**Suggested APA style reference:**

Sommers-Flanagan, R., & Sommers-Flanagan, J. (2008). Advanced ethical considerations in the use of evidenced-based practices and in crisis/humanitarian work. In G. R. Walz, J. C. Bleuer, & R. K. Yep (Eds.), *Compelling counseling interventions: Celebrating VISTAS' fifth anniversary* (pp. 259-269). Ann Arbor, MI: Counseling Outfitters.

*Article 25*

# Advanced Ethical Considerations in the Use of Evidenced-Based Practices and in Crisis/Humanitarian Work

Rita Sommers-Flanagan and John Sommers-Flanagan

Morality, a loaded term in our current political climate, is closely associated with values and matters of conscience. Ethics, on the other hand, is more closely associated with the business and professional world. The term ethics also refers to the study of human expressions of morality, or the good life.

## Ethics in the Professions

From a constructivist perspective, ethics codes such as ACA's articulate the good, effective, counselor narrative (Mahoney, 2003). When developed well, professional ethics codes address the best and most correct and effective way to use the knowledge that defines the profession. The code describes the heart of professional endeavor and identity. Using Berry's (2003) model, which identifies four possible adaptation strategies people use when faced with joining a new culture, Handelsman, Gottlieb, and Knapp (2005) describe four ways a new member of the counseling culture might adapt. These include: Assimilation, Separation, Marginalization, and Integration.

Integration is the ideal, but most professionals can see themselves occasionally in each of the stages as they develop and as

their professions grow and change. Even though we make a distinction between morals and ethics, our professional ethical lives are touched by our common morality. And moral values are pervasive, "...because our every action has a universal dimension, a potential impact on others' happiness, ethics are necessary as a means to ensure that we do not harm others" (Tenzin Gyatso, the14th Dalai Lama, 1999). Ethics codes that veer away from basic moral values become legal documents with some other mission than guiding best practices. General moral values include respect for others, compassion, tolerance, honesty, generosity, fidelity, kindness, fairness, forgiveness, and justice. However, achieving agreement on what constitutes specific moral behavior, such as what sort of action is a true representation of "compassion" is an ongoing challenge and sometimes the focus of heated arguments. APA's 1995 addition of the possibility of warning partners of clients who are HIV positive and are having unprotected sex is an example. More recently, the end-of-life permission also gives one opportunities for serious debate.

## Moving Deeper Into Ethics

With apologies for gross generalizations, the following section provides a brief description of three of the dominant philosophical positions regarding applied ethics.

*Virtue/Character Ethics*

A person using a character ethics perspective would ask, "What is a good person, and what does it take to become a good person?" Aristotle (born 384 BCE) is given credit for the earliest and most complete articulation of this position. He believed that the ultimate, highest moral outcome of existence is for people to become what they were meant to be, both specifically and more generally. At the pragmatic level, he believed that people have many diverse callings and gifts, and in the best case scenario, will become the profession they are most gifted at. But beyond these vocations, Aristotle believed that mature humans are meant to grow into their full potential, which will bring about profound happiness, or

*eudaimonia*. And how do humans achieve this state of happiness? They do so by becoming virtuous. For Aristotle, the fully actualized, or fulfilled human is a virtuous human being. Most people glimpse the truth of this when they do something good in the world—a small act of kindness, and inside, experience a sense of satisfaction or even joy.

Aristotle believed that virtue exists in the middle of human extremes. Courage is a virtue, but too much is foolhardiness, and too little is cowardice. Generosity is good, whereas one can be overly generous and give away too much, or not generous enough and be seen as stingy.

*Kant and Deontology*

Immanuel Kant (1724-1804) is most closely associated with deontological ethics. From a deontological perspective, we ask, "Am I making the kind of choice that fulfills my duty? Is this the action I would want everyone to take, regardless of the circumstances?" The deontological stance is one that emphasizes doing what is right and doing one's duty, not based on outcome or preference. Regardless of how one feels about it, and regardless of outcome, Kant believed there are moral duties applicable at all times and in all places. Some actions are always morally wrong and some are always right. In a translation by T. Abbot (1998), Kant wrote, "…if a law is to have moral force, that is, to be the basis of an obligation, it must carry with it absolute necessity…" (p. 276). For Kant, there were no exceptions or mitigating circumstances interfering with pure moral law.

Kant formulated what he called the "categorical imperative." One version is this: *So act that you could will your action to be a universal law for all humankind* (Abbott, 1998). As Kant developed the notion of his categorical imperative, he offered another version that he believed achieved the same outcome: *So act as to treat humanity, whether yourself or another person, as an end-in-itself, never as a means only.*

Kant argued that even though there will be compelling practical or emotional factors in a given situation, it is our duty to consider the action through the lens of "always, everywhere, for everyone."

Rachels (1986) explains that one of Kant's lasting contributions is the notion that individuals cannot make themselves into special cases. He proposed that a perhaps less troublesome way to approach deontological moral reasoning would be to only violate absolute rules for reasons that everyone would agree to be acceptable.

*Utilitarian or Consequentialist Ethics*

Utilitarian or consequentialist approaches focus exclusively on the end result—the outcome of the act, with the measure being what will bring about the greatest good for the greatest number. The "greatest good" is not considered via an internal equation that excludes others. The equation must assess the pain/pleasure ratio for all affected parties.

Building from the original works of Jeremy Bentham, John Stuart Mill (1806-1873) argued that some forms of human pleasure were of higher quality than others, and therefore worth more in the utilitarian equation. His utilitarian position argued for the overall betterment of all humankind. Mill believed, like Alfred Adler later believed, at the core people want the best for each other and are inclined to promote the common good.

Utilitarians do not claim moral certainty. James Burtness (1999) writes, "Morality is a fluid and porous social institution" (p. 80). Many social reform movements are expressions of consequentialist thinking. The welfare of the disenfranchised members of society is counted as having equal weight and import in the overall fabric of society. Democracy is an expression of utilitarian orientation. Robert Bellah and his co-authors (1996) have pointed out that the right to vote empowers individuals to assess and support the common good. Corrupt politicians advocate policies motivated by personal gain. The voter who votes not for the common good, but for personal gain, is equally corrupt. In a democracy, we are charged to decide what is best for the whole community. Consequentialists require us to go beyond our own desires and preferences to an objective standpoint (Singer, 1993), evaluating what is best for the all, not just ourselves.

## Applying Reason to the Empirical Mandate

*Using Core Ethics and General Trends*

How does this relate to evidenced-based practice? It is disconcerting for most professionals to be told that they cannot rely exclusively on their ethics codes to sort out some difficult decisions they will face as mental health practitioners. Being told to only engage in evidenced-based practices is simply too broad of an ethical edict, and may be ill-informed. That said, there are many sources of general empirical trends in mental health practice that help an ethical practitioner make treatment decisions. In an article titled "Empirically Based Decision Making in Clinical Practice," Beutler (2000) identified eight optimal treatment principles. The following list is based on Beutler's principles, with our additional comments [in brackets].

1. Therapeutic change is greatest when therapists are skillful and provide trust, acceptance, acknowledgment, collaboration, and respect for the client within an environment that supports risk and provides maximal safety. [This principle is based on decades of research that supports the central function of a therapeutic alliance in positive treatment outcome (Norcross, 2002; Rogers, 1957).]
2. Therapeutic change is most likely when the counseling procedures do not evoke client resistance. [Research on motivational interviewing has been especially informative regarding the fact that therapist confrontation is likely to evoke resistance and interferes with positive treatment outcomes (Miller & Rollnick, 2002).]
3. Therapeutic change is most likely when clients are exposed to objects or targets of behavioral and emotional avoidance. [This principle articulates the efficacy of exposure treatments which have been documented since Mary Cover Jones's early experiments (1924) and Joseph Wolpe's publication of *Psychotherapy by Reciprocal Inhibition* (1958).]
4. Therapeutic change is greatest when clients are stimulated to emotional arousal in a safe environment until problematic responses diminish or extinguish. [Again, this refers to the behavior therapy exposure and extinction paradigm, but also might

be explained by the psychoanalytically-oriented corrective emotional experience (Alexander & French, 1946).]

5. Therapeutic change is most likely if the initial focus of change efforts is to build new skills and alter disruptive symptoms. [Clients often do best when they immediately begin learning new skills, often within the context of behavioral response prevention (Foa, Rothbaum, & Furr, 2003). Immediate skill-building seems to facilitate initial hope and motivation (Frank & Frank, 1991)].
6. Therapeutic change is greatest when the relative balance of interventions either favors the use of skill building and symptom removal procedures among clients who externalize or favors the use of insight and relationship-focused procedures among clients who internalize. [This differential treatment principle speaks to the fact that some clients seem to need more concrete interventions, while others thrive with more abstract, relationship-based interventions (Ackerman et al., 2001; Linehan, 1993).]
7. Therapeutic change is greatest when the directiveness of the intervention is either inversely correspondent with clients' current resistance or authoritatively prescribes a continuation of the symptomatic behavior. [When clients are not resistant, then very directive interventions can be successful; when they are resistant, less directive interventions are warranted; and sometimes paradoxical strategies are effective when resistance is high (Shoham-Salomon & Rosenthal, 1987).]
8. The likelihood of therapeutic change is greatest when clients' emotional stress is moderate, neither being excessively high nor excessively low. [Similar to the transtheoretical change model, this principle suggests there is an optimal time for effective therapy to occur (Prochaska & DiClemente, 1982).]

## Principle-based Ethical Considerations in Crisis Counseling

Ethical counselors know that authentic help is a complicated endeavor, especially in crisis situations. The help offered must be: culturally acceptable, developmentally appropriate, interpersonally sensitive, politically neutral, and attuned to the real life parameters of

the environment and situation. Besides considering the philosophical positions elucidated above, the ethical principles (Beauchamp & Childress, 2001; Kitchener, 2000) that originated in bioethics serve as a lens to consider ethical pitfalls in crisis work. These principals are: beneficence, nonmaleficence, justice, autonomy, and fidelity.

Beneficence, which refers to promoting good for others, would guide us to assess our motives. Unacceptable primary motives include: wishes for media exposure; curiosity, boredom, or indignation; opportunities to grandstand one's expertise; and hopes of converting traumatized people to a certain faith system or philosophical orientation—even if the professional believes such a conversion would offer comfort. Beneficent professional interventions are based on doing good and helping others. To have the best chance of actually doing good, being of real help, professional crisis counseling requires professional preparation. Further, crisis workers can themselves be traumatized by trying to help those ravaged by trauma and crises (Pearlman & MacIan, 1995). Volunteers must self-monitor so that they do not become so traumatized, the help they offer is ineffective or damaging.

The second principle, nonmaleficence, refers to doing no unjustified harm. This is a challenging principle because the potential for unintentional but significant harm is exceptionally high in crisis counseling. In crisis situations, every resource is precious. Simply taking up space while having nothing to offer is a form of harm. Potential problems exist with diagnosis, case conceptualization, and treatment choices. Further, there are problems crossing cultures. Crisis volunteers often come from all parts of the country or world, and are not even privy to the usual community understandings, let alone the deeper concerns of race or culture within the community (Jackson & Cook, 1999).

The next principle, justice, refers to a group of norms used to distribute benefits, risks, and costs fairly, or equal treatment for equals (Beauchamp & Childress, 2001). Tragedy violates our sense of security and justice in the world. Terrible things happen to innocent people. Crisis workers can be tempted to play favorites, or try to secure goods or services in ways that are not fair. While

understandable, it is not ethical for professionals to use their status or influence to secure special favor for some traumatized clients and not others.

Autonomy, another ethical principle, holds that humans should have authority over decisions affecting their health and well-being (e.g., Thornicroft & Tansella, 2005). Crisis situations can severely limit autonomy (Rosenstein, 2004). When moved to shelters and forced to leave behind all their worldly goods, survivors may not have much of a sense of personal autonomy. In the face of disaster, people question how much control they really have over their lives (Bonanno, 2004). In times of immediate crisis, mental health work may be directive and authoritative. However, interventions should never be insistent, combative, or punitive (Foa, 2000). When possible, crisis counselors allow people in crisis to make choices. They offer support and reassurance in this choice-making process.

Finally, the principle of fidelity involves honesty, reliability, and good faith. It includes loyalty, personal commitment, and integrity in one's actions with clients (Warner & Roberts, 2004). Crisis situations will challenge or transform many of the ethical practices in the codes, including informed consent and confidentiality. Certain customary boundaries may be suspended. However, crisis counselors must hold themselves to the spirit of ethical, professional interactions.

It has been said that the truest test of morality is how people behave when no one is looking and no one will know. The compelling human dimensions of crisis heighten every human emotion. The chaos of crisis obscures accountability. It is therefore essential that professionals who volunteer to do crisis or humanitarian work consider their ethical mandates and danger zones in great depth before they begin.

## References

Abbott, T. K. (1998). Fundamental principles of the metaphysic of morals. In S. M. Cahn & P. Markie (Eds.), *Ethics: History, theory, and contemporary issues.* New York: Oxford University Press.

Ackerman, S. J., Benjamin, L. S., Beutler, L. E., Gelso, C. J., Goldfried, M. R., Hill, C., et al. (2001). Empirically supported therapy relationships: Conclusions and recommendations of the Division 29 Task Force. *Psychotherapy: Theory, Research, Practice, Training, 38*(4), 495-497.

Alexander, F., & French, T. M. (1946). *Psychoanalytic psychotherapy.* New York: Ronald Press.

Beauchamp, T., & Childress, J. (2001). *Principles of biomedical ethics*. New York: Oxford University Press.

Bellah, R. N., Madsen, R., Sullivan, W., Swindler, A., & Tipton, S. M. (1996). *Habits of the heart.* Berkeley, CA: University of California Press.

Berry, J. W. (2003). Conceptual approaches to acculturation. In K. M. Chun, P. B. Organista, & G. Marin (Eds.), *Acculturation: Advances in theory, measurement, and applied research* (pp. 17-37). Washington, DC: American Psychological Association.

Beutler, L. E. (2000, September 1). Empirically based decision making in clinical practice. *Prevention & Treatment*, 3(1). Retrieved January 30, 2008, from http://journals.apa.org/prevention/volume3/pre0030027a.html

Bonanno, G. A. (2004). Loss, trauma and human resilience. *American Psychologist, 59*(1), 20-28.

Burtness, J. H. (1999). *Consequences: Morality, ethics and the future.* Minneapolis, MN: Fortress Press.

Foa, E. B. (2000). Psychosocial treatment of posttraumatic stress disorder. *Journal of Clinical Psychiatry Special Issue: Focus on posttraumatic stress disorder, 61*(Suppl 5), 43-51.

Foa, E. B., Rothbaum, B. O., & Furr, J. M. (2003). Augmenting exposure therapy with other CBT procedures. *Psychiatric Annals, 33*(1), 47-53.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing* (3rd ed.). Baltimore: Johns Hopkins University Press.

Handelsman, M., Gottlieb, M., & Knapp, S. (2005). Training ethical psychologist: an acculturation model. *Professional Psychology: Research and Practice. 36*(1), 54-65.

Jackson, G., & Cook, C. G. (1999). *Disaster mental health: Crisis counseling programs for the rural community.* Retrieved December 14, 2004, from http://www.mentalhealth.samhsa.gov/publications/allpubs/sma99-3378/crisiscounseling_ch2.asp

Jones, M. C. (1924). The elimination of children's fear. *Journal of Experimental Psychology*, *8*, 382-390.

Kitchener, K. S. (2000). *Foundations of ethical practice, research, and teaching in psychology*. Mahwah, New Jersey: Lawrence Erlbaum Associates.

Linehan, M. M. (1993). *Skills training manual for treating borderline personality disorder.* New York: Guilford Press.

Mahoney, M. J. (2003). *Constructive psychotherapy*. New York: Guilford Press.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford Press.

Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work.* New York: Oxford University Press.

Pearlman, L. A., & MacIan, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma on trauma therapists. *Professional Psychology: Research & Practice*, *26*, 558-565.

Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy*, *19*, 276-278.

Rachels, J. (1986). *The elements of moral philosophy*. Philadelphia: Temple University Press.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*, 95-103.

Rosenstein, D. (2004). Decision-making capacity and disaster research. *Journal of Traumatic Stress*, *17*(5), 373-381.

Shoham-Salomon, V., & Rosenthal, R. (1987). Paradoxical interventions: A meta-analysis. *Journal of Consulting and Clinical Psychology*, *55*, 22-28.

Singer, P. (1993). *Practical ethics* (2nd ed.). Cambridge, England: Cambridge University Press.

Tenzin Gyatso (the14th Dalai Lama). (1999). *Ethics for a new millennium*. New York: Penguin Putnam.

Thornicroft, G., & Tansella, M. (2005). Growing recognition of the importance of service user involvement in mental health serve planning and evaluation. *Epidemiologia e Psichiatria Sociale*, *14*(1), 1-3.

Warner, T. D., & Roberts, L. W. (2004). Scientific integrity, fidelity and conflicts of interest in research. *Current Opinion in Psychiatry*, *17*(5), 381-385.

Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Stanford, CA: Stanford University Press.