks of participation in research involving human participants. Investigators maintain all research records in a secure manner.

They explain to participants the risks of violations of privacy and confidentiality and disclose to participants any limits of confidentiality that reasonably can be expected. Regardless of the degree to which confidentiality will be maintained, investigators must disclose to participants any limits of confidentiality that reasonably can be expected. (See G.2.e.)

#### **B.7.d. Disclosure of Research Information**

Counselors do not disclose confidential information that reasonably could lead to the identification of a research participant unless they have obtained the prior consent of the person. Use of data derived from counseling relationships for purposes of training, research, or publication is confined to content that is disguised to ensure the anonymity of the individuals involved. (See G.2.a., G.2.d.)

#### **B.7.e. Agreement for Identification**

Identification of clients, students, or supervisees in a presentation or publication is permissible only when they have reviewed the material and agreed to its presentation or publication. (See G.4.d.)

### **B.8. Consultation**

#### **B.8.a. Agreements**

When acting as consultants, counselors seek agreements among all parties involved concerning each individual's rights to confidentiality, the obligation of each individual to preserve confidential information, and the limits of confidentiality of information shared by others.

#### **B.8.b. Respect for Privacy**

Information obtained in a consulting relationship is discussed for professional purposes only with persons directly involved with the case. Written and oral reports present only data germane to the purposes of the consultation, and every effort is made to protect client identity and to avoid undue invasion of privacy.

#### **B.8.c. Disclosure of Confidential Information**

When consulting with colleagues, counselors do not disclose confidential information that reasonably could lead to the identification of a client or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclo-

sure cannot be avoided. They disclose information only to the extent necessary to achieve the purposes of the consultation. (See D.2.d.)

## **Section C**

### **Professional Responsibility**

#### **Introduction**

Counselors aspire to open, honest, and accurate communication in dealing with the public and other professionals. They practice in a non-discriminatory manner within the boundaries of professional and personal competence and have a responsibility to abide by the *ACA Code of Ethics*. Counselors actively participate in local, state, and national associations that foster the development and improvement of counseling. Counselors advocate to promote change at the individual, group, institutional, and societal levels that improve the quality of life for individuals and groups and remove potential barriers to the provision or access of appropriate services being offered. Counselors have a responsibility to the public to engage in counseling practices that are based on rigorous research methodologies. In addition, counselors engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities.

#### **C.1. Knowledge of Standards**

Counselors have a responsibility to read, understand, and follow the *ACA Code of Ethics* and adhere to applicable laws and regulations.

#### **C.2. Professional Competence**

##### **C.2.a. Boundaries of Competence**

Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Counselors gain knowledge, personal awareness, sensitivity, and skills pertinent to working with a diverse client population. (See A.9.b., C.4.e., E.2., F.2., F.11.b.)

##### **C.2.b. New Specialty Areas of Practice**

Counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and to protect others from possible harm. (See F.6.f.)

##### **C.2.c. Qualified for Employment**

Counselors accept employment only for positions for which they are qualified by education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Counselors hire for professional counseling positions only individuals who are qualified and competent for those positions.

##### **C.2.d. Monitor Effectiveness**

Counselors continually monitor their effectiveness as professionals and take steps to improve when necessary. Counselors in private practice take reasonable steps to seek peer supervision as needed to evaluate their efficacy as counselors.

##### **C.2.e. Consultation on Ethical Obligations**

Counselors take reasonable steps to consult with other counselors or related professionals when they have questions regarding their ethical obligations or professional practice.

##### **C.2.f. Continuing Education**

Counselors recognize the need for continuing education to acquire and maintain a reasonable level of awareness of current scientific and professional information in their fields of activity. They take steps to maintain competence in the skills they use, are open to new procedures, and keep current with the diverse populations and specific populations with whom they work.

##### **C.2.g. Impairment**

Counselors are alert to the signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until such time it is determined that they may safely resume their work. Counselors assist colleagues or supervisors in recognizing their own professional impairment

and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients. (See *A.11.b., F.8.b.*)

#### **C.2.h. Counselor Incapacitation or Termination of Practice**

When counselors leave a practice, they follow a prepared plan for transfer of clients and files. Counselors prepare and disseminate to an identified colleague or "records custodian" a plan for the transfer of clients and files in the case of their incapacitation, death, or termination of practice.

### **C.3. Advertising and Soliciting Clients**

#### **C.3.a. Accurate Advertising**

When advertising or otherwise representing their services to the public, counselors identify their credentials in an accurate manner that is not false, misleading, deceptive, or fraudulent.

#### **C.3.b. Testimonials**

Counselors who use testimonials do not solicit them from current clients nor former clients nor any other persons who may be vulnerable to undue influence.

#### **C.3.c. Statements by Others**

Counselors make reasonable efforts to ensure that statements made by others about them or the profession of counseling are accurate.

#### **C.3.d. Recruiting Through Employment**

Counselors do not use their places of employment or institutional affiliation to recruit or gain clients, supervisees, or consultees for their private practices.

#### **C.3.e. Products and Training Advertisements**

Counselors who develop products related to their profession or conduct workshops or training events ensure that the advertisements concerning these products or events are accurate and disclose adequate information for consumers to make informed choices. (See *C.6.d.*)

#### **C.3.f. Promoting to Those Served**

Counselors do not use counseling, teaching, training, or supervisory relationships to promote their products or training events in a manner that is deceptive or would exert undue influence on individuals who may be vulnerable. However, coun-

selor educators may adopt textbooks they have authored for instructional purposes.

### **C.4. Professional Qualifications**

#### **C.4.a. Accurate Representation**

Counselors claim or imply only professional qualifications actually completed and correct any known misrepresentations of their qualifications by others. Counselors truthfully represent the qualifications of their professional colleagues. Counselors clearly distinguish between paid and volunteer work experience and accurately describe their continuing education and specialized training. (See *C.2.a.*)

#### **C.4.b. Credentials**

Counselors claim only licenses or certifications that are current and in good standing.

#### **C.4.c. Educational Degrees**

Counselors clearly differentiate between earned and honorary degrees.

#### **C.4.d. Implying Doctoral-Level Competence**

Counselors clearly state their highest earned degree in counseling or closely related field. Counselors do not imply doctoral-level competence when only possessing a master's degree in counseling or a related field by referring to themselves as "Dr." in a counseling context when their doctorate is not in counseling or related field.

#### **C.4.e. Program Accreditation Status**

Counselors clearly state the accreditation status of their degree programs at the time the degree was earned.

#### **C.4.f. Professional Membership**

Counselors clearly differentiate between current, active memberships and former memberships in associations. Members of the American Counseling Association must clearly differentiate between professional membership, which implies the possession of at least a master's degree in counseling, and regular membership, which is open to individuals whose interests and activities are consistent with those of ACA but are not qualified for professional membership.

### **C.5. Nondiscrimination**

Counselors do not condone or engage in discrimination based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital status/partnership, language preference,

socioeconomic status, or any basis proscribed by law. Counselors do not discriminate against clients, students, employees, supervisees, or research participants in a manner that has a negative impact on these persons.

### **C.6. Public Responsibility**

#### **C.6.a. Sexual Harassment**

Counselors do not engage in or condone sexual harassment. Sexual harassment is defined as sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with professional activities or roles, and that either

1. is unwelcome, is offensive, or creates a hostile workplace or learning environment, and counselors know or are told this; or
2. is sufficiently severe or intense to be perceived as harassment to a reasonable person in the context in which the behavior occurred.

Sexual harassment can consist of a single intense or severe act or multiple persistent or pervasive acts.

#### **C.6.b. Reports to Third Parties**

Counselors are accurate, honest, and objective in reporting their professional activities and judgments to appropriate third parties, including courts, health insurance companies, those who are the recipients of evaluation reports, and others. (See *B.3., E.4.*)

#### **C.6.c. Media Presentations**

When counselors provide advice or comment by means of public lectures, demonstrations, radio or television programs, prerecorded tapes, technology-based applications, printed articles, mailed material, or other media, they take reasonable precautions to ensure that

1. the statements are based on appropriate professional counseling literature and practice,
2. the statements are otherwise consistent with the *ACA Code of Ethics*, and
3. the recipients of the information are not encouraged to infer that a professional counseling relationship has been established.

#### **C.6.d. Exploitation of Others**

Counselors do not exploit others in their professional relationships. (See *C.3.e.*)

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

Counselors use techniques/procedures/modalities that are grounded in



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

## C.7. Responsibility to Other Professionals

### C.7.a. Personal Public Statements

When making personal statements in a public context, counselors clarify that they are speaking from their personal perspectives and that they are not speaking on behalf of all counselors or the profession.

# Section D

## Relationships With Other Professionals

### Introduction

Professional counselors recognize that the quality of their interactions with colleagues can influence the quality of services provided to clients. They work to become knowledgeable about colleagues within and outside the field of counseling. Counselors develop positive working relationships and systems of communication with colleagues to enhance services to clients.

## D.1. Relationships With Colleagues, Employers, and Employees

### D.1.a. Different Approaches

Counselors are respectful of approaches to counseling services that differ from their own. Counselors are respectful of traditions and practices of other professional groups with which they work.

### D.1.b. Forming Relationships

Counselors work to develop and strengthen interdisciplinary relations with colleagues from other disciplines to best serve clients.

### D.1.c. Interdisciplinary Teamwork

Counselors who are members of interdisciplinary teams delivering multifaceted services to clients, keep the focus on how to best serve the clients.

They participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the counseling profession and those of colleagues from other disciplines. (See A.1.a.)

### D.1.d. Confidentiality

When counselors are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, they clarify role expectations and the parameters of confidentiality with their colleagues. (See B.1.c., B.1.d., B.2.c., B.2.d., B.3.b.)

### D.1.e. Establishing Professional and Ethical Obligations

Counselors who are members of interdisciplinary teams clarify professional and ethical obligations of the team as a whole and of its individual members. When a team decision raises ethical concerns, counselors first attempt to resolve the concern within the team. If they cannot reach resolution among team members, counselors pursue other avenues to address their concerns consistent with client well-being.

### D.1.f. Personnel Selection and Assignment

Counselors select competent staff and assign responsibilities compatible with their skills and experiences.

### D.1.g. Employer Policies

The acceptance of employment in an agency or institution implies that counselors are in agreement with its general policies and principles. Counselors strive to reach agreement with employers as to acceptable standards of conduct that allow for changes in institutional policy conducive to the growth and development of clients.

### D.1.h. Negative Conditions

Counselors alert their employers of inappropriate policies and practices. They attempt to effect changes in such policies or procedures through constructive action within the organization. When such policies are potentially disruptive or damaging to clients or may limit the effectiveness of services provided and change cannot be effected, counselors take appropriate further action. Such action may include referral to appropriate certification, accreditation, or state licensure organizations, or voluntary termination of employment.

### D.1.i. Protection From Punitive Action

Counselors take care not to harass or dismiss an employee who has acted in a responsible and ethical manner

to expose inappropriate employer policies or practices.

## D.2. Consultation

### D.2.a. Consultant Competency

Counselors take reasonable steps to ensure that they have the appropriate resources and competencies when providing consultation services. Counselors provide appropriate referral resources when requested or needed. (See C.2.a.)

### D.2.b. Understanding Consultees

When providing consultation, counselors attempt to develop with their consultees a clear understanding of problem definition, goals for change, and predicted consequences of interventions selected.

### D.2.c. Consultant Goals

The consulting relationship is one in which consultee adaptability and growth toward self-direction are consistently encouraged and cultivated.

### D.2.d. Informed Consent in Consultation

When providing consultation, counselors have an obligation to review, in writing and verbally, the rights and responsibilities of both counselors and consultees. Counselors use clear and understandable language to inform all parties involved about the purpose of the services to be provided, relevant costs, potential risks and benefits, and the limits of confidentiality. Working in conjunction with the consultee, counselors attempt to develop a clear definition of the problem, goals for change, and predicted consequences of interventions that are culturally responsive and appropriate to the needs of consultees. (See A.2.a., A.2.b.)

# Section E

## Evaluation, Assessment, and Interpretation

### Introduction

Counselors use assessment instruments as one component of the counseling process, taking into account the client personal and cultural context. Counselors promote the well-being of individual clients or groups of clients by developing and using appropriate educational, psychological, and career assessment instruments.

## **E.1. General**

### **E.1.a. Assessment**

The primary purpose of educational, psychological, and career assessment is to provide measurements that are valid and reliable in either comparative or absolute terms. These include, but are not limited to, measurements of ability, personality, interest, intelligence, achievement, and performance. Counselors recognize the need to interpret the statements in this section as applying to both quantitative and qualitative assessments.

### **E.1.b. Client Welfare**

Counselors do not misuse assessment results and interpretations, and they take reasonable steps to prevent others from misusing the information these techniques provide. They respect the client's right to know the results, the interpretations made, and the bases for counselors' conclusions and recommendations.

## **E.2. Competence to Use and Interpret Assessment Instruments**

### **E.2.a. Limits of Competence**

Counselors utilize only those testing and assessment services for which they have been trained and are competent. Counselors using technology assisted test interpretations are trained in the construct being measured and the specific instrument being used prior to using its technology based application. Counselors take reasonable measures to ensure the proper use of psychological and career assessment techniques by persons under their supervision. (See A.12.)

### **E.2.b. Appropriate Use**

Counselors are responsible for the appropriate application, scoring, interpretation, and use of assessment instruments relevant to the needs of the client, whether they score and interpret such assessments themselves or use technology or other services.

### **E.2.c. Decisions Based on Results**

Counselors responsible for decisions involving individuals or policies that are based on assessment results have a thorough understanding of educational, psychological, and career measurement, including validation criteria, assessment research, and guidelines for assessment development and use.

## **E.3. Informed Consent in Assessment**

### **E.3.a. Explanation to Clients**

Prior to assessment, counselors explain the nature and purposes of assessment and the specific use of results by potential recipients. The explanation will be given in the language of the client (or other legally authorized person on behalf of the client), unless an explicit exception has been agreed upon in advance. Counselors consider the client's personal or cultural context, the level of the client's understanding of the results, and the impact of the results on the client. (See A.2., A.12.g, F.1.c.)

### **E.3.b. Recipients of Results**

Counselors consider the examinee's welfare, explicit understandings, and prior agreements in determining who receives the assessment results. Counselors include accurate and appropriate interpretations with any release of individual or group assessment results. (See B.2.c., B.5.)

## **E.4. Release of Data to Qualified Professionals**

Counselors release assessment data in which the client is identified only with the consent of the client or the client's legal representative. Such data are released only to persons recognized by counselors as qualified to interpret the data. (See B.1., B.3., B.6.b.)

## **E.5. Diagnosis of Mental Disorders**

### **E.5.a. Proper Diagnosis**

Counselors take special care to provide proper diagnosis of mental disorders. Assessment techniques (including personal interview) used to determine client care (e.g., locus of treatment, type of treatment, or recommended follow-up) are carefully selected and appropriately used.

### **E.5.b. Cultural Sensitivity**

Counselors recognize that culture affects the manner in which clients' problems are defined. Clients' socioeconomic and cultural experiences are considered when diagnosing mental disorders. (See A.2.c.)

### **E.5.c. Historical and Social Prejudices in the Diagnosis of Pathology**

Counselors recognize historical and social prejudices in the misdiagnosis and pathologizing of certain indi-

viduals and groups and the role of mental health professionals in perpetuating these prejudices through diagnosis and treatment.

### **E.5.d. Refraining From Diagnosis**

Counselors may refrain from making and/or reporting a diagnosis if they believe it would cause harm to the client or others.

## **E.6. Instrument Selection**

### **E.6.a. Appropriateness of Instruments**

Counselors carefully consider the validity, reliability, psychometric limitations, and appropriateness of instruments when selecting assessments.

### **E.6.b. Referral Information**

If a client is referred to a third party for assessment, the counselor provides specific referral questions and sufficient objective data about the client to ensure that appropriate assessment instruments are utilized. (See A.9.b., B.3.)

### **E.6.c. Culturally Diverse Populations**

Counselors are cautious when selecting assessments for culturally diverse populations to avoid the use of instruments that lack appropriate psychometric properties for the client population. (See A.2.c., E.5.b.)

## **E.7. Conditions of Assessment Administration**

(See A.12.b., A.12.d.)

### **E.7.a. Administration Conditions**

Counselors administer assessments under the same conditions that were established in their standardization. When assessments are not administered under standard conditions, as may be necessary to accommodate clients with disabilities, or when unusual behavior or irregularities occur during the administration, those conditions are noted in interpretation, and the results may be designated as invalid or of questionable validity.

### **E.7.b. Technological Administration**

Counselors ensure that administration programs function properly and provide clients with accurate results when technological or other electronic methods are used for assessment administration.

### **E.7.c. Unsupervised Assessments**

Unless the assessment instrument is designed, intended, and validated for self-administration and/or scoring,

counselors do not permit inadequately supervised use.

#### **E.7.d. Disclosure of Favorable Conditions**

Prior to administration of assessments, conditions that produce most favorable assessment results are made known to the examinee.

#### **E.8. Multicultural Issues / Diversity in Assessment**

Counselors use with caution assessment techniques that were normed on populations other than that of the client. Counselors recognize the effects of age, color, culture, disability, ethnic group, gender, race, language preference, religion, spirituality, sexual orientation, and socioeconomic status on test administration and interpretation, and place test results in proper perspective with other relevant factors. (*See A.2.c., E.5.b.*)

#### **E.9. Scoring and Interpretation of Assessments**

##### **E.9.a. Reporting**

In reporting assessment results, counselors indicate reservations that exist regarding validity or reliability due to circumstances of the assessment or the inappropriateness of the norms for the person tested.

##### **E.9.b. Research Instruments**

Counselors exercise caution when interpreting the results of research instruments not having sufficient technical data to support respondent results. The specific purposes for the use of such instruments are stated explicitly to the examinee.

##### **E.9.c. Assessment Services**

Counselors who provide assessment scoring and interpretation services to support the assessment process confirm the validity of such interpretations. They accurately describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use. The public offering of an automated test interpretations service is considered a professional-to-professional consultation. The formal responsibility of the consultant is to the consultee, but the ultimate and overriding responsibility is to the client. (*See D.2.*)

#### **E.10. Assessment Security**

Counselors maintain the integrity and security of tests and other assessment

techniques consistent with legal and contractual obligations. Counselors do not appropriate, reproduce, or modify published assessments or parts thereof without acknowledgment and permission from the publisher.

#### **E.11. Obsolete Assessments and Outdated Results**

Counselors do not use data or results from assessments that are obsolete or outdated for the current purpose. Counselors make every effort to prevent the misuse of obsolete measures and assessment data by others.

#### **E.12. Assessment Construction**

Counselors use established scientific procedures, relevant standards, and current professional knowledge for assessment design in the development, publication, and utilization of educational and psychological assessment techniques.

#### **E.13. Forensic Evaluation: Evaluation for Legal Proceedings**

##### **E.13.a. Primary Obligations**

When providing forensic evaluations, the primary obligation of counselors is to produce objective findings that can be substantiated based on information and techniques appropriate to the evaluation, which may include examination of the individual and/or review of records. Counselors are entitled to form professional opinions based on their professional knowledge and expertise that can be supported by the data gathered in evaluations. Counselors will define the limits of their reports or testimony, especially when an examination of the individual has not been conducted.

##### **E.13.b. Consent for Evaluation**

Individuals being evaluated are informed in writing that the relationship is for the purposes of an evaluation and is not counseling in nature, and entities or individuals who will receive the evaluation report are identified. Written consent to be evaluated is obtained from those being evaluated unless a court orders evaluations to be conducted without the written consent of individuals being evaluated. When children or vulnerable adults are being evaluated, informed written

consent is obtained from a parent or guardian.

##### **E.13.c. Client Evaluation Prohibited**

Counselors do not evaluate individuals for forensic purposes they currently counsel or individuals they have counseled in the past. Counselors do not accept as counseling clients individuals they are evaluating or individuals they have evaluated in the past for forensic purposes.

##### **E.13.d. Avoid Potentially Harmful Relationships**

Counselors who provide forensic evaluations 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.

## **Section F**

### **Supervision, Training, and Teaching**

#### **Introduction**

Counselors aspire to foster meaningful and respectful professional relationships and to maintain appropriate boundaries with supervisees and students. Counselors have theoretical and pedagogical foundations for their work and aim to be fair, accurate, and honest in their assessments of counselors-in-training.

#### **F.1. Counselor Supervision and Client Welfare**

##### **F.1.a. Client Welfare**

A primary obligation of counseling supervisors is to monitor the services provided by other counselors or counselors-in-training. Counseling supervisors monitor client welfare and supervisee clinical performance and professional development. To fulfill these obligations, supervisors meet regularly with supervisees to review case notes, samples of clinical work, or live observations. Supervisees have a responsibility to understand and follow the *ACA Code of Ethics*.

##### **F.1.b. Counselor Credentials**

Counseling supervisors work to ensure that clients are aware of the qualifications of the supervisees who render services to the clients. (*See A.2.b.*)

### **F.1.c. Informed Consent and Client Rights**

Supervisors make supervisees aware of client rights including the protection of client privacy and confidentiality in the counseling relationship. Supervisees provide clients with professional disclosure information and inform them of how the supervision process influences the limits of confidentiality. Supervisees make clients aware of who will have access to records of the counseling relationship and how these records will be used. (*See A.2.b., B.1.d.*)

## **F.2. Counselor Supervision Competence**

### **F.2.a. Supervisor Preparation**

Prior to offering clinical supervision services, counselors are trained in supervision methods and techniques. Counselors who offer clinical supervision services regularly pursue continuing education activities including both counseling and supervision topics and skills. (*See C.2.a., C.2.f.*)

### **F.2.b. Multicultural Issues/Diversity in Supervision**

Counseling supervisors are aware of and address the role of multiculturalism/diversity in the supervisory relationship.

## **F.3. Supervisory Relationships**

### **F.3.a. Relationship Boundaries With Supervisees**

Counseling supervisors clearly define and maintain ethical professional, personal, and social relationships with their supervisees. Counseling supervisors avoid nonprofessional relationships with current supervisees. If supervisors must assume other professional roles (e.g., clinical and administrative supervisor, instructor) with supervisees, they work to minimize potential conflicts and explain to supervisees the expectations and responsibilities associated with each role. They do not engage in any form of nonprofessional interaction that may compromise the supervisory relationship.

### **F.3.b. Sexual Relationships**

Sexual or romantic interactions or relationships with current supervisees are prohibited.

### **F.3.c. Sexual Harassment**

Counseling supervisors do not condone or subject supervisees to sexual harassment. (*See C.6.a.*)

### **F.3.d. Close Relatives and Friends**

Counseling supervisors avoid accepting close relatives, romantic partners, or friends as supervisees.

### **F.3.e. Potentially Beneficial Relationships**

Counseling supervisors are aware of the power differential in their relationships with supervisees. If they believe nonprofessional relationships with a supervisee may be potentially beneficial to the supervisee, they take precautions similar to those taken by counselors when working with clients. Examples of potentially beneficial interactions or relationships include attending a formal ceremony; hospital visits; providing support during a stressful event; or mutual membership in a professional association, organization, or community. Counseling supervisors engage in open discussions with supervisees when they consider entering into relationships with them outside of their roles as clinical and/or administrative supervisors. Before engaging in nonprofessional relationships, supervisors discuss with supervisees and document the rationale for such interactions, potential benefits or drawbacks, and anticipated consequences for the supervisee. Supervisors clarify the specific nature and limitations of the additional role(s) they will have with the supervisee.

## **F.4. Supervisor Responsibilities**

### **F.4.a. Informed Consent for Supervision**

Supervisors are responsible for incorporating into their supervision the principles of informed consent and participation. Supervisors inform supervisees of the policies and procedures to which they are to adhere and the mechanisms for due process appeal of individual supervisory actions.

### **F.4.b. Emergencies and Absences**

Supervisors establish and communicate to supervisees procedures for contacting them or, in their absence, alternative on-call supervisors to assist in handling crises.

### **F.4.c. Standards for Supervisees**

Supervisors make their supervisees aware of professional and ethical standards and legal responsibilities. Supervisors of postdegree counselors encourage these counselors to adhere to professional standards of practice. (*See C.1.*)

### **F.4.d. Termination of the Supervisory Relationship**

Supervisors or supervisees have the right to terminate the supervisory

relationship with adequate notice. Reasons for withdrawal are provided to the other party. When cultural, clinical, or professional issues are crucial to the viability of the supervisory relationship, both parties make efforts to resolve differences. When termination is warranted, supervisors make appropriate referrals to possible alternative supervisors.

## **F.5. Counseling Supervision Evaluation, Remediation, and Endorsement**

### **F.5.a. Evaluation**

Supervisors document and provide supervisees with ongoing performance appraisal and evaluation feedback and schedule periodic formal evaluative sessions throughout the supervisory relationship.

### **F.5.b. Limitations**

Through ongoing evaluation and appraisal, supervisors are aware of the limitations of supervisees that might impede performance. Supervisors assist supervisees in securing remedial assistance when needed. They recommend dismissal from training programs, applied counseling settings, or state or voluntary professional credentialing processes when those supervisees are unable to provide competent professional services. Supervisors seek consultation and document their decisions to dismiss or refer supervisees for assistance. They ensure that supervisees are aware of options available to them to address such decisions. (*See C.2.g.*)

### **F.5.c. Counseling for Supervisees**

If supervisees request counseling, supervisors provide them with acceptable referrals. Counselors do not provide counseling services to supervisees. Supervisors address interpersonal competencies in terms of the impact of these issues on clients, the supervisory relationship, and professional functioning. (*See F.3.a.*)

### **F.5.d. Endorsement**

Supervisors endorse supervisees for certification, licensure, employment, or completion of an academic or training program only when they believe supervisees are qualified for the endorsement. Regardless of qualifications, supervisors do not endorse supervisees whom they believe to be impaired in any way that would interfere with the performance of the duties associated with the endorsement.

## **F.6. Responsibilities of Counselor Educators**

### **F.6.a. Counselor Educators**

Counselor educators who are responsible for developing, implementing, and supervising educational programs are skilled as teachers and practitioners. They are knowledgeable regarding the ethical, legal, and regulatory aspects of the profession, are skilled in applying that knowledge, and make students and supervisees aware of their responsibilities. Counselor educators conduct counselor education and training programs in an ethical manner and serve as role models for professional behavior. (See *C.1., C.2.a., C.2.c.*)

### **F.6.b. Infusing Multicultural Issues/Diversity**

Counselor educators infuse material related to multiculturalism/diversity into all courses and workshops for the development of professional counselors.

### **F.6.c. Integration of Study and Practice**

Counselor educators establish education and training programs that integrate academic study and supervised practice.

### **F.6.d. Teaching Ethics**

Counselor educators make students and supervisees aware of the ethical responsibilities and standards of the profession and the ethical responsibilities of students to the profession. Counselor educators infuse ethical considerations throughout the curriculum. (See *C.1.*)

### **F.6.e. Peer Relationships**

Counselor educators make every effort to ensure that the rights of peers are not compromised when students or supervisees lead counseling groups or provide clinical supervision. Counselor educators take steps to ensure that students and supervisees understand they have the same ethical obligations as counselor educators, trainers, and supervisors.

### **F.6.f. Innovative Theories and Techniques**

When counselor educators teach counseling techniques/procedures that are innovative, without an empirical foundation, or without a well-grounded theoretical foundation, they define the counseling techniques/procedures as “unproven” or “developing” and explain to students the potential risks and ethical considerations of using such techniques/procedures.

### **F.6.g. Field Placements**

Counselor educators develop clear policies within their training programs regarding field placement and other clinical experiences. Counselor educators provide clearly stated roles and responsibilities for the student or supervisee, the site supervisor, and the program supervisor. They confirm that site supervisors are qualified to provide supervision and inform site supervisors of their professional and ethical responsibilities in this role.

### **F.6.h. Professional Disclosure**

Before initiating counseling services, counselors-in-training disclose their status as students and explain how this status affects the limits of confidentiality. Counselor educators ensure that the clients at field placements are aware of the services rendered and the qualifications of the students and supervisees rendering those services. Students and supervisees obtain client permission before they use any information concerning the counseling relationship in the training process. (See *A.2.b.*)

## **F.7. Student Welfare**

### **F.7.a. Orientation**

Counselor educators recognize that orientation is a developmental process that continues throughout the educational and clinical training of students. Counseling faculty provide prospective students with information about the counselor education program’s expectations:

1. the type and level of skill and knowledge acquisition required for successful completion of the training;
2. program training goals, objectives, and mission, and subject matter to be covered;
3. bases for evaluation;
4. training components that encourage self-growth or self-disclosure as part of the training process;
5. the type of supervision settings and requirements of the sites for required clinical field experiences;
6. student and supervisee evaluation and dismissal policies and procedures; and
7. up-to-date employment prospects for graduates.

### **F.7.b. Self-Growth Experiences**

Counselor education programs delineate requirements for self-disclosure or self-growth experiences in their

admission and program materials. Counselor educators use professional judgment when designing training experiences they conduct that require student and supervisee self-growth or self-disclosure. Students and supervisees are made aware of the ramifications their self-disclosure may have when counselors whose primary role as teacher, trainer, or supervisor requires acting on ethical obligations to the profession. Evaluative components of experiential training experiences explicitly delineate predetermined academic standards that are separate and do not depend on the student’s level of self-disclosure. Counselor educators may require trainees to seek professional help to address any personal concerns that may be affecting their competency.

## **F.8. Student Responsibilities**

### **F.8.a. Standards for Students**

Counselors-in-training have a responsibility to understand and follow the *ACA Code of Ethics* and adhere to applicable laws, regulatory policies, and rules and policies governing professional staff behavior at the agency or placement setting. Students have the same obligation to clients as those required of professional counselors. (See *C.1., H.1.*)

### **F.8.b. Impairment**

Counselors-in-training refrain from offering or providing counseling services when their physical, mental, or emotional problems are likely to harm a client or others. They are alert to the signs of impairment, seek assistance for problems, and notify their program supervisors when they are aware that they are unable to effectively provide services. In addition, they seek appropriate professional services for themselves to remediate the problems that are interfering with their ability to provide services to others. (See *A.1., C.2.d., C.2.g.*)

## **F.9. Evaluation and Remediation of Students**

### **F.9.a. Evaluation**

Counselors clearly state to students, prior to and throughout the training program, the levels of competency expected, appraisal methods, and timing of evaluations for both didactic and clinical competencies. Counselor educators provide students

with ongoing performance appraisal and evaluation feedback throughout the training program.

#### **F.9.b. Limitations**

Counselor educators, throughout ongoing evaluation and appraisal, are aware of and address the inability of some students to achieve counseling competencies that might impede performance. Counselor educators

1. assist students in securing remedial assistance when needed,
2. seek professional consultation and document their decision to dismiss or refer students for assistance, and
3. ensure that students have recourse in a timely manner to address decisions to require them to seek assistance or to dismiss them and provide students with due process according to institutional policies and procedures. (See C.2.g.)

#### **F.9.c. Counseling for Students**

If students request counseling or if counseling services are required as part of a remediation process, counselor educators provide acceptable referrals.

### **F. 10. Roles and Relationships Between Counselor Educators and Students**

#### **F.10.a. Sexual or Romantic Relationships**

Sexual or romantic interactions or relationships with current students are prohibited.

#### **F.10.b. Sexual Harassment**

Counselor educators do not condone or subject students to sexual harassment. (See C.6.a.)

#### **F.10.c. Relationships With Former Students**

Counselor educators are aware of the power differential in the relationship between faculty and students. Faculty members foster open discussions with former students when considering engaging in a social, sexual, or other intimate relationship. Faculty members discuss with the former student how their former relationship may affect the change in relationship.

#### **F.10.d. Nonprofessional Relationships**

Counselor educators avoid nonprofessional or ongoing professional relationships with students in which

there is a risk of potential harm to the student or that may compromise the training experience or grades assigned. In addition, counselor educators do not accept any form of professional services, fees, commissions, reimbursement, or remuneration from a site for student or supervisee placement.

#### **F.10.e. Counseling Services**

Counselor educators do not serve as counselors to current students unless this is a brief role associated with a training experience.

#### **F.10.f. Potentially Beneficial Relationships**

Counselor educators are aware of the power differential in the relationship between faculty and students. If they believe a nonprofessional relationship with a student may be potentially beneficial to the student, they take precautions similar to those taken by counselors when working with clients. Examples of potentially beneficial interactions or relationships include, but are not limited to, attending a formal ceremony; hospital visits; providing support during a stressful event; or mutual membership in a professional association, organization, or community. Counselor educators engage in open discussions with students when they consider entering into relationships with students outside of their roles as teachers and supervisors. They discuss with students the rationale for such interactions, the potential benefits and drawbacks, and the anticipated consequences for the student. Educators clarify the specific nature and limitations of the additional role(s) they will have with the student prior to engaging in a nonprofessional relationship. Nonprofessional relationships with students should be time-limited and initiated with student consent.

### **F.11. Multicultural/Diversity Competence in Counselor Education and Training Programs**

#### **F.11.a. Faculty Diversity**

Counselor educators are committed to recruiting and retaining a diverse faculty.

#### **F.11.b. Student Diversity**

Counselor educators actively attempt to recruit and retain a diverse student body. Counselor educators

demonstrate commitment to multicultural/diversity competence by recognizing and valuing diverse cultures and types of abilities students bring to the training experience. Counselor educators provide appropriate accommodations that enhance and support diverse student well-being and academic performance.

#### **F.11.c. Multicultural/Diversity Competence**

Counselor educators actively infuse multicultural/diversity competency in their training and supervision practices. They actively train students to gain awareness, knowledge, and skills in the competencies of multicultural practice. Counselor educators include case examples, role-plays, discussion questions, and other classroom activities that promote and represent various cultural perspectives.

## **Section G**

### **Research and Publication**

#### **Introduction**

Counselors who conduct research are encouraged to contribute to the knowledge base of the profession and promote a clearer understanding of the conditions that lead to a healthy and more just society. Counselors support efforts of researchers by participating fully and willingly whenever possible. Counselors minimize bias and respect diversity in designing and implementing research programs.

#### **G.1. Research Responsibilities**

##### **G.1.a. Use of Human Research Participants**

Counselors plan, design, conduct, and report research in a manner that is consistent with pertinent ethical principles, federal and state laws, host institutional regulations, and scientific standards governing research with human research participants.

##### **G.1.b. Deviation From Standard Practice**

Counselors seek consultation and observe stringent safeguards to protect the rights of research participants when a research problem suggests a deviation from standard or acceptable practices.

### **G.1.c. Independent Researchers**

When independent researchers do not have access to an Institutional Review Board (IRB), they should consult with researchers who are familiar with IRB procedures to provide appropriate safeguards.

### **G.1.d. Precautions to Avoid Injury**

Counselors who conduct research with human participants are responsible for the welfare of participants throughout the research process and should take reasonable precautions to avoid causing injurious psychological, emotional, physical, or social effects to participants.

### **G.1.e. Principal Researcher Responsibility**

The ultimate responsibility for ethical research practice lies with the principal researcher. All others involved in the research activities share ethical obligations and responsibility for their own actions.

### **G.1.f. Minimal Interference**

Counselors take reasonable precautions to avoid causing disruptions in the lives of research participants that could be caused by their involvement in research.

### **G.1.g. Multicultural/Diversity**

#### **Considerations in Research**

When appropriate to research goals, counselors are sensitive to incorporating research procedures that take into account cultural considerations. They seek consultation when appropriate.

## **G.2. Rights of Research Participants**

(See A.2, A.7.)

### **G.2.a. Informed Consent in Research**

Individuals have the right to consent to become research participants. In seeking consent, counselors use language that

1. accurately explains the purpose and procedures to be followed,
2. identifies any procedures that are experimental or relatively untried,
3. describes any attendant discomforts and risks,
4. describes any benefits or changes in individuals or organizations that might be reasonably expected,
5. discloses appropriate alternative procedures that would be advantageous for participants,
6. offers to answer any inquiries concerning the procedures,
7. describes any limitations on confidentiality,

8. describes the format and potential target audiences for the dissemination of research findings, and

9. instructs participants that they are free to withdraw their consent and to discontinue participation in the project at any time without penalty.

### **G.2.b. Deception**

Counselors do not conduct research involving deception unless alternative procedures are not feasible and the prospective value of the research justifies the deception. If such deception has the potential to cause physical or emotional harm to research participants, the research is not conducted, regardless of prospective value. When the methodological requirements of a study necessitate concealment or deception, the investigator explains the reasons for this action as soon as possible during the debriefing.

### **G.2.c. Student/Supervisee Participation**

Researchers who involve students or supervisees in research make clear to them that the decision regarding whether or not to participate in research activities does not affect one's academic standing or supervisory relationship. Students or supervisees who choose not to participate in educational research are provided with an appropriate alternative to fulfill their academic or clinical requirements.

### **G.2.d. Client Participation**

Counselors conducting research involving clients make clear in the informed consent process that clients are free to choose whether or not to participate in research activities. Counselors take necessary precautions to protect clients from adverse consequences of declining or withdrawing from participation.

### **G.2.e. Confidentiality of Information**

Information obtained about research participants during the course of an investigation is confidential. When the possibility exists that others may obtain access to such information, ethical research practice requires that the possibility, together with the plans for protecting confidentiality, be explained to participants as a part of the procedure for obtaining informed consent.

### **G.2.f. Persons Not Capable of Giving Informed Consent**

When a person is not capable of giving informed consent, counselors

provide an appropriate explanation to, obtain agreement for participation from, and obtain the appropriate consent of a legally authorized person.

### **G.2.g. Commitments to Participants**

Counselors take reasonable measures to honor all commitments to research participants. (See A.2.c.)

### **G.2.h. Explanations After Data Collection**

After data are collected, counselors provide participants with full clarification of the nature of the study to remove any misconceptions participants might have regarding the research. Where scientific or human values justify delaying or withholding information, counselors take reasonable measures to avoid causing harm.

### **G.2.i. Informing Sponsors**

Counselors inform sponsors, institutions, and publication channels regarding research procedures and outcomes. Counselors ensure that appropriate bodies and authorities are given pertinent information and acknowledgement.

### **G.2.j. Disposal of Research Documents and Records**

Within a reasonable period of time following the completion of a research project or study, counselors take steps to destroy records or documents (audio, video, digital, and written) containing confidential data or information that identifies research participants. When records are of an artistic nature, researchers obtain participant consent with regard to handling of such records or documents. (See B.4.a, B.4.g.)

## **G.3. Relationships With Research Participants (When Research Involves Intensive or Extended Interactions)**

### **G.3.a. Nonprofessional Relationships**

Nonprofessional relationships with research participants should be avoided.

### **G.3.b. Relationships With Research Participants**

Sexual or romantic counselor–research participant interactions or relationships with current research participants are prohibited.

### **G.3.c. Sexual Harassment and Research Participants**

Researchers do not condone or subject research participants to sexual harassment.

### **G.3.d. Potentially Beneficial Interactions**

When a nonprofessional interaction between the researcher and the research participant may be potentially beneficial, the researcher must document, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the research participant. Such interactions should be initiated with appropriate consent of the research participant. Where unintentional harm occurs to the research participant due to the nonprofessional interaction, the researcher must show evidence of an attempt to remedy such harm.

## **G.4. Reporting Results**

### **G.4.a. Accurate Results**

Counselors plan, conduct, and report research accurately. They provide thorough discussions of the limitations of their data and alternative hypotheses. Counselors do not engage in misleading or fraudulent research, distort data, misrepresent data, or deliberately bias their results. They explicitly mention all variables and conditions known to the investigator that may have affected the outcome of a study or the interpretation of data. They describe the extent to which results are applicable for diverse populations.

### **G.4.b. Obligation to Report Unfavorable Results**

Counselors report the results of any research of professional value. Results that reflect unfavorably on institutions, programs, services, prevailing opinions, or vested interests are not withheld.

### **G.4.c. Reporting Errors**

If counselors discover significant errors in their published research, they take reasonable steps to correct such errors in a correction erratum, or through other appropriate publication means.

### **G.4.d. Identity of Participants**

Counselors who supply data, aid in the research of another person, report research results, or make original data available take due care to disguise the identity of respective participants in the absence of specific authorization from the participants to do otherwise. In situations where participants self-identify their involvement in research studies, researchers take active steps to ensure that data is adapted/changed to protect

the identity and welfare of all parties and that discussion of results does not cause harm to participants.

### **G.4.e. Replication Studies**

Counselors are obligated to make available sufficient original research data to qualified professionals who may wish to replicate the study.

## **G.5. Publication**

### **G.5.a. Recognizing Contributions**

When conducting and reporting research, counselors are familiar with and give recognition to previous work on the topic, observe copyright laws, and give full credit to those to whom credit is due.

### **G.5.b. Plagiarism**

Counselors do not plagiarize, that is, they do not present another person's work as their own work.

### **G.5.c. Review/Republication of Data or Ideas**

Counselors fully acknowledge and make editorial reviewers aware of prior publication of ideas or data where such ideas or data are submitted for review or publication.

### **G.5.d. Contributors**

Counselors give credit through joint authorship, acknowledgment, footnote statements, or other appropriate means to those who have contributed significantly to research or concept development in accordance with such contributions. The principal contributor is listed first and minor technical or professional contributions are acknowledged in notes or introductory statements.

### **G.5.e. Agreement of Contributors**

Counselors who conduct joint research with colleagues or students/supervisees establish agreements in advance regarding allocation of tasks, publication credit, and types of acknowledgement that will be received.

### **G.5.f. Student Research**

For articles that are substantially based on students course papers, projects, dissertations or theses, and on which students have been the primary contributors, they are listed as principal authors.

### **G.5.g. Duplicate Submission**

Counselors submit manuscripts for consideration to only one journal at a time. Manuscripts that are published in whole or in substantial part in another journal or published work are not submitted for publication

without acknowledgment and permission from the previous publication.

### **G.5.h. Professional Review**

Counselors who review material submitted for publication, research, or other scholarly purposes respect the confidentiality and proprietary rights of those who submitted it. Counselors use care to make publication decisions based on valid and defensible standards. Counselors review article submissions in a timely manner and based on their scope and competency in research methodologies. Counselors who serve as reviewers at the request of editors or publishers make every effort to only review materials that are within their scope of competency and use care to avoid personal biases.

# Section H

## Resolving Ethical Issues

## **Introduction**

Counselors behave in a legal, ethical, and moral manner in the conduct of their professional work. They are aware that client protection and trust in the profession depend on a high level of professional conduct. They hold other counselors to the same standards and are willing to take appropriate action to ensure that these standards are upheld.

Counselors strive to resolve ethical dilemmas with direct and open communication among all parties involved and seek consultation with colleagues and supervisors when necessary. Counselors incorporate ethical practice into their daily professional work. They engage in ongoing professional development regarding current topics in ethical and legal issues in counseling.

## **H.1. Standards and the Law**

*(See F.9.a.)*

### **H.1.a. Knowledge**

Counselors understand the *ACA Code of Ethics* and other applicable ethics codes from other professional organizations or from certification and licensure bodies of which they are members. Lack of knowledge or misunderstanding of an ethical responsibility is not a



defense against a charge of unethical conduct.

#### **H.1.b. Conflicts Between Ethics and Laws**

If ethical responsibilities conflict with law, regulations, or other governing legal authority, 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.

### **H.2. Suspected Violations**

#### **H.2.a. Ethical Behavior Expected**

Counselors expect colleagues to adhere to the *ACA Code of Ethics*. When counselors possess knowledge that raises doubts as to whether another counselor is acting in an ethical manner, they take appropriate action. (See *H.2.b.*, *H.2.c.*)

#### **H.2.b. Informal Resolution**

When counselors have reason to believe that another counselor is violating or has violated an ethical standard, they attempt first to resolve the issue informally with the other counselor if feasible, provided such action does not violate confidentiality rights that may be involved.

#### **H.2.c. Reporting Ethical Violations**

If an apparent violation has substantially harmed, or is likely to substantially harm a person or organization

and is not appropriate for informal resolution or is not resolved properly, counselors take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, voluntary national certification bodies, state licensing boards, or to the appropriate institutional authorities. This standard does not apply when an intervention would violate confidentiality rights or when counselors have been retained to review the work of another counselor whose professional conduct is in question.

#### **H.2.d. Consultation**

When uncertain as to whether a particular situation or course of action may be in violation of the *ACA Code of Ethics*, counselors consult with other counselors who are knowledgeable about ethics and the *ACA Code of Ethics*, with colleagues, or with appropriate authorities

#### **H.2.e. Organizational Conflicts**

If the demands of an organization with which counselors are affiliated pose a conflict with the *ACA Code of Ethics*, counselors specify the nature of such conflicts and express to their supervisors or other responsible officials their commitment to the *ACA Code of Ethics*. When possible, counselors work toward change within the organization to allow full adherence to the *ACA Code of Ethics*. In doing so, they address any confidentiality issues.

#### **H.2.f. Unwarranted Complaints**

Counselors do not initiate, participate in, or encourage the filing of ethics complaints that are made with reckless disregard or willful ignorance of facts that would disprove the allegation.

#### **H.2.g. Unfair Discrimination Against Complainants and Respondents**

Counselors do not deny persons employment, advancement, admission to academic or other programs, tenure, or promotion based solely upon their having made or their being the subject of an ethics complaint. This does not preclude taking action based upon the outcome of such proceedings or considering other appropriate information.

### **H.3. Cooperation With Ethics Committees**

Counselors assist in the process of enforcing the *ACA Code of Ethics*. Counselors cooperate with investigations, proceedings, and requirements of the ACA Ethics Committee or ethics committees of other duly constituted associations or boards having jurisdiction over those charged with a violation. Counselors are familiar with the *ACA Policy and Procedures for Processing Complaints of Ethical Violations* and use it as a reference for assisting in the enforcement of the *ACA Code of Ethics*.

# Glossary of Terms

- Advocacy** – promotion of the well-being of individuals and groups, and the counseling profession within systems and organizations. Advocacy seeks to remove barriers and obstacles that inhibit access, growth, and development.
- Assent** – to demonstrate agreement, when a person is otherwise not capable or competent to give formal consent (e.g., informed consent) to a counseling service or plan.
- Client** – an individual seeking or referred to the professional services of a counselor for help with problem resolution or decision making.
- Counselor** – a professional (or a student who is a counselor-in-training) engaged in a counseling practice or other counseling-related services. Counselors fulfill many roles and responsibilities such as counselor educators, researchers, supervisors, practitioners, and consultants.
- Counselor Educator** – a professional counselor engaged primarily in developing, implementing, and supervising the educational preparation of counselors-in-training.
- Counselor Supervisor** – a professional counselor who engages in a formal relationship with a practicing counselor or counselor-in-training for the purpose of overseeing that individual's counseling work or clinical skill development.
- Culture** – membership in a socially constructed way of living, which incorporates collective values, beliefs, norms, boundaries, and lifestyles that are cocreated with others who share similar worldviews comprising biological, psychosocial, historical, psychological, and other factors.
- Diversity** – the similarities and differences that occur within and across cultures, and the intersection of cultural and social identities.
- Documents** – any written, digital, audio, visual, or artistic recording of the work within the counseling relationship between counselor and client.
- Examinee** – a recipient of any professional counseling service that includes educational, psychological, and career appraisal utilizing qualitative or quantitative techniques.
- Forensic Evaluation** – any formal assessment conducted for court or other legal proceedings.
- Multicultural/Diversity Competence** – a capacity whereby counselors possess cultural and diversity awareness and knowledge about self and others, and how this awareness and knowledge is applied effectively in practice with clients and client groups.
- Multicultural/Diversity Counseling** – counseling that recognizes diversity and embraces approaches that support the worth, dignity, potential, and uniqueness of individuals within their historical, cultural, economic, political, and psychosocial contexts.
- Student** – an individual engaged in formal educational preparation as a counselor-in-training.
- Supervisee** – a professional counselor or counselor-in-training whose counseling work or clinical skill development is being overseen in a formal supervisory relationship by a qualified trained professional.
- Supervisor** – counselors who are trained to oversee the professional clinical work of counselors and counselors-in-training.
- Teaching** – all activities engaged in as part of a formal educational program designed to lead to a graduate degree in counseling.
- Training** – the instruction and practice of skills related to the counseling profession. Training contributes to the ongoing proficiency of students and professional counselors.

APPENDIX C

PUBLISHED STUDIES ON COMMON FACTORS ASSOCIATED WITH STUDENT  
UNSUITABILITY IN SOCIAL SCIENCE PROGRAMS

Table II. Published studies regarding the most common factors associated with student unsuitability in social science training programmes.

Date published	Authors	Listing type	Five most frequently cited factors, with the first listed being the highest ranked
1983	Biaggio, Gasparikova-Krasnec, and Bauer	Categories provided: 6	Most frequently ranked conditions considered sufficient to warrant dismissing a doctoral clinical student presuming warning has been given: violation of professional ethics psychopathology substandard academic performance therapy skills not mastered judgment poor
1986	Boxley, Drew, and Rangel	Respondents generated the categories	Most frequently cited factors associated with intern's impairment: personality disorder depression emotional problems marital problems physical illness
1991	Olkin and Gaughen	Categories provided: 7	Most frequently cited problems for which students are identified: academic deficits problems in clinical skills pervasive interpersonal problems problems in supervision intrapersonal problems
1995	Koerin and Miller	Respondents generated the categories	Most frequently listed types of non-academic situations or behaviours that warrant terminating a student from a masters social work programme: ethics issues mental health issues substance abuse field performance problems classroom behaviour problems
1995	Procidano, Busch-Rossnagel, Reznikoff, and Geisinger	Respondents generated the categories	Most frequently cited problems of a non-academic nature which show evidence of being unsuitable for clinical work: * limited clinical skills personality/emotional problem unethical behaviour
1997	Ryan, Habibis, and Craft	Categories provided: 10	Most likely non-academic reasons our programme actively pursues counselling out a student: * obvious emotional/mental problems inability to respect human diversity non-conformity to social work values personal values inconsistent with social work
2003	Russell and Peterson	Categories provided: 16	Most frequently ranked concerns from list of indicators of student impairment: ethical violations unprofessional conduct suicide attempts substance use/abuse possible signs of a personality disorder
2004	Huprich and Rudd	Unspecified	Most commonly reported impairments based on knowledge of programme over past 10 years: personality disorder depressive symptoms adjustment disorder anxiety symptoms alcohol
2004	Lafrance, Gray, and Herbert	Focus group generated the categories	Most frequently cited potential indicators that suggest a person may not be suitable for the practice of social work: * personal qualities: maturity, integrity capacity and willingness for self awareness capacity to develop professional social work relationships with clients, colleagues, staff, and community members congruence between what individuals bring to the profession and the values, principles, and beliefs of the social work profession
2004	Oliver, Bernstein, Anderson, Blashfield, and Roberts	Respondents generated the categories	Most frequently cited types of problems/impairments observed in student colleagues: depression and other mood disorders personality disorders or traits anxiety disorders eating disorders substance abuse

Table II (Continued)

Date published	Authors	Listing type	Five most frequently cited factors, with the first listed being the highest ranked
2004	Vacha-Haase, Davenport, and Kerevsky	Categories provided: 14	Most frequently cited types of student difficulties actually encountered during the past year that did not lead to termination: inadequate clinical skills defensiveness in supervision deficient interpersonal skills emotional problems physical illness
2005	Busseri, Tyler, and King	Respondents generated the categories	Most commonly cited reasons, apart from academic performance, for making judgments about the need for dismissal of a particular trainee: ethical infractions or reasoning problematic clinical skills development or performance failure to respond sufficiently to remediation plans unprofessional demeanor concerns raised by supervisors
2005	Rosenberg, Getzelman, Arcinue, and Oren	Categories provided: 34	Most common types of problems students observed in their peers lack of awareness of impact on others: emotional problems clinical deficiency poor interpersonal skills academic deficiency
2006	Bogo et al.	Categories provided: 7	Most common themes to emerge regarding the performance of problematic practicum students: personal qualities: irritable, defensive, judgmental, lacking in empathy personal qualities and their impact on approach to learning: unenthusiastic, unreceptive personal qualities and their impact on behaviour in the field setting: needy, opinionated personal qualities and their impact on ability to conceptualise practice personal qualities and their impact on practice abilities: relational and procedural components

Note: \*Fewer than five factors reported.

Chart obtained from the work of Brear (2008)

APPENDIX D  
AMERICAN PERSONNEL AND GUIDANCE ASSOCIATION  
CODE OF ETHICS

*Oct. 1961*  
*2.40.2*

**ETHICAL STANDARDS**  
**American Personnel and Guidance Association**

# ETHICAL STANDARDS

## American Personnel and Guidance Association

### Preamble

The American Personnel and Guidance Association is an educational, scientific, and professional organization dedicated to service to society. This service is committed to profound faith in the worth, dignity, and great potentiality of the individual human being.

The marks of a profession, and therefore of a professional organization, can be stated as follows:

1. Possession of a body of specialized knowledge, skills, and attitudes known and practiced by its members.

2. This body of specialized knowledge, skills, and attitudes is derived through scientific inquiry and scholarly learning.

3. This body of specialized knowledge, skills, and attitudes is acquired through professional preparation, preferably on the graduate level, in a college or university as well as through continuous in-service training and personal growth after completion of formal education.

4. This body of specialized knowledge, skills, and attitudes, is constantly tested and extended through research and scholarly inquiry.

5. A profession has a literature of its own, even though it may, and indeed must, draw portions of its content from other areas of knowledge.

6. A profession exalts service to the individual and society above personal gain. It possesses a philosophy and a code of ethics.

7. A profession through the voluntary association of its members constantly examines and improves the quality of its professional preparation and services to the individual and society.

8. Membership in the professional organization and the practice of the profession must be limited to persons meeting stated standards of preparation and competencies.

9. The profession affords a life career and permanent membership as long as services meet professional standards.

10. The public recognizes, has confidence in, and is willing to compensate the members of the profession for their services.

The Association recognizes that the vocational roles and settings of its members are identified with a wide variety of academic disciplines and levels of

academic preparation. This diversity reflects the pervasiveness of the Association's interest and influence. It also poses challenging complexities in efforts to conceptualize:

- a. the characteristics of members;
- b. desired or requisite preparation or practice; and
- c. supporting social, legal and/or ethical controls.

The specification of ethical standards enables the Association to clarify to members, future members, and to those served by members the nature of ethical responsibilities held in common by its members.

The introduction of such standards will inevitably stimulate greater concern by members for practice and preparation for practice. It will also stimulate a general growth and identification with and appreciation for both the common and diverse characteristics of the definable roles within the world of work of Association members.

There are six major areas of professional activity which encompass the work of members of APGA. For each of these areas certain general principles are listed below to serve as guide lines for ethical practice. These are preceded by a general section which includes certain principles germane to the six areas and common to the entire work of the Association members.

### Section A

#### General

1. The member exerts what influence he can to foster the development and improvement of the profession and continues his professional growth throughout his career.

2. The member has a responsibility to the institution within which he serves. His acceptance of employment by the institution implies that he is in substantial agreement with the general policies and principles of the institution. Therefore, his professional activities are also in accord with the objectives of the institution. Within the member's own work setting, if, despite his efforts, he cannot reach agreement as to acceptable ethical standards of conduct with his superiors, he should end his affiliation with them.



3. The member must expect ethical behavior among his professional associates in APGA at all times. He is obligated, in situations where he possesses information raising serious doubt as to the ethical behavior of other members, to attempt to rectify such conditions.

4. The member is obligated to concern himself with the degree to which the personnel functions of non-members with whose work he is acquainted represent competent and ethical performance. Where his information raises serious doubt as to the ethical behavior of such persons, it is his responsibility to attempt to rectify such conditions.

5. The member must not seek self-enhancement through expressing evaluations or comparisons damaging to other ethical professional workers.

6. The member should not claim or imply professional qualifications exceeding those possessed and is responsible for correcting any misrepresentations of his qualifications by others.

7. The member providing services for personal remuneration shall, in establishing fees for such services, take careful account of the charges made for comparable services by other professional persons.

8. The member who provides information to the public or to his subordinates, peers, or superiors has a clear responsibility to see that both the content and the manner of presentation are accurate and appropriate to the situation.

9. The member has an obligation to ensure that evaluative information about such persons as clients, students, and applicants shall be shared only with those persons who will use such information for professional purposes.

10. The member shall offer professional services only, through the context of a professional relationship. Thus testing, counseling, and other services are not to be provided through the mail by means of newspaper or magazine articles, radio or television programs, or public performances.

## Section B

### Counseling

This section refers to practices involving a counseling relationship with a counselee or client and is not intended to be applicable to practices involving administrative relationships with the persons being helped. A counseling relationship denotes that the person seeking help retain full freedom of choice and decision and that the helping person has no authority or responsibility to approve or disapprove of the choices or decisions of the counselee or client. "Counselee" or "client" is used here to indicate the person (or persons) for whom the mem-

ber has assumed a professional responsibility. Typically the counselee or client is the individual with whom the member has direct and primary contact. However, at times, "client" may include another person (s) when the other person (s) exercise significant control and direction over the individual being helped in connection with the decisions and plans being considered in counseling.

1. The member's *primary* obligation is to respect the integrity and promote the welfare of the counselee or client with whom he is working.

2. The counseling relationship and information resulting therefrom must be kept confidential consistent with the obligations of the member as a professional person.

3. Records of the counseling relationship including interview notes, test data, correspondence, tape recordings, and other documents are to be considered professional information for use in counseling, research, and teaching of counselors but always with full protection of the identity of the client and with precaution so that no harm will come to him.

4. The counselee or client should be informed of the conditions under which he may receive counseling assistance at or before the time he enters the counseling relationship. This is particularly true in the event that there exist conditions of which the counselee or client would not likely be aware.

5. The member reserves the right to consult with any other professionally competent person about his counselee client. In choosing his professional consultant the member must avoid placing the consultant in a conflict of interest situation, *i.e.*, the consultant must be free of any other obligatory relation to the member's client that would preclude the consultant being a proper party to the member's efforts to help the counselee or client.

6. The member shall decline to initiate or shall terminate a counseling relationship when he cannot be of professional assistance to the counselee or client either because of lack of competence or personal limitation. In such instances the member shall refer his counselee or client to an appropriate specialist. In the event the counselee or client declines the suggested referral, the member is not obligated to continue the counseling relationship.

7. When the member learns from counseling relationships of conditions which are likely to harm others over whom his institution or agency has responsibility, he is expected to report *the condition* to the appropriate responsible authority, but in such a manner as not to reveal the identity of his counselee or clients.

8. In the event that the counselee or client's condition is such as to require others to assume responsibility for him, or when there is clear and im-

minent danger to the counselee or client or to others, the member is expected to report this fact to an appropriate responsible authority, and/or take such other emergency measures as the situation demands.

9. Should the member be engaged in a work setting which calls for any variation from the above statements, the member is obligated to ascertain that such variations are justifiable under the conditions and that such variations are clearly specified and made known to all concerned with such counseling services.

### Section C

#### Testing

1. The primary purpose of psychological testing is to provide objective and comparative measures for use in self-evaluation or evaluation by others of general or specific attributes.

2. Generally, test results constitute only one of a variety of pertinent data for personnel and guidance decisions. It is the member's responsibility to provide adequate orientation or information to the examinee(s) so that the results of testing may be placed in proper perspective with other relevant factors.

3. When making any statements to the public about tests and testing care must be taken to give accurate information and to avoid any false claims or misconceptions.

4. Different tests demand different levels of competence for administration, scoring, and interpretation. It is therefore the responsibility of the member to recognize the limits of his competence and to perform only those functions which fall within his preparation and competence.

5. In selecting tests for use in a given situation or with a particular client the member must consider not only general but also specific validity, reliability, and appropriateness of the test(s).

6. Tests should be administered under the same conditions which were established in their standardization. Except for research purposes explicitly stated, any departures from these conditions, as well as unusual behavior or irregularities during the testing session which may affect the interpretation of the test results, must be fully noted and reported. In this connection, unsupervised test-taking or the use of tests through the mails are of questionable value.

7. The value of psychological tests depends in part on the novelty to persons taking them. Any prior information, coaching, or reproduction of test materials tends to invalidate test results. Therefore, test security is one of the professional obligations of the member.

8. The member has the responsibility to inform the examinee(s) as to the purpose of testing. The criteria of examinee's welfare and/or explicit prior understanding with him should determine who the recipients of the test results may be.

9. The member should guard against the appropriation, reproduction, or modifications of published tests or parts thereof without express permission and adequate recognition of the original author or publisher.

Regarding the preparation, publication, and distribution of tests reference should be made to:

"Tests and Diagnostic Techniques"—Report of the Joint Committee of the American Psychological Association, American Educational Research Association, and National Council of Measurements used in Education. Supplement to *Psychological Bulletin*, 1954, 2, 1-38.

### Section D

#### Research and Publication

1. In the performance of any research on human subjects, the member must avoid causing any injurious effects or after-effects of the experiment upon his subjects.

2. The member may withhold information or provide misinformation to subjects only when it is essential to the investigation and where he assumes responsibility for corrective action following the investigation.

3. In reporting research results, explicit mention must be made of all variables and conditions known to the investigator which might affect interpretation of the data.

4. The member is responsible for conducting and reporting his investigations so as to minimize the possibility that his findings will be misleading.

5. The member has an obligation to make available original research data to qualified others who may wish to replicate or verify the study.

6. In reporting research results or in making original data available, due care must be taken to disguise the identity of the subjects, in the absence of specific permission from such subjects to do otherwise.

7. In conducting and reporting research, the member should be familiar with, and give recognition to, previous work on the topic.

8. The member has the obligation to give due credit to those who have contributed significantly to his research, in accordance with their contributions.

9. The member has the obligation to honor commitments made to subjects of research in return for their cooperation.

10. The member is expected to communicate to other members the results of any research he judges to be of professional or scientific value.

### Section E

#### Consulting and Private Practice

Consulting refers to a voluntary relationship between a professional helper and help-needing social unit (industry, business, school, college, etc.) in which the consultant is attempting to give help to the client in the solving of some current or potential problem.\*

1. The member acting as a consultant must have a high degree of self-awareness of his own values and needs in entering a helping relationship which involves change in a social unit.

2. There should be understanding and agreement between consultant and client as to directions or goals of the attempted change.

3. The consultant must be reasonably certain that he or his organization have the necessary skills and resources for giving the kind of help which is needed now or that may develop later.

4. The consulting relationship must be one in which client adaptability and growth toward self-direction are encouraged and cultivated. The consultant must consistently maintain his role as a consultant and not become a decision maker for the client.

5. The consultant in announcing his availability for service as a consultant follows professional rather than commercial standards in describing his services with accuracy, dignity, and caution.

6. For private practice in testing, counseling, or consulting the ethical principles stated in all previous sections of this document are pertinent. In addition, any individual, agency, or institution offering educational and vocational counseling to the public should meet the standards of the American Board on Professional Standards in Vocational Counseling, Inc.

### Section F

#### Personnel Administration

1. The member is responsible for establishing working agreements with supervisors and with subordinates especially regarding counseling or clinical relationships, confidentiality, distinction between public and private material, and a mutual

\* This definition is adapted from "Dimensions of the Consultant's Job" by Ronald Lippitt, *The Journal of Social Issues*, Vol. XV, No. 2, 1959.

respect for the positions of parties involved in such issues.

2. Such working agreements may vary from one institutional setting to another. What should be the case in each instance, however, is that agreements have been specified, made known to those concerned, and whenever possible the agreements reflect institutional policy rather than personal judgment.

3. The member's responsibility to his superiors requires that he keep them aware of conditions affecting the institution, particularly those which may be potentially disrupting or damaging to the institution.

4. The member has a responsibility to select competent persons for assigned responsibilities and to see that his personnel are used maximally for the skills and experience they possess.

5. The member has responsibility for constantly stimulating his staff for their and his own continued growth and improvement. He must see that staff members are adequately supervised as to the quality of their functioning and for purposes of professional development.

6. The member is responsible for seeing that his staff is informed of policies, goals, and programs toward which the department's operations are oriented.

### Section G

#### Preparation for Personnel Work

1. The member in charge of training sets up a strong program of academic study and supervised practice in order to prepare the trainees for their future responsibilities.

2. The training program should aim to develop in the trainee not only skills and knowledge, but also self-understanding.

3. The member should be aware of any manifestations of personal limitations in a student trainee which may influence the latter's provision of competent services and has an obligation to offer assistance to the trainee in securing professional remedial help.

4. The training program should include preparation in research and stimulation for the future personnel worker to do research and add to the knowledge in his field.

5. The training program should make the trainee aware of the ethical responsibilities and standards of the profession he is entering.

6. The program of preparation should aim at inculcating among the trainees, who will later become the practitioners of our profession, the ideal of service to individual and society above personal gain.

APPENDICES E

AWARENESS OF PROBLEMATIC BEHAVIOR SURVEY

Problematic behavior is defined as a practitioner who may be functioning below an acceptable standard. This may be influenced by either deficient clinical skills or psychological sensitivities potentially causing damage to clients, students, supervisees, colleagues or society-at-large (Kress & Protivnak, 2009). Among counselors-in-training this may include problematic behavior in the areas of academic, clinical skill development, intra/interpersonal behavior or psychological/emotional difficulties. These are behaviors that interfere in overall development, functioning and growth as a professional counselor.

The following survey addresses issues related to self-care and problematic behavior. This includes examining self-care and self/peer problematic behavior. The survey should take no more than 20 minutes to complete.

### Demographics

\_\_\_\_\_ Male \_\_\_\_\_ Female

Degree Program: \_\_\_\_\_Masters \_\_\_\_\_Doctoral

Credit Hours Completed in Program: \_\_\_\_\_0-12 \_\_\_\_\_13-24 \_\_\_\_\_25-40 \_\_\_\_\_41+

Specialty Area (**fill in**): \_\_\_\_\_

### Self-Care

1. Self-care is defined as behaviors that one engages in to maintain professional and personal well-being.

What type of self-care behaviors do you engage in? Check all that apply:

- \_\_\_\_\_Exercise
- \_\_\_\_\_Meditation
- \_\_\_\_\_Spending time with friends
- \_\_\_\_\_Seeking consultation
- \_\_\_\_\_Discussing concerns with supervisors
- \_\_\_\_\_Spending time with hobbies
- \_\_\_\_\_Discussing concerns with peers
- \_\_\_\_\_Relaxation exercises
- \_\_\_\_\_Listening to music
- \_\_\_\_\_Seeing a counselor for personal issues

Other:

---

---

2. Have you had training in your counselor education program on self-care?

Yes

No

2a. If you answered yes what was the nature of the training? Check all that apply.

Integrated into course(s)

Supervision

Academic advisement/meeting

Other:

---

---

3. Have you had training in your counselor education program on identifying self problematic behavior?

Yes

No

3a. If you answered yes what was the nature of the training? Check all that apply.

Integrated into course(s)

Supervision

Academic advisement/meeting

Other:

---

---

4. What are the behavioral or personal indicators you would use to determine if you were having challenges or experiencing problematic behaviors?

---

---

---

---

---

5. Have you experienced any of the following problematic behaviors? Check all that apply:

- Engagement in unprofessional behavior
- Emotional problems or concerns
- Academic limitations or deficiencies
- Eating disordered behavior
- Counseling skill limitations or deficiencies
- Substance abuse
- Difficulties maintaining appropriate and professional boundaries
- Personality problems or concerns
- Unprofessional behavior
- Avoidant or withdrawal behavior
- Anger or aggressive behavior
- Problems in interactions with peers
- Inappropriate dual relationships
- Problems in using or responding to supervision
- Inappropriate sexual behavior

If you answered **yes**, did you receive any remediation within your program?

- Yes
- No

If you received remediation please describe:

---

---

---

---

### Peer Concerns and Issues

These questions pertain to observation and or experiences of problematic behavior with peers

1. Does your program have a policy/procedure that addresses remediation and problematic behavior?

- Yes
- No

2. Have you had training on identifying problematic behavior among colleagues when you are a professional counselor?

Yes

No

2a. If you answered yes what was the nature of the training? Please check all that apply.

Integrated into course(s)

Supervision

Academic advisement/meeting

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Have you observed any peer related problematic behaviors while in your program?

Yes

No

3a. If you answered yes, estimate what percentage of students in your program you believe have experienced problematic behavior?

1-5%

6-10%

11-15%

16% or higher

3b. If you answered yes, what types of problematic behaviors have you observed?

Check all that apply:

Difficulty in collaborating or working with others

Problems in self-awareness

Difficulties in interpersonal skills

Engagement in unprofessional behavior

Emotional problems or concerns

Academic limitations or deficiencies

Eating disordered behavior

Counseling skill limitations or deficiencies

Substance abuse



- Difficulties maintaining appropriate and professional boundaries
- Personality problems or concerns
- Unprofessional behavior
- Difficulty in identifying or responding to social cues
- Avoidant or withdrawal behavior
- Anger or aggressive behavior
- Problems in interactions with peers
- Inappropriate dual relationships
- Problems in using or responding to supervision
- Inappropriate sexual behavior
- Maturity problems

Other:

---



---

4. What concerns or problems **have your experienced** relating to peer problematic behavior?

Check all that apply:

- Disruption of class
- Difficulty completing group projects
- Needed to avoid contact with the peer(s)
- Concerns about ability to self-disclose
- Challenging social interactions with peers
- Problems participating in class discussions
- Concerns that they may harm or hurt clients
- Frustration that faculty/program did not address problem
- Disruption of group cohesion in classes or group supervision
- Motivates me to address my own issues or concerns
- Frustration that the program did not screen out the peer or identify the problem
- Peer disrupts the learning process
- The problematic behavior has not had a direct effect on me

Other:

---

5. Have you ever discussed a peer's problematic behavior with: (Please check **all** that apply)

- Faculty Member
- Peers

- \_\_\_\_\_ University Supervisor
- \_\_\_\_\_ Site Supervisor
- \_\_\_\_\_ Counselor
- \_\_\_\_\_ Department Head/Chair

6. To what extent are each of the following a concern(s) when considering reporting a peer's problem? Circle the response that is most appropriate for you.

<u>Scale:</u>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Concern	Not a Concern	Somewhat of Concern	Neutral	A Concern	Significant
Faculty are not aware of student problematic behavior	1	2	3	4	5
Faculty are not receptive to reports about peer problematic behavior	1	2	3	4	5
The environment in the program is not conducive to reporting	1	2	3	4	5
I have not been prepared to identify or report	1	2	3	4	5
There is no policy or procedure for reporting	1	2	3	4	5
I am not comfortable reporting on peers	1	2	3	4	5
I do not feel competent to decide if I need to report behavior	1	2	3	4	5
I am not confident that the problem will be addressed	1	2	3	4	5

Other:

---



---

7. Discuss your experiences with faculty intervening or addressing problematic behavior among peers in your program:

---



---



---



---

APPENDICES F  
INFORMATION SHEET



COLLEGE OF EDUCATION

DEPARTMENT OF SPECIAL EDUCATION, REHABILITATION,  
COUNSELING/SCHOOL PSYCHOLOGY

INFORMATION SHEET

for Research Study Entitled  
**The Influence of Problematic Behaviors on Counseling Students Ability to Self-Monitor**

You are invited to participate in a research study designed to assess problematic behaviors within the graduate counseling programs. Under the direct supervision of Dr. Jamie Carney, Committee Chair and Professor at Auburn University, I, Amanda M. Thomas am the primary investigator for this particular study. This study has been developed to explore counselor education graduate students ability to self-monitor problematic behaviors. You have been selected as a possible candidate because you are currently enrolled in a graduate level counseling program.

If you choose to participate in this study, you will be prompted to complete a survey that will take approximately 20 minutes of your time. Once the survey is filled out, please place the item into the accompanying large envelope you received in the information packet, seal the document closed and please resend via mail. I do not anticipate any risks associated with this study or your participation.

Information obtained from this study will remain anonymous and will not be traced to specific participants. Data gleaned from your responses will be utilized in a doctoral dissertation that may also be published in a professional journal at a later date.

There are no direct benefits to you for participating in this study; however, there will be a direct benefit to the general population as you provide information related to current perspectives within the counseling profession. This study will help to improve student training and ability to regulate their own behaviors in an effort to prevent harm to clients, the counseling profession, and society-at-large. You may withdrawal at any point - without penalty.

If you have any questions, I invite you to contact me, Amanda M. Thomas, at [amt0004@auburn.edu](mailto:amt0004@auburn.edu) or 724.510.1152 or my faculty advisor, Dr. Jamie Carney at 334.844.2885 or [carneys@auburn.edu](mailto:carneys@auburn.edu).

For more information regarding your rights as a research participant, please contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone 334.844.5966 or [hsubjec@auburn.edu](mailto:hsubjec@auburn.edu).

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. THIS LETTER IS YOURS TO KEEP.

*Amanda M. Thomas*  
Amanda M. Thomas, Investigator

3-5-10  
Date

The Auburn University Institutional Review Board has approved this document for use from 1/22/10 to 1/1/11 Protocol # 09-341 EX (02)

2054 HALEY CENTER  
AUBURN, AL 36849-5222

TELEPHONE:  
334-844-7676

FAX:  
334-844-7677

APPENDICES G

AUBURN UNIVERSITY INSTITUTIONAL REVIEW BOARD APPROVAL  
TO CONDUCT STUDY EMAIL

Dear Ms. Thomas,

Your revisions to your protocol entitled "The Influence of Problematic Behaviors on Counseling Students Ability to Self-Monitor" have been reviewed. The protocol has now been approved as "Exempt".

We will be forwarding your approval documents to you to your Wisconsin address. If you need your stamped information letter quickly, please let us know.

Please note that you may not begin your research that involves human subjects until your information letter with an IRB approval stamp applied has been returned to you. You must use copies of that document when you consent participants, and provide a copy for them to keep.

Your protocol will expire on January 11, 2011. Put that date on your calendar now. About three weeks before that time you will need to submit a final report or renewal request.

If you have any questions, please let us know.

Best wishes for success with your research!

Office of Research Compliance  
307 Samford Hall  
Auburn University, AL 36849  
(334) 844-5966  
hsubjec@auburn.edu

APPENDIX H  
LENOIR-RHYNE INSTITUTIONAL REVIEW BOARD  
APPROVAL TO CONDUCT STUDY EMAIL

# LENOIR-RHYNE UNIVERSITY

## Institutional Review Board (IRB) for the Protection of Human Subjects

April 15, 2010

Amanda M. Thomas  
Doctoral Student  
Auburn University  
430 15<sup>th</sup> Avenue  
Baldwin, WI 54002

Re: The Influence of Problematic Behaviors on Counseling Students Ability to Self-Monitor  
IRB#: 2010-04-13 EXP

Dear Amanda:

This letter is to officially notify you that your research project has been approved by the IRB. It is the IRB's opinion that you have provided adequate safeguards for the rights, welfare, and privacy of the participants in this study. You are authorized to implement this study as of April 15, 2010. This approval is valid for one year.

Please review the following summary carefully.

IRB classification: Exempt  
IRB approval number: 2010-04-13 EXP  
IRB approval date: April 15, 2010  
IRB approval expires: April 15, 2011  
Protocol version and documents approved: Auburn Research Protocol Review Form, Consent Form, and Survey

This project should be conducted in full accordance with all applicable sections of the IRB Guidelines. No subjects may be involved in any study procedure prior to the IRB approval date or after the expiration date. You should notify the IRB immediately of any proposed changes that may affect the status of your research project, including protocol deviations, recruitment materials, and methods. You should report to the IRB any unanticipated problems involving risks to the participants or others. For projects which continue beyond one year from the starting date, the Principle Investigator and Sponsors are responsible for initiating continuing review and update of the research project. Your project will be due for continuing review as indicated above. The Principle Investigator must also advise the IRB when this study is finished or discontinued. Forms for continuing review and termination are located on the IRB Website.

If you have any questions, please contact Ginger Bishop, Director of Institutional Research, at 828-328-7335 or email at [ginger.bishop@lr.edu](mailto:ginger.bishop@lr.edu).

Sincerely,



Ginger Bishop, Director  
Office of Institutional Research



APPENDIX I  
RECRUITMENT EMAIL

Greetings Counseling Faculty,

This email was developed to request assistance in accessing your graduate community and school counseling program students regarding *The Influence of Problematic Behaviors on Counseling Students Ability to Self-Monitor*. If interested, we are asking that you a) identify a class of either school and/or community counseling students, b) respond to this email (amt0004@auburn.edu) with an approximate number of students in your identified class c) pass out the survey to students once received via U.S. mail.

If you agree to permit us access to your student body, I will then send you a large envelope that includes consent to participate and the surveys. Please expect this packet within 8-10 business days. Thank you for your assistance in this effort. Feel free to contact us with any questions or comments at carnejs@auburn.edu or amt0004@auburn.edu.

Thank you for the consideration,

Dr. Jamie Carney and Amanda M. Thomas