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Addressing Ethical Dilemmas in Doctoral Level Counseling Education and Supervision Programs: A Case Scenario

Paper based on 2013-2014 ACA Graduate Student Ethics Competition (doctoral-level team) first place essay.

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Abstract

Counseling and counselor education involve complex interactions among clients, counselors, students, educators, and supervisors. Professional ethical standards for counseling provide guidance for how to maneuver these interactions. This paper applies an ethical decision making model to a case scenario that illuminates the potential dilemmas in counseling and counselor education. Dilemmas in this scenario involve multiple relationships, potential impairment, duty to report, and the use of social media in counseling. A thorough discussion of each dilemma is followed by potential courses of action, and means to resolve each dilemma.

Professional counseling ethics can be viewed as the implicit and explicit understanding of the covenantal relationship between the profession and society (Ponton & Duba, 2009). Central to this covenant are commitments to uphold the welfare of society and to prioritize the interests of clients (Gardner & Shulman, 2005). Subsequently, counselor educators and supervisors are charged in promoting students' development of vibrant and internalized professional ethical identities (Bebeau, 2008). Considering the ethical contexts of the counseling profession and counselor education, the current case scenario (See Appendix A) involving Dr. Clinic, Rachael, and Kelly suggests four primary, and overlapping, areas of potential ethical conflict that include:

- a counselor's duty to intervene and/or report ethical violations;
- romantic supervisor/supervisee relationship;
- a potential impairment issue involving a doctoral-level student;
- the use of social media in professional practice.

The following essay will examine these professional quandaries with attention to the commitments underlying the counseling profession that protect the public, clients, and the profession. To facilitate this examination, Forester-Miller and Davis's (1996)

ethical decision making model will be applied to the current case scenario. This model will allow for a thorough examination of the identified ethical dilemmas, subsequent collateral damage, and potential courses of action, and thus, result in a substantiated ethical plan that upholds the profession's covenantal commitments to the public it serves.

Ethical Decision Making Model

Forester-Miller and Davis (1996) proposed a seven step ethical decision making model that integrates previous literature into an applicable step-by-step guide. This model entails the following consecutive steps: (a) identify the problem, (b) apply the American Counseling Association (ACA) *Code of Ethics* (2005), (c) determine the nature and dimensions of the dilemma, (d) generate potential courses of action, (e) consider the potential consequences of all options and choose a course of action, (f) evaluate the selected course of action, and (g) implement the course of action. While numerous ethical decision making models exist that may guide counselors, Forester-Miller and Davis's (1996) model was selected as it affords simple steps that facilitate a comprehensive consideration of the inherent complexities in ethical decision making.

Although Forester-Miller and Davis (1996) noted that "there is rarely one right answer to a complex ethical dilemma" (p. 4), application of these seven steps permits delineation of a course of action that is contextualized by the specific ethical dilemmas that have been identified. When making ethical decisions, it is important to recognize codes of ethics as socially constructed and to consider the decision making as interactive, rather than as individual or intrapsychic processes (Cottone, 2001). Ethical decision making entails more than an ability to reason about an issue; individuals must also possess ethical sensitivity to recognize potential dilemmas, as well as ethical motivation and character to act on these judgments (Rest, Narvaez, Bebeau, & Thoma, 1999). Further, as ethical matters arise in the context of interpersonal relationships, feelings, emotions, and competing interests, these intertwined factors must also be considered in the ethical decision making processes (Rogerson, Gottlieb, Handelsman, Knapp, & Younggren, 2011). Forester-Miller and Davis's (1996) model allots for a multifaceted examination of the ethical dilemma, addressing the above noted complexities and variables that ultimately can influence the decision making process.

Application of the Ethical Decision Making Model to Case Scenario

The ethical decision making model discussed above will be applied to a case scenario involving multiple ethical dilemmas. The scenario involves two doctoral level counselor education students, Kelly and Rachael, and their faculty supervisor, Dr. Clinic. In the scenario (see Appendix A), Kelly learns that Rachael has an untreated substance use problem that might be impairing her ability as a student and counselor. Additionally, Rachael has been romantically involved with Dr. Clinic who provides clinical supervision to her, Rachael, and other counseling students. Dr. Clinic has a counseling practice and solicited Rachael's help in establishing an online presence using a social media site.

This section will examine the following identified ethical conflicts: (a) duty to intervene/report, (b) romantic supervisee relationship, (c) potential impairment issue, and (d) the use of social media. For each conflict, the application of Forester-Miller and

Davis's (1996) ethical decision making model will be outlined through the following subheadings: (a) *identified dilemma*, including reference to relevant codes of ethics and potential confounding factors and collateral consequences (Steps 1-3); (b) *potential courses of action* and evaluation of all noted options (Steps 4-5); and (c) the *plan of action* that was chosen considering the context and potential solutions of the identified dilemma (Steps 6-7).

Duty to Intervene and/or Report

Identified dilemma. The provided case scenario suggests Kelly is the only party cognizant of potential ethical violations; thus, the following discussion will focus on Kelly's obligations related to the duty to intervene or report ethical violations. However, this duty exists for all members of the professional community, including Dr. Clinic, Rachael, and other faculty members and students at the university. As a counselor-in-training, Kelly holds a responsibility to understand and adhere to the *Code of Ethics* (ACA, 2005, F.8.a). Section H of the ACA (2005) code speaks to counselors' commitment of internalizing ethical behavior as a representation of the profession's covenantal promises to the public. Counselors are called to place the interests of clients before their own and to appreciate that the trust of the public is predicated on maintaining high levels of professional behavior. Toward this, counselors are charged to take appropriate courses of action to ensure that professional commitments outlined in the codes of ethics are upheld.

Potential courses of action. As consequent ethical violations may occur by failing to intervene, consideration of contextual issues confounding Kelly's ethical decision making process become warranted. An inherent power differential exists between Kelly and the faculty members, including Dr. Clinic. As Dr. Clinic serves as Kelly's clinical supervisor, vulnerability also becomes evident given that this relationship entails intimate disclosures of clinical casework and the counselor's own internal processes. Additionally, the faculty members at the university are ascribed functions of monitoring and gatekeeping students' and peers' professional performance. If these faculty roles are not being transparently and consistently executed, the students' development of a clear professional ethical identity may be thwarted (Foster & McAdams, 2009). This is exponentially treacherous territory, as Kelly and others in her program are training to be future counselor educators and supervisors.

Consideration should also be given to the dynamics and personal/professional relationships among Kelly and her peers. In deciding to intervene, Kelly's relationship with Rachael may be negatively impacted - a price she might not be willing to pay. Further, whether Kelly decides to intervene or not, it is possible her relationships with the other students and faculty may be affected. In essence, as the ethical decision making and action processes unfold, the impacts (known and unknown) on the institution, student body, and broader counseling field necessitate sensitive, and iterative, consideration.

Plan of action. While Kelly does not appear to have committed any overt ethical violation herself, to avoid doing so, she must "take appropriate action" as she possesses "knowledge that raises doubts" about others' ethical behavior (ACA, 2005, Standard H.2.a., pp. 18-19). Before proceeding with any intervention, it is essential that Kelly is first knowledgeable about the ACA *Code of Ethics* (2005), other applicable codes of ethics from licensing bodies, credentialing organizations, and professional associations

(ACA, 2005, Standard H.1.a), as well as relevant state and national laws (H.1.b). Consultation is also recommended throughout the ethical decision making process to ensure optimal understanding of these complex domains, as well as to support Kelly in subsequent courses of action. It is likely that intervening may feel scary or overwhelming to Kelly, but the *Code of Ethics* (ACA, 2005) safeguard against unfair discrimination against complainants and respondents (Standard H.2.g); this should provide some respite. Additionally, given the ethical commitments all members of the profession hold to provide oversight and monitoring of the field, it seems reasonable to believe Kelly would receive support from her faculty, peers, and the larger counseling field, as she enacts her role within the professional covenantal commitment to the society it serves.

Romantic Supervisee Relationship

Identified dilemma. The romantic relationship between Dr. Clinic and Rachael illustrates a blatant ethical conflict in which Dr. Clinic is the perpetrator. The ACA *Code of Ethics* (2005) clearly states that supervisors “are prohibited” from having these types of relationships with current supervisees (Standard F.3.b., p.14). The residual effects of this relationship may be ubiquitous throughout the program warranting further evaluation on the breadth of damage.

Counselor educators are bound to behave in an “ethical manner and serve as role models for professional behavior” (ACA, 2005, Standard F.6.a, p.15). Dr. Clinic’s relationship might have inadvertently modeled an unethical norm, leaving students/supervisees to erroneously believe in its ethical justification. Additionally, students’/supervisees’ professional and personal growth may be affected; some might feel awkward within supervision or classes with Dr. Clinic, keeping their involvement superficial within these arenas.

Dr. Clinic’s relationship with his supervisee may also impact service delivery to clients. As a supervisor, Dr. Clinic bears the ethical responsibilities of monitoring client welfare, providing evaluative feedback to supervisees, and acting as gatekeeper (ACA, 2005, Standards F.1.a., F.5.a., and F.5.b.). Professional ethical practice also dictates that Dr. Clinic manages appropriate relational boundaries with his supervisees as to minimize potential conflicts. The ability of Dr. Clinic to maintain objectivity becomes jeopardized due to the nature of the dual relationship and the conflict that exists between the divergent and conflicting roles that he holds (Kitchener, 1988). His evaluation of Rachael might be skewed as a result of their relationship, diminishing his ability to identify limitations in her performance (ACA, 2005, Standard F.5.a.). As such, Dr. Clinic is not fulfilling his primary obligation to appropriately monitor client welfare.

Potential courses of action. Reasonable actions concerning this ethical dilemma in accordance with the ACA *Code of Ethics* (2005) include the following: informal resolution (Standard H.2.b); consultation with professional peers (Standard H.2.d); and/or reporting the issue (Standard H.2.c.). Following an informal resolution, Dr. Clinic might choose to do nothing, end the romantic/supervisory relationship with Rachael, or report his own ethical infraction. Neither of the first two choices would alleviate the damage already caused, nor erase the ethical infraction. This situation violates both the ACA (2005) and National Board for Certified Counselors (NBCC; 2012) ethical codes. Specifically, directive 11 of the NBCC code outlines a two-year window prior to entering such romantic relationships (NBCC, 2012). In regards to self-reporting, Dr. Clinic’s

acceptance and empowerment to take personal responsibility would reflect an acceptable outcome. However, given the inherent context of this case scenario, wherein Dr. Clinic serves as Kelly's supervisor, the impact of this power differential on informal resolution should be considered.

Consultation with professional peers entails a second potential course of action. Although certainty exists about the unethicity of this romantic supervisee relationship, Kelly may be reluctant to act due to her position as a doctoral student. Additionally, other faculty members in the program may not yet be aware of this relationship. Consultation with these program leaders could propel action from individuals not in a power differential with Dr. Clinic. The program faculty may be better able to proactively address the negative implications that this ethical violation may have on Kelly, Rachael, as well as other students. Further, if Kelly were not comfortable consulting with the program faculty, she could also feasibly contact an ACA ethics consultant for further guidance.

The final potential course of action entails making a formal report of the issue to ACA and/or to the standards committees of other professional organizations with which Dr. Clinic may be associated. Given the severity of this ethical infraction, as well as the potential breadth of collateral damage, formal reporting may be necessitated. Formal action also becomes substantiated when considering that transparent and consistent modeling of appropriate responses to ethical infractions is imperative to the development of a professional ethical identity for students within the program.

Plan of action. Based on the potential courses of action relative to this ethical infraction, the following action steps are recommended. First, given the power differential between supervisors and supervisees, informal resolution between Kelly and Dr. Clinic is not recommended. Instead, it is suggested that Kelly consult with a trusted faculty member(s) at her program. Following this consultation, further action, led by the other faculty members, would be expected contingent on evaluation of the ethical violation and its potential impact on the student body. Depending on consensus, the faculty may attempt an informal resolution with Dr. Clinic, providing him the option for self-reporting. A clear and concrete plan should be developed at this time, with agreed upon consequences if a self-report is not made. Additionally, it is imperative that the faculty consider how this relationship may impact Kelly, Rachael, and other students in the program. Substantiated supplemental follow-up may include supportive meetings for impacted students and/or program-wide discussions. Through this proactive and stringent, but also respectful action, the students are supported in developing clear professional ethical identities, which are essential to both their time in the program and in practice-settings beyond.

Potential Impairment

Identified dilemma. ACA (2005) Standard F.8.b speaks to the refrainment of services from impaired counselors. Impairment can be described as problems in professional competence (PPC) that Rust, Raskin, and Hill (2013) defined as "consistent maladaptive behaviors... that interfere with the ability to adequately provide services" (p. 31). A history of substance use does not equal impairment; however, in Rachael's case, red flags emerge. Rachael voluntarily attends Alcoholics Anonymous (AA) meetings, yet socializing in bars contradicts the 'changing places' slogan of this support group. AA

(2001) also equates current substance use to a loss of control and unmanageability. Although Rachael's current use is unknown, documented behavioral changes justify further assessment. Missed meetings and classes illustrate an uncharacteristic change in Rachael's professional behavior, potentially indicating a related competency issue.

As a doctoral student, further pertinent considerations include Rachael's potential statuses as a clinical supervisor to master's-level students, an instructor, and/or a practice provider. Applied to the latter, impairment can have grave consequences, stemming from a violation of ACA's (2005) standards regarding the primary responsibility of counselors (Standard A.1a) and ability to assist clients (Standard C.2.d). In the role of a supervisor or instructor, impairment not only negates ACA's (2005) codes on ethical role-modeling (Standard F.4.c and F.6.a), but also may encumber the following professional duties: monitoring the client welfare of supervisees (Standard F.1.a), properly evaluating supervisees and/or students (Standard F. 5 and F.9.a), and remediating supervisees and/or students when necessary (Standard F.5.b. and F.9.b).

Potential courses of action. Reasonable actions concerning potential impairment include the following per ACA (2005) standards: informal resolution (Standard H.2.b); consultation with professional peers (Standard H.2.d); and/or reporting the issue (Standard H.2.c.). Using informal resolution, Kelly can directly address her concerns with Rachael, gaining an understanding of factors perpetuating Rachael's behavioral changes. Though speculation exists about current alcohol/drug consumption, these assumptions cannot be concretely substantiated. The use of "I" statements grounded in observable behaviors might be fruitful when addressing these concerns. For example, Kelly might use a statement such as, "I have noticed that you have been missing a lot of classes/meetings, can we talk about this?"

Through these conversations, Rachael might admit to current problematic use, disclose another reason for changes in behavior, or react defensively. If problematic alcohol/drug use is reported, Rachael should self-intervene (ACA, 2005, Standard C.2.g.) which could be achieved through treatment, AA attendance, or temporarily limiting/terminating her professional involvement. The applicability of self-intervention still holds if other factors are linked to the behavioral changes; feasible courses of action become contingent on the disclosed reason. Lastly, Rachael might react defensively, rationalizing the stated concerns. If this occurs and/or Rachael's behavior does not improve, the informal resolution was unsuccessful and further action might become warranted.

Another option in addressing the impairment includes consultation with professional peers. Ideally, Kelly would consult with her supervisor; however, Dr. Clinic's sexual relationship with Rachael muddles this option. Consultation with another faculty member becomes substantiated, allowing for intervention at the institutional level. The program might decide to do nothing, assess for impairment, place Rachael on a Professional Performance Review (PPR), and/or report the violation. Doing nothing does not alleviate the concerns; instead, a viable solution first includes assessment. Then, if needed, the utilization of a PPR can be used in accordance with the standards of the Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2009) and ACA (2005, F.9.b) that outline remediation as a process in which students are given opportunity to address noted concerns. If problematic behavior continues after the PPR, further action entails suspension from the program and reporting of the violation.

During this entire process, thorough documentation should be kept related to the remediation proceedings (ACA, 2005, Standard F.9.b; CACREP, 2009).

Reporting the impairment encompasses another plan of action that can either be taken immediately or after unsuccessful resolution attempts. Immediate reporting ignores ACA (2005) Standard H.2.c., given that this ethical conflict is appropriate for informal resolution. Furthermore, this action violates Standard H.2.f and entails a “reckless disregard... of facts” (ACA, 2005, p. 19) as the impairment is not conclusive. However, reporting the violation becomes substantiated after all the facts have been gathered, impairment can be proven via documentation, and other remedial processes have been implemented without success.

Plan of action. In considering the above courses of action, the decided upon resolution encompasses a sequential process. First, Kelly will attempt an informal resolution; success will be evidenced if Rachael is open and honest about the current problem, seeks help, and the noted behaviors abate. However, if Kelly’s concerns are not alleviated, consultation with faculty members denotes the next step. Hopefully, this consultation will perpetuate an institutional intervention that adequately addresses the potential impairment (e.g., assessment, PPR). If behavioral progress does not occur, the third step involves the reporting of the violation by the faculty (and if not, by Kelly). Prior to reporting, documentation should substantiate that multiple steps were taken unsuccessfully to address the issue, that Rachael was given time to remediate the concerned behaviors, and that the noted concerned behaviors are detrimental and continuous.

Use of Social Media

Identified dilemma. The current ACA *Code of Ethics* (2005) does not address social networking specifically; however, the 2014 ACA code will likely provide clearer guidelines, largely as a result of the public's increased use of social media (Francis, n.d.). In the ACA (2005) codes, the use of technology for professional counseling purposes is outlined in Section A.12., a necessitated inclusion since clients might expect or want electronic communication from counseling professionals (Kaplan, Wade, Conteh, & Martz, 2011). Though Dr. Clinic’s Facebook page reflects current trends in the use of technology for professional purposes, questions remain regarding whether this Facebook page provides a space that protects clients from undue harm. ACA’s (2005) Standard A.12.g.5 speaks to encrypted communication when using Internet sites, such as Facebook, and Standard A.12.h.4. requires “establish[ing] a method of verifying client identity” (p. 7). Without doing so, HIPAA confidentiality regulations and ethical standards may be breached (Kaplan et al., 2011).

According to ACA’s (2005) Standard A.12.f., Dr. Clinic should have also sought business, legal, and technical assistance when creating the Facebook page; deferment to a graduate student well-versed in the use of social networking does not meet this standard. Additionally, by requesting Rachael’s help, Dr. Clinic may not have served as a professional role-model (ACA, 2005, Standard F.6.a.), particularly if steps were not taken to protect the privacy of his clients. As a counselor educator, Dr. Clinic is also responsible for educating Rachael on the ethical use of social media. However, there is no indication that Dr. Clinic informed Rachael of professional considerations such as those

outlined by Lannin and Scott (2013) that include potential role confusion, informed consent, and confidentiality.

Potential courses of action. Given the limited guidance of the current ACA (2005) code concerning the use of social media by counselors, the NBCC ethical guidelines will be used in conjunction with the ACA standards to identify and evaluate the following potential courses of action concerning the Facebook page: (a) keep the page and take no further action, (b) remove the page, and (c) keep the page but develop a professional policy regarding its use.

There currently are no direct prohibitions of the professional use of Facebook and other social media Web sites in either the ACA or NBCC ethical codes. Thus, Dr. Clinic could maintain the page for his clinical practice citing the absence of such prohibitions in the ethical standards for the profession. Additionally, by maintaining the page, Dr. Clinic would be providing an additional method of communication for his clients to use, particularly one that is consistent with social and cultural trends (Kaplan et al., 2011). However, by keeping the page and taking no further action, Dr. Clinic would be negligent in his ethical responsibility to take steps to ensure confidentiality. Moreover, with no established informed consent notice, Dr. Clinic's clients may be unaware of the limits to confidentiality as well as risks to privacy associated with social media. His clients may also experience confusion regarding boundaries and expectations of communication.

Dr. Clinic could remove the Facebook page, seemingly eliminating concerns about confidentiality, HIPAA violations, and boundary confusion; if there is no page, there can be no breaches or confusion. That said, Dr. Clinic may inadvertently damage his therapeutic relationship with his clients by removing the page. Aside from disappointing clients who may expect to connect with him via social media, Dr. Clinic's removal of the page may be interpreted as abandonment by those in his clientele who have already accessed the page. The use of the word "abandonment" in this context does not suggest a violation of Standard A.11.a. of the ACA (2005) ethical code. Rather, it is being used to describe the subjective experience of his clients that could potentially result. Although Dr. Clinic could explain the rationale for removing the page, he cannot be certain that his clients will not take the removal personally.

Another option is for Dr. Clinic to maintain his professional Facebook page but create a professional use policy that reflects ACA and NBCC standards, addressing the following: (a) the need for legal, business, and technical assistance prior to the creation of a page (ACA, 2005, Standard A.12.f.), 2); (b) clear differentiation between personal and professional pages (NBCC, 2012, Directive 19); and (c) the creation of an informed consent document that outlines the benefits and limitations of social media (ACA, 2005, Standard A.12.a. and g.). Additionally, procedures and policies regarding the use of information gained via social media including the documentation of digital communication in clients' records (NBCC, 2012, Directives 54 and 66) would need to be established. Finally, Dr. Clinic would also need to take steps to ensure that client identity can be verified (ACA, 2005, Standard A.12.h.4.) and confidentiality maintained. Such a use policy would clarify the professional purpose and expectations for the use of technology and social media. However, such policies do not eliminate the risk of confidentiality breaches, HIPAA violations, or boundary confusion. Moreover, Dr. Clinic has already created the Facebook page, which may make the implementation of the policy difficult at this point.

Plan of action. The revised ethical codes of the ACA are set to be released in 2014, and will include an expanded discussion of the professional use of technology due to the “burgeoning use of social media” (Francis, n.d., p. 4). Hence, in an effort to be forward-thinking in regard to the ACA *Code of Ethics* and to align with the directives of the NBCC *Code of Ethics*, the recommended course of action regarding Dr. Clinic’s Facebook page is to maintain the page with a use policy informed by legal and ethical standards. This action is not a perfect resolution; it does not completely eliminate the risk of confidentiality breaches and boundary violations. However, it does provide space for the integration of technology and social media into professional practice in a manner that considers legal and ethical standards. Dr. Clinic bears the responsibility to establish the use policy, and should do so after consultation with other practitioners as well as legal and technical consultants. Additionally, university officials connected to the counseling program in which Dr. Clinic is a counselor educator would be wise to establish a policy for faculty, given the prevalence of Facebook use among graduate students (Brew, Cervantes, & Shepard, 2013). Brew, Cervantes and Shepard (2013) also noted that incorporating the use of technology and social media into the counseling curriculum would benefit counseling students who may need guidance regarding professional use of Web sites, such as Facebook.

Summary

The reviewed case scenario involving Dr. Clinic, Rachael, and Kelly presented an array of complex and interrelated ethical conflicts. These included the duty to report/intervene, romantic supervisee relationships, potential impairment, and the use of social media. Toward disentangling this ethical conglomerate, a justification for Forester-Miller and Davis’s (1996) seven step ethical decision making model was forwarded and applied to each of the identified ethical dilemmas. Competing and contextual factors were also considered and evaluated to determine an appropriate prioritization of components within this layered situation.

While perhaps constructed for competition purposes, these ethical dilemmas are reflective of the multifaceted ethical territory traversed by counselors within the scope of professional practice and professional training. Further, this case scenario brings attention to the covenantal commitments that counseling professionals hold to the public, including engaging in self-reflection and honest self-monitoring. This is the crux of our professional ethical identity as counselors and one we are all entrusted to uphold in order to maintain the trust of those we “hold” within practice and training settings.

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Appendix A

ACA 2013 Ethics Competition Doctoral Level Scenario

Kelly is a doctoral student in a Counselor Education and Supervision program and has become friends with one of her peers in the program, Rachael. Rachael has shared that she had a substance abuse problem in the past, but did not attend an addiction counseling program; rather, she chooses to self-monitor and attend Alcoholics Anonymous meetings as needed. Rachael also confided that she has been involved in a sexual relationship for several weeks with Dr. Clinic, a new faculty member in the Counseling Department; Dr. Clinic is 54, and Rachael is 25. Neither Kelly nor Rachael is currently enrolled in any of Dr. Clinic's classes, but he does provide internship supervision to them both as well as four other students in the program. Rachael began spending time with Dr. Clinic 3 months ago when he asked for her assistance in setting up a professional Facebook page so he can better communicate with students and clients in his private practice; being well-versed in social media, Rachael helped him set one up and taught him how to use it. Over the next few weeks, they spent more time together, initially working on Dr. Clinic's Facebook profile and then eventually going out for dinner. After 2 months, their interactions evolved into a sexual relationship. Rachael tells Kelly that she's not concerned about any conflict of interest and that she and Dr. Clinic will likely get engaged once she graduates from the program at the end of the year. Kelly is becoming increasingly concerned, however, as she has seen Rachael and Dr. Clinic meeting at an off-campus bar multiple times in recent weeks, and Rachael has begun to miss classes and other regularly scheduled meetings.