ADVOCACY COMPETENCIES: Lewis, Arnold, House & Toporek, 2003

Client/Student Empowerment

- An advocacy orientation involves not only systems change interventions but also the implementation of empowerment strategies in direct counseling.
- Advocacy-oriented counselors recognize the impact of social, political, economic, and cultural factors on human development.
- They also help their clients and students understand their own lives in context. This lays the groundwork for self-advocacy.

**Empowerment Counselor Competencies**

In direct interventions, the counselor is able to:

1. Identify strengths and resources of clients and students.
2. Identify the social, political, economic, and cultural factors that affect the client/student.
3. Recognize the signs indicating that an individual's behaviors and concerns reflect responses to systemic or internalized oppression.
4. At an appropriate development level, help the individual identify the external barriers that affect his or her development.
5. Train students and clients in self-advocacy skills.
6. Help students and clients develop self-advocacy action plans.
7. Assist students and clients in carrying out action plans.

Client/Student Advocacy

- When counselors become aware of external factors that act as barriers to an individual's development, they may choose to respond through advocacy.
- The client/student advocate role is especially significant when individuals or vulnerable groups lack access to needed services.

**Client/Student Advocacy Counselor Competencies**

In environmental interventions on behalf of clients and students, the counselor is able to:

8. Negotiate relevant services and education systems on behalf of clients and students.
9. Help clients and students gain access to needed resources.
10. Identify barriers to the well-being of individuals and vulnerable groups.
11. Develop an initial plan of action for confronting these barriers.
12. Identify potential allies for confronting the barriers.
13. Carry out the plan of action.

Community Collaboration

- Their ongoing work with people gives counselors a unique awareness of recurring themes. Counselors are often among the first to become aware of specific difficulties in the environment.
- Advocacy-oriented counselors often choose to respond to such challenges by alerting existing organizations that are already working for change and that might have an interest in the issue at hand.
- In these situations, the counselor's primary role is as an ally. Counselors can also be helpful to organizations by making available to them our particular skills: interpersonal relations, communications, training, and research.
Community Collaboration Counselor Competencies
14. Identify environmental factors that impinge upon students’ and clients’ development.
15. Alert community or school groups with common concerns related to the issue.
16. Develop alliances with groups working for change.
17. Use effective listening skills to gain understanding of the group's goals.
18. Identify the strengths and resources that the group members bring to the process of systemic change.
19. Communicate recognition of and respect for these strengths and resources.
20. Identify and offer the skills that the counselor can bring to the collaboration.
21. Assess the effect of counselor’s interaction with the community.

Systems Advocacy
- When counselors identify systemic factors that act as barriers to their students’ or clients’ development, they often wish that they could change the environment and prevent some of the problems that they see every day.
- Regardless of the specific target of change, the processes for altering the status quo have common qualities. Change is a process that requires vision, persistence, leadership, collaboration, systems analysis, and strong data. In many situations, a counselor is the right person to take leadership.

Systems Advocacy Counselor Competencies
In exerting systems-change leadership at the school or community level, the advocacy-oriented counselor is able to:
22. Identify environmental factors impinging on students’ or clients’ development
23. Provide and interpret data to show the urgency for change.
24. In collaboration with other stakeholders, develop a vision to guide change.
25. Analyze the sources of political power and social influence within the system.
27. Develop a plan for dealing with probable responses to change.
28. Recognize and deal with resistance.
29. Assess the effect of counselor’s advocacy efforts on the system and constituents.

Public Information
- Across settings, specialties, and theoretical perspectives, professional counselors share knowledge of human development and expertise in communication.
- These qualities make it possible for advocacy-oriented counselors to awaken the general public to macro-systemic issues regarding human dignity.

Public Information Counselor Competencies
In informing the public about the role of environmental factors in human development, the advocacy-oriented counselor is able to:
30. Recognize the impact of oppression and other barriers to healthy development.
31. Identify environmental factors that are protective of healthy development.
32. Prepare written and multi-media materials that provide clear explanations of the role of specific environmental factors in human development.
33. Communicate information in ways that are ethical and appropriate for the target population.
34. Disseminate information through a variety of media.
35. Identify and collaborate with other professionals who are involved in disseminating public information.
36. Assess the influence of public information efforts undertaken by the counselor.

Social/Political Advocacy
- Counselors regularly act as change agents in the systems that affect their own students and clients most directly. This experience often leads toward the recognition that some of the concerns they have addressed affected people in a much larger arena.
- When this happens, counselors use their skills to carry out social/political advocacy.

Social/Political Advocacy Counselor Competencies
In influencing public policy in a large, public arena, the advocacy-oriented counselor is able to:
37. Distinguish those problems that can best be resolved through social/political action.
38. Identify the appropriate mechanisms and avenues for addressing these problems.
39. Seek out and join with potential allies.
40. Support existing alliances for change.
41. With allies, prepare convincing data and rationales for change.
42. With allies, lobby legislators and other policy makers.
43. Maintain open dialogue with communities and clients to ensure that the social/political advocacy is consistent with the initial goals.
Culture or Domestic Violence? A Tale of Two Cultures

Sufen is a 28-year-old female Northern Mainland Chinese client went to counseling because of family issues and martial problem. She received a master’s degree in chemistry in a research university in Kentucky and she is currently working full-time as a laboratory assistant. She lives with her husband, 4-year-old son, and parents-in-law (from Southern Mainland Chinese) and all of them are immigrants from China.

Sufen’s parents-in-law are wealthy, traditional, educated, and had high expectations of their children and grandson. Sufen is not close to her parents-in-law, and at times had a difficult relationship with them, particularly, issues about raising her son and running the house. Sufen felt that her parents-in-law are highly critical of her, so she is very stressed and tired while living with her parents-in-law. She tried many times to get support from her husband, but he refused to help. In fact, he told her to stop complaining and learn to understand and respect his parents.

During the session, the counselor encouraged Sufen to express uncomfortable feelings that are related to parents-in-law and husband. Sufen really wanted to talk about her suffering, but, she is reluctant to open her feelings to the counselor because in China therapy is not acceptable nor is sharing family conflicts with outsiders. The counselor tried to invite Sufen’s husband to the counseling session and encouraged her to share her feelings with her parents-in-law. But Sufen refused to do that because she thought that it would bring shame to her family and make things worse. In fact, shortly after, she did ask him to come to counseling and the physical abuse began again. Without knowing this, the counselor advised Sufen and her husband to move out and keep a distance with her parents-in-law. Sufen disagreed with the counselor because she thought that it is her and her husband’s responsibility of taking care of parents. The abuse continues, and the counselor never knew the truth.
Ethical Decision-Making Models: A Review of the Literature

R. Rocco Cottone and Ronald E. Claus

A comprehensive review of the literature on ethical decision-making models in counseling is presented, beginning in the fall of 1984 through the summer of 1998. (Materials "in press" were considered.) A general overview of the literature is provided. Theoretically or philosophically based, practice-based, and specialty-relevant approaches are surveyed. The literature is rich with publications describing decision-making models, although few models have been assessed empirically, and few models seem well grounded philosophically or theoretically.

In 1984, Kitchener published a seminal work related to ethical decision making in counseling and counseling psychology. In her article, Kitchener argued that in the absence of clear ethical guidelines, relying on personal value judgments (as some other authors had proposed) was not adequate because "[i]ndependent of . . . external considerations, not all value judgments are equally valid" (p. 44). Kitchener argued that counseling professionals should "develop a deeper understanding of the basis for ethical decision making" (p. 44). She then presented a model integrating Hare's (1981) work on levels of moral thinking (intuitive and critical-evaluative) and Beauchamp and Childress's (1979) suggested ethical "principles" (autonomy, beneficence, nonmaleficence, and justice) and the ethical "rule" of fidelity. Since Kitchener's 1984 publication, there have been many publications on ethical issues in counseling. However, to this date, no formal review of the literature on ethical decision-making models has been published. There has been no accounting of philosophical, theoretical, practical, or empirical developments related to ethical decision-making models in counseling. This article offers such an accounting.

The literature on ethical decision-making models from the fall of 1984 (the date of Kitchener's publication) to the summer of 1998 was systematically reviewed. ("In press" materials available to the authors were included.) Computer searches of PsychLit and ERIC were accomplished using the key terms "ethical/decision making/model"; also complete hand searches of the following journals were made between those dates: the Journal of Counseling & Development, The Counseling Psychologist, Professional Psychology: Research and Practice, and the American Psychologist. Other sources known to us were also included. Although an overview of the literature on ethical issues is included in this review, the intent and focus of the review is to address and to thoroughly review the literature specifically relating to ethical decision-making models. Therefore, literature addressing moral reasoning, clinical issues, and specific code-directed actions is not fully reviewed.

GENERAL OVERVIEW OF THE LITERATURE ON ETHICAL ISSUES

Since Kitchener's (1984) article was published, Beauchamp and Childress's (1979) Principles of Biomedical Ethics has been revised several times; it is a frequently cited work in its fourth edition (Beauchamp & Childress, 1994) that has laid the groundwork for other authors. Although the Beauchamp and Childress (1994) text is a foundation text providing guiding principles for ethical decision making, it fails to address decision-making models or processes in depth. Instead, the authors provided a thorough analysis of ethical theory, including criteria of theory construction and an overview of widely recognized ethical theories (e.g., utilitarianism, Kantianism, liberal individualism). In a work published in the same year, Beauchamp and Walters (1994) provided a "set of considerations" or "methods" for resolving moral disagreements as a way "of easing and perhaps settling controversies" (p. 4). The methods included (a) "obtaining objective information"; (b) "providing definitional clarity"; (c) "adopting a code"; (d) "using examples and counterexamples"; and (e) "analyzing arguments" (pp. 4-7). Beauchamp and Walters did not present a review of decision-making processes, but they took a position and presented a basic model for judging ethical decisions. As with the Beauchamp and Childress (1994) and the Beauchamp and Walters works, there was a lack of in-depth discussion of ethical decision-making processes in the literature. Rather,
authors simply listed the act of making a decision as a step, or they did not list it as a step at all; however, in either case, an explanatory framework for the decision process itself was not addressed. There were some exceptions, especially involving theoretical and philosophical foundations.

THEORETICAL OR PHILOSOPHICALLY BASED MODELS OF ETHICAL DECISION MAKING

Several authors made an attempt to ground ethical decision making on some theory or philosophy. Notably, Hare’s (1991) “The Philosophical Basis of Psychiatric Ethics,” which in its original 1981 form was used by Kitchener as a guiding work, argued that absolute thinking (dealing with rights and duties) and utilitarian thinking (doing the greatest good for the greatest number; considering the interests of patients) were both involved in ethical decision making. Hare then invoked two levels of moral reasoning to address ethical dilemmas—the “intuitive” and “critical” levels. Hare (1991) said:

[that we have a duty to serve the interests of the patient, and that we have a duty to respect his rights, can both perhaps be ascertained by consulting our intuitions at the bottom level. But if we ask which duty or which intuition ought to carry the day, we need some means other than intuition, some higher kind of thinking (let us call it “critical moral thinking”) to settle the question between them. (p. 35)]

Although Hare (1991) believed that the “intuitive level, with its prima facie duties and principles, is the main locus of everyday moral decisions” (p. 35), he argued that it is “not sufficient” (p. 36) and must be supplemented by critical (utilitarian) thinking when “no appeal to intuitions” can “settle the dispute” (p. 38). Although Hare’s work was applied to psychiatry, it has direct relevance to counseling in that many have followed the lead of Kitchener and incorporated his ideas in their works.

Rest (1984) produced another work that is frequently cited in the literature. Rest has published extensively on the topic of developmental issues related to moral reasoning (e.g., Rest, Cooper, Coder, Maganz, & Anderson, 1974; Rest, Davison, & Robbins, 1978). Rest’s (1984) work, written specifically for the applied ethics of psychology, drew heavily on theories of moral development (e.g., Kohlberg, 1969, 1980) and research findings (e.g., Schwartz, 1977) to present a four-component model of “processes involved in the production of moral behavior” (p. 19). The components are (a) “To interpret the situation in terms of how one’s actions affect the welfare of others”; (b) “To formulate what a moral course of action would be; to identify the moral ideal in a specific situation”; (c) “To select among competing value outcomes of ideals, the one to act upon; deciding whether or not to try to fulfill one’s moral ideal”; (d) “To execute and implement what one intends to do” (Rest, 1984, p. 20). The four components are not temporally linear, and they are not virtues or traits of individuals. Rather, “they are major units of analysis in tracing out how a particular course of action was produced in the context of a particular situation” (p. 20). Rest (1984) argued that “The four component model provides a framework for ordering existing research on moral development, identifying needed research and deriving implications for moral education. There are many directives for the moral education of counselors that come from this research” (p. 27). For instance, he believed an assessment instrument could be developed for each component in order to assess counseling students entering training or the outcomes of training programs themselves. In a later work, Rest (1994) reviewed the works of Kohlberg and gave an up-to-date summary of research findings related to Kohlberg’s theory. He also offered a revised version of the four-component model. Rest (1994) defined the four components as “the major determinants of moral behavior” (p. 22), and he summarized the components as (a) “Moral Sensitivity”; (b) “Moral Judgment”; (c) “Moral Motivation”; and (d) “Moral Character” (pp. 23–24). Rest (1994) stated the following:

In summary, moral failure can occur because of deficiency in any component. All four components are determinants of moral action. In fact, there are complex interactions among the four components, and it is not supposed that the four represent a temporal order such that a person performs one, then two, then three, then four—rather the four components comprise a logical analysis of how it takes to behave morally. (p. 24)

Rest’s (1994) model is clearly theoretically linked to cognitive theory through the works of Kohlberg, and he has one of the most empirically grounded approaches to analyzing moral behavior.

Gutheil, Bursztajn, Brodsky, and Alexander (1991), in a text on decision making in psychiatry and law, provided a chapter titled “Probability, Decision Analysis, and Conscious Gambling.” The chapter reviewed the mechanistic and probabilistic paradigms in science and took a stand that decision making must account for some level of uncertainty (probability). Gutheil et al. argued in favor of “decision analysis” as a formal decision-making tool:

Decision analysis is a step-by-step procedure enabling us to break down a decision into its components, to lay them out in an orderly fashion, and to trace the sequence of events that might follow from choosing one course of action or another. This procedure offers several benefits. It can help us to make the best possible decision in a given situation. Moreover, it can help us to clarify our values, that is, the preferences among possible outcomes by which we judge what the best decision might be. Decision analysis can also be used to build logic and rationality into our intuitive decision making—to educate our intuition about probabilities and about the paths of contingency by which our actions, in combination with chance or “outside” events, lead to outcomes. (p. 41)

Decision analysis involves several “approaches,” including (a) acknowledging the decision, (b) listing the pros and cons, (c) structuring the decision (including development of a decision “tree” to graph decisional paths and subsequent decisional branches, (d) estimating probabilities and values, and (e) calculating expected value. Estimating probabilities by means of a decision tree may involve calculating "the
relative frequency with which the event in question occurs over a large number of trials in similar circumstances" (Gutheil et al., 1991, p. 46). The authors contrast the procedure of decision analysis with the notion that the process of decision making is otherwise little more than gambling, with actions ruled by chance or outside events. Their model is clearly linked to nonmechanistic probability theory in science (e.g., the uncertainty principle).

Two articles integrated Berne's (1972) transactional analysis therapeutic approach with ethical decision-making processes. For example, Chang (1994) identified a five-step model of making an ethical decision and emphasized three core values implicit in transactional analysis that affect the decision-making process: (a) the principle that people are born acceptable or "OK," (b) clients are capable of understanding their problems and are actively involved in healing, and (c) people can take charge of their lives. She addressed the interplay of transactional analysis values and other ethical standards or directives. McGrath (1994) believed that Kitchener's (1988) discussion of roles was relevant to transactional analysis, because it was common to view transactional analysis supervisors also as therapists. Accordingly, role theory would have direct relevance to individual transactional analysis therapists making decisions.

Based on a theory of feminism, a model for ethical decision making was proposed by Hill, Glaser, and Harden (1995). They valued the emotional responses of the counselor and the social context in which the therapeutic relationship takes place. In accord with feminist beliefs regarding power, the client is engaged as fully as possible in the decision-making process. At each step, the feminist model included a rational-evaluative procedure with corresponding emotional and intuitive queries to assist the counselor. This model included a review process in which the counselor considers the impact of personal values, the universality of the proposed solution, and the intuitive feel of the proposed solution. Because personal characteristics affect ethical decisions, the authors believed that integration of this factor into their model improves the decision-making process.

Betan (1997) proposed a hermeneutic perspective to ethical decision making. Betan stated that "hermeneutics represents a shift in views of the nature of knowledge and the process of how we come to know" since "knowledge is situated in the context of human relationships in which the interpreter (as knowledge is interpretation) participates in narrating meaning" (p. 352). He advocated that hermeneutics adds to rather than replaces the principled approaches of Kitchener (1984) and Rest (1984). "The context of the therapeutic relationship and the clinician's psychological needs and dynamics are fundamental considerations in the interpretation and application of ethical principles" (p. 356). Furthermore, Betan stated what is universal (in this regard, a standard or principle) is a product of shared subjective experiences, which in turn are embedded in a context of cultural interpretation. (p. 356)

The prima facie obligation of ethical principles asserted by Kitchener must instead, according to Betan, be applied in the context of personal and cultural values. That an ethical truth is constructed in the framework of one's conception of self; others, and the world holds implications for counselor training; counselors must work to gain awareness of ethical dilemmas, their own personal and moral values, and the interaction between ethical principles and context.

Cottone (in press) took an even more radical relational position than did Betan (1997). Cottone proposed an ethical decision-making approach based on social constructivism. He argued that decision making is not a psychological process. Rather, decision making is a social process always involving interaction with other individuals. Building on the works of Gergen (1985) in social psychology and the works of Maturana (Maturana, 1978, 1988; Maturana & Varela, 1980) in the biology of cognition, Cottone argued that ethical decisions "are not compelled internally; rather, they are socially compelled." Furthermore, he asserted that ethical decision making occurs in the interactive processes of negotiating, consensualizing, and arbitrating. An individual's psychological process is not involved. The social constructivism perspective of ethical decision making takes the decision out of the "head," so to speak, and places it in the interactive process between people.

**EMPIRICAL FINDINGS RELATED TO A THEORETICAL OR PHILOSOPHICALLY BASED MODEL**

Two empirical studies in the published literature had direct theoretical linkage. Cottone, Tarvydas, and House (1994) derived hypotheses about how counseling graduate students make decisions based on social systems theory. According to social systems theory, they posited that "all thinking and decision making would be highly socially and relationally influenced, and both number and types of relationships would potentially influence how individuals act and think" (p. 57). Cottone et al. concluded the following:

The results indicate that interpersonal relations influenced the ethical decision making of graduate counseling student participants when they were asked to reconsider a decision. In other words, relationships seem to influence ethical decision making linearly and cumulatively. Additionally, there seems to be an interaction between the number and type of consulted relationships in a way that eludes simple explanation. Although there was only a small interaction effect size, the results support a conclusion that ethical decision making in a reconsideration circumstance is a relatively complex issue, with at least the number and type of relationships interacting. (p. 63)

The results supported a conclusion of social influence over ethical choice. The second study was a test of Janis and Mann's (1977) theory of decision making under stress by Hinkeldey and Spokane (1985). Hinkeldey and Spokane concluded that "consistent with Janis and Mann's theory, results showed
that decision making was affected negatively by pressure but that participants relied little on legal guidelines in making responses to ethical conflict dilemmas” (p. 240).

Dinger (1997) presented dissertation findings on a study that compared the Ethical Justification model of Kitchener (1984) to the A-B-C-D-E worksheet model of Sileo and Kopala (1993) and concluded that the Kitchener model better served participants in identifying the ethical issues presented in different scenarios. (The Dinger work is discussed in more detail at the conclusion of this article.)

**PRACTICE-BASED MODELS OF ETHICAL DECISION MAKING**

Some authors have proposed models based on pragmatic procedures derived largely from experience or intended primarily as practical guides for counselors. These models tend to be less theory specific or philosophically pure than those discussed in the prior sections of this article. Table 1 provides a summary of steps or stages of decision-making models that are discussed in this section. Table 1 is organized to reflect similarities of the models; it does not present a one-to-one or step-by-step correspondence for every step listed in a row.

Keith-Spiegel and Koocher (1985) pointed out that ethical decision-making models do not make ethical decisions, but describe a process for examining a situation. Decisions made in crisis situations may involve alternate strategies and criteria. Their process (see Table 1) drew from the work of Tymchuk (1981). Values, personal characteristics, clinical orientation, ethical training received, and years of experience are understood to affect the choice of action made by a counselor. Careful implementation and monitoring of all actions taken to address the ethical dilemma is favored.

Stadler (1986) presented an ethical decision-making model (see Table 1) that embraced moral principles as the basis for action (Kitchener, 1984; Rest, 1984). She believed that the counselor's moral beliefs influence the actions taken in response to an ethical dilemma, and she viewed the counselor as a moral agent with special responsibilities to the client. Stressing the principles of autonomy and beneficence, Stadler stated that counselors should "conscientiously endeavor" to reduce the impact of their values on their clients by "clarifying" their own value expectations and "by allowing clients to consider their own values and freely chosen goals" (p. 3). She encouraged counselors to examine "competing nonmoral values" (p. 8), factors such as potential financial benefits or transference issues, that may potentially interfere with ethical responsibilities. Stadler proposed an ethical test, evaluating the universality, publicity, and justice of the proposed course of action. Stadler served as chair of the American Counseling Association (ACA) Ethics Committee.

Tymchuk (1986) stressed that the goal of ethical decision making should be one of justice. In addition to laws, regulations, ethical codes and practical experience, Tymchuk encouraged reliance on utilitarianism as a guide to decision making. He called for research-based ethical guidelines and challenged counselors to go beyond reacting to emerging ethical issues to anticipate future trends. The Canadian Psychological Association code of ethics incorporates the steps presented in his model, which are listed in Table 1.

Sileo and Kopala (1993) developed a worksheet to simplify the counselor's consideration of ethical issues. With a primary goal of promoting beneficence, their "A-B-C-D-E" method is simple and easy to remember: assessment (A), benefit (B), consequences and consultation (C), duty (D), and education (E). The components incorporate the moral standards of autonomy, beneficence, nonmaleficence, fidelity, and justice. The worksheet allows a counselor to systematically join personal character, virtue, and sound thinking to ensure the best response to an ethical dilemma.

Forster-Miller and Davis (1996), also as members of the ACA Ethics Committee, offered a straightforward model. They referred to the moral principles of autonomy, justice, beneficence, nonmaleficence, and fidelity as the touchstones of the model and as helpful for clarifying the ethical dilemma at hand. In Forster-Miller and Davis's seven-step method (Table 1), the counselor uses Stadler's (1986) three-question test to determine the appropriateness of a course of action: (a) Is the action fair? (b) Would the counselor recommend it to a peer? and (c) Would the counselor want his or her behavior made public?

In developing her “Integrative Decision-Making Model of Ethical Behavior," Tarvydas (1998) drew on the work of Rest (1984), Kitchener (1984), and Tarvydas and Cottone (1991). The model was designed to illuminate the thinking, feeling, and contextual aspects of the psychological process of ethical decision making. Kitchener's (1984) intuitive and critical-evaluative levels of thinking provided the lynchpin for this model's selection of the best course of action. Tarvydas described stages (Table 1) with detailed components that guide the counselor through each stage. Notably, Tarvydas stressed the importance of the decision-maker's self-awareness, attention to context, and collaboration with all stakeholders.

Steinman, Richardson, and McEnroe (1998) wrote a manual for helping professionals that proposed and applied an ethical decision-making model to areas such as confidentiality, client welfare and client relationships, supervision, research, teaching, and consulting. They sensitized the reader to four ethical traps, or most common reasons for ethical violations, as part of learning to identify dilemmas. Furthermore, they established an ethical hierarchy by ranking the potential beneficiaries of ethical decisions when interests are in conflict. Nonmaleficence is considered by many ethicists (cf. Kitchener, 1984) to be the strongest ethical obligation. However, Steinman et al. believed that the interests of counselors, then society, then the client should be considered when making ethical choices. This model (Table 1) directed the counselor to prepare an ethical resolution that details the dilemma, the action suggested by relevant ethical codes and laws, the outcome of consultation about the dilemma, and the proposed action and perceived consequences of this action, then to review the resolution with peers and supervisor.

Welfel (1998) presented a model (Table 1) based on the two-level decision-making model proposed by Kitchener (1984). She emphasized that analysis of a dilemma must
## TABLE 1

Summary of Steps or Stages of Practice-Based Ethical Decision-Making Models

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<td>1. Identify the problem</td>
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<td>1. Identify the problem</td>
<td>1. Interpret</td>
<td>1. Determine</td>
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<td>2. Identify potential issues</td>
<td>2. Define the potential issues</td>
<td>1. Gather information</td>
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<td>standards that apply to dilemma</td>
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<td>5. Consider possible and</td>
<td>4. Generate potential courses of action</td>
<td>responsibilities, and welfare of</td>
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<td>standards</td>
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<td>3. Refer to</td>
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<td>probable courses of action</td>
<td>5. Generate alternate decisions</td>
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<td>9. Implement course of action</td>
<td>9. Test the course of action</td>
<td>7. Select an action by weighing</td>
<td>outcomes</td>
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<td>consequences</td>
<td>with supervisor</td>
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<td>10. Implement best choice and</td>
<td>10. Identify steps, take action, evaluate</td>
<td>competing values, given context</td>
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<td>evaluate</td>
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<td>alternative</td>
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<td>11. Modify practices to avoid</td>
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<td>and decide</td>
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**Note.** ACA = American Counseling Association.

be rooted in a commitment to the virtues of professional values. According to this system, the counselor gathers information and consults with others regarding the dilemma but must deliberate alone before making an informed decision. Welfel pointed out that counselor preparation through familiarity with ethical codes and practical experience can shorten the decision-making process.

Corey, Corey, and Callanan (1998) noted that because ethical codes cannot be applied in a rote manner, practitioners are more likely to respond to a dilemma based on their personal values and practical considerations. They review two decision-making models in depth—the virtue ethics of Jordan and Meara (1990) and the critical-evaluation model of Kitchener (1984)—and stressed the four fundamental principles of autonomy, beneficence, nonmaleficence, and justice. Corey et al. presented a series of steps for ethical decision making (Table 1) that blends practices from different models.

### MODELS DEVELOPED FOR SPECIALTY PRACTICE

The literature contains examples of ethical decision-making models applied to or developed for a specific area of counsel-
ing practice (e.g., marriage/family counseling, mental health counseling, counseling children, or counselor education) or for a specific problem (e.g., AIDS). Family counseling, for instance, stands on theoretical grounds and presents practical and ethical situations that differ from counseling an individual (Cottone & Tarvydas, 1998). Woody (1990) recognized the complexities of ethical dilemmas that emerge in a couple or family format. Believing that "clinical decision making consists of an unpredictable mix of intuition and rationality" (p. 144), Woody based her model on the work of Hare (1981) and Hundert (1987). She identified five sources of information, or "decision bases," for the counselor to draw on in choosing a course: ethical theories, professional codes of ethics, counseling theory, sociological context, and personal/professional identity. Examples taken from marriage and family counseling situations are used to illustrate how the counselor reflects on all decision bases and balances ethical principles to come to a decision.

Tarvydas (1987) reviewed decision-making models for application to rehabilitation counseling. On the basis of several models, she described decision making as "professional self exploration," "moral reasoning discourse," "a developmental process," or as a "multidimensional integrative process" (pp. 50–51). Tarvydas stated, "There is virtually no empirical or theoretical information available in the rehabilitation counseling literature to guide decision-making processes in ethics" (p. 50).

Zygmond and Boorhem (1989) encouraged family therapists to apply Kitchener's (1984) model. Concurring with Woody (1990), Zygmond and Boorhem held that relying solely on therapeutic tenets to guide one's choices might lead to unethical decisions. Systems theory approaches, for instance, may conflict with the ethical principle of justice when the family therapist is faced with unequal partnership in families. The contextual importance of the therapist's values and theoretical beliefs, the relationship between family and therapist, and the unique particulars of each family denies standard solutions to ethical dilemmas.

Rae, Fournier, and Roberts (in press) addressed assessment of children with special needs. In addition to describing practice issues and ethical guidelines for these particularly vulnerable children, they present a model for ethical decision making (Table 1). The importance of assessing potential actions from the perspective of the child is stressed. The authors noted that the context of the situation (e.g., school versus private practice) might alter the counselor's choice of action. Consultation with colleagues and professional organizations is encouraged at any point throughout the process. The counselor is encouraged to evaluate the actions taken and modify standard practices as necessary to avoid future problems.

Related to counselor education, Kitchener (1986) applied Rest's (1983) four psychological processes for deciding and carrying forth a moral action as an introduction to an argument to integrate moral thinking and ethical reasoning into the counselor education curriculum. Kitchener (1986) argued that such a curriculum could stimulate the ethical sensitivity, improve the ethical reasoning, and develop moral responsibility of counselors. Kitchener (1991) made a similar argument specifically related to the subdiscipline of mental health counseling; applying Rest's (1983) ideas, she argued that mental health counselors, during graduate training and through their careers, have an obligation to attend to the processes that are involved in making ethical decisions (implying Rest's, 1983, model of moral action).

The ethical limits to confidentiality when working with clients with AIDS has drawn considerable attention in recent years. Several models (Cohen, 1990; Erickson, 1990; Harding, Gray, & Neal, 1993) for ethical decision making have been proposed that address the counselor's dilemma of preserving confidentiality and protecting the partners of sexually active, HIV-positive clients.

Decisions about dual relationships can be troublesome for counselors. Gottlieb (1993) developed a decision-making model for avoiding exploitive dual relationships. An extension of Kitchener's (1988) work, the model examines the established relationship along three dimensions: power, duration, and termination status. Gottlieb's protocol then makes recommendations based on the circumstances of the current and contemplated relationships. Examination of these three dimensions from the viewpoint of the consumer, not simply the counselor, is emphasized.

**THE PROCESS OF DECISION MAKING**

Other authors have addressed the process of ethical decision making without presenting a comprehensive model. Hillerbrand and Stone (1986) invited counselors to more fully engage clients in the ethical decision process to link the profession's concepts with the framework of the client.

Hundert (1987) addressed the actual making of an ethical decision. He pointed out the difficulty of articulating the process by which the worth of one value is balanced against another. Hundert offered two methods for recognizing the best ethical choice. The first is an intuitive, affective guide:

Perhaps the only scale we have to carry out such a balancing act is the anxiety that our conscience dutifully provides in the process. By striving to find the path that makes us less anxious, we presumably balance a host of incomprehensible values according to the scale of our conscience. (p. 839)

Second, using a "reflective equilibrium" or decisional balance approach allows one to explore choices in an ethical dilemma. Writing, saving, and reviewing lists of conflicting values in each situation provides the opportunity to clarify one's position and to grow as a professional. No single value will always prevail in all dilemmas, according to Hundert; "exceptions to the rule" demonstrate how conflicting values can prevail in different contexts. Viewed at a broader level, different systems (for instance, the medical and legal professions) can hold different balance points for ethical decision making.

Eberlein (1987) presented a practice-based approach to training psychologists in ethical decision making. According
to Eberlein, the Canadian Psychological Association code of ethics prioritized ethical principles: (1) respect for the dignity of persons, (2) responsible caring, (3) integrity in relationships, and (4) responsibility to society. Except in cases of emerging violence, the practitioner is directed to give greater emphasis to the higher of conflicting principles. A problem-solving approach based on the work of Tymchuk (1986) was used to teach practitioners to ask questions about ethical dilemmas: Who needs to be considered in making the decision? What consideration is owed to whom, and why? What course of action would you take, and why? What alternatives did you consider, and why were they dismissed? What minimal circumstance would lead to a different solution? What thoughts do you have about this or similar situations? Noting that ethical codes are incomplete guidelines that reflect the values of the majority, Eberlein believed that personal values ultimately inform the counselor’s ethical decisions.

Smith, McGuire, Abbott, and Blau (1991) surveyed practitioners about their reasoning during an ethical conflict. They found that professionals acknowledged laws and ethical codes when identifying what they should do but more often identified personal values and practical factors when determining what they would actually do when faced with a dilemma.

Garfat and Ricks (1995) viewed the counselor as the focus of ethical decision making. From this perspective, ethics is no longer about determining “right answers,” but whether and how the counselor decides what action to take: “Ultimately ethical practice is moderated through and driven by the self as opposed to being driven by external variables” (p. 397). Internalized codes, standards, and organizational values are applied to the ethical dilemma, critical and reflective analysis is involved, the decision is implemented and evaluated, and feedback is used to modify the counselor’s framework of beliefs as needed. Attributes necessary for this self-driven ethical practice include self-awareness, ability for critical thinking, willingness to take personal responsibility, openness to alternative choices, and ability to monitor and implement feedback subsequent to ethical actions.

CONCLUSION

Do ethical decision-making models really work? Dinger, in a study presented at the 1997 American Counseling Association World Conference, compared the A-B-C-D-E worksheet of Sileo and Kopala (1993) to the Ethical Justification model of Kitchener (1984) and found that “only the Ethical Justification model equipped participants with the requisite skills to tease out the ethical issues embedded in different counseling scenarios. Participants trained in the placebo condition performed as well as the participants in the Worksheet condition.” Dinger suggested that “counselor educators exercise caution when recommending to their colleagues and to their trainees the utility of ethical decision-making models.” Aside from the few empirical studies presented in this review article, surprisingly little research has been done on ethical decision making or models of decision making in counseling. There is much work in the ethics area that must be accomplished.

Although there may be caveats to ethical decision-making training, certainly ethics training should not happen by “osmosis” (Handelman, 1986). Ethics is a critical element of counseling practice, and competent training in ethical decision making should be a component of professional training programs.

Since 1984, the date of publication of Kitchener’s work, many decision-making model publications have appeared. What is evident from this review is that several works have become established as seminal. In addition to Kitchener’s work, the foundational works of Hare (1981, 1991), Beauchamp and Childress (1979, 1994), and Rest (1984) are widely cited. This reliance on what is predominantly a “principle” ethics perspective has lead some to argue for a rapprochement with “virtue” ethics (in which an individual’s character is involved, for instance; see Meara, Schmidt, & Day, 1996). “Principle” ethics is also in contrast to newer models emphasizing the social interactive nature of decision making, such as the work of Betan (1997) who takes a critical view of Kitchener’s work or Cottone (in press) who takes a radical social constructivism approach. Given that foundational theory is identifiable in the literature, contrasting approaches may continue to emerge allowing for competitive empirical tests of the proposed theories. The fact that little empirical research has been published on the topic of ethical decision making implies that the study of decision-making models is immature. It may be some time before empirically based approaches to teaching ethical decision making can be developed.

In addition, it was surprising to find the number of practice-based models developed apparently without attention to underlying philosophical or theoretical tenets. Although there are common elements (steps or stages) in these models (as can be seen in Table 1), there seems to be little attention to foundational premises or to the roots of commonality. These models may be criticized as not theoretically grounded, not philosophically pure, or as hodgepodge approaches to specific problems. It is difficult to justify their use without questioning the coherence or utility of the model, especially in the absence of clear empirical support for such models.

As this review makes clear, there are many practice-relevant models (many building on foundational works) that can be chosen as guides for ethical decisions in particular practice settings, within specialties, with specific types of clients, or according to a published standard of practice. As to whether one model is better than another is yet to be determined. In fact, the criteria for what makes a “better” model are not clearly defined in the field, and empirical comparisons are lacking. Certainly, a dialogue on these matters would be worthwhile.

REFERENCES


Ethical Decision-Making Model at a Glance

1. Identify the Problem

2. Apply the ACA Code of Ethics (latest version)

3. Determine the Nature of Dimensions of the Dilemma

4. Generate Potential Courses of Action

5. Consider the Potential Consequences of all Options then Choose a Course of Action

6. Examine the Selected Course of Action

7. Implement the Course of Action
AMCD Multicultural Counseling Competencies

I. Counselor Awareness of Own Cultural Values and Biases

A. Attitudes and Beliefs

1. Culturally skilled counselors believe that cultural self-awareness and sensitivity to one’s own cultural heritage is essential.

2. Culturally skilled counselors are aware of how their own cultural background and experiences have influenced attitudes, values, and biases about psychological processes.

3. Culturally skilled counselors are able to recognize the limits of their multicultural competency and expertise.

4. Culturally skilled counselors recognize their sources of discomfort with differences that exist between themselves and clients in terms of race, ethnicity and culture.

B. Knowledge

1. Culturally skilled counselors have specific knowledge about their own racial and cultural heritage and how it personally and professionally affects their definitions and biases of normality/abnormality and the process of counseling.

2. Culturally skilled counselors possess knowledge and understanding about how oppression, racism, discrimination, and stereotyping affect them personally and in their work. This allows individuals to acknowledge their own racist attitudes, beliefs, and feelings. Although this standard applies to all groups, for White counselors it may mean that they understand how they may have directly or indirectly benefited from individual, institutional, and cultural racism as outlined in White identity development models.

3. Culturally skilled counselors possess knowledge about their social impact upon others. They are knowledgeable about communication style differences, how their style may clash with or foster the counseling process with persons of color or others different from themselves based on the A, B and C, Dimensions, and how to anticipate the impact it may have on others.

C. Skills

1. Culturally skilled counselors seek out educational, consultative, and training experiences to improve their understanding and effectiveness in working with culturally different populations. Being able to recognize the limits of their competencies, they (a) seek consultation, (b) seek further training or education, (c) refer out to more qualified individuals or resources, or (d) engage in a combination of these.

2. Culturally skilled counselors are constantly seeking to understand themselves as racial and cultural beings and are actively seeking a non racist identity.

II. Counselor Awareness of Client’s Worldview

A. Attitudes and Beliefs

1. Culturally skilled counselors are aware of their negative and positive emotional reactions toward other racial and ethnic groups that may prove detrimental to the counseling relationship.
They are willing to contrast their own beliefs and attitudes with those of their culturally different clients in a nonjudgmental fashion.

2. Culturally skilled counselors are aware of their stereotypes and preconceived notions that they may hold toward other racial and ethnic minority groups.

**B. Knowledge**

1. Culturally skilled counselors possess specific knowledge and information about the particular group with which they are working. They are aware of the life experiences, cultural heritage, and historical background of their culturally different clients. This particular competency is strongly linked to the "minority identity development models" available in the literature.

2. Culturally skilled counselors understand how race, culture, ethnicity, and so forth may affect personality formation, vocational choices, manifestation of psychological disorders, help seeking behavior, and the appropriateness or inappropriateness of counseling approaches.

3. Culturally skilled counselors understand and have knowledge about sociopolitical influences that impinge upon the life of racial and ethnic minorities. Immigration issues, poverty, racism, stereotyping, and powerlessness may impact self esteem and self concept in the counseling process.

**C. Skills**

1. Culturally skilled counselors should familiarize themselves with relevant research and the latest findings regarding mental health and mental disorders that affect various ethnic and racial groups. They should actively seek out educational experiences that enrich their knowledge, understanding, and cross-cultural skills for more effective counseling behavior.

2. Culturally skilled counselors become actively involved with minority individuals outside the counseling setting (e.g., community events, social and political functions, celebrations, friendships, neighborhood groups, and so forth) so that their perspective of minorities is more than an academic or helping exercise.

### III. Culturally Appropriate Intervention Strategies

**A. Beliefs and Attitudes**

1. Culturally skilled counselors respect clients' religious and/or spiritual beliefs and values, including attributions and taboos, because they affect worldview, psychosocial functioning, and expressions of distress.

2. Culturally skilled counselors respect indigenous helping practices and respect help-giving networks among communities of color.

3. Culturally skilled counselors value bilingualism and do not view another language as an impediment to counseling (monolingualism may be the culprit).

**B. Knowledge**

1. Culturally skilled counselors have a clear and explicit knowledge and understanding of the generic characteristics of counseling and therapy (culture bound, class bound, and monolingual) and how they may clash with the cultural values of various cultural groups.

2. Culturally skilled counselors are aware of institutional barriers that prevent minorities from using mental health services.
3. Culturally skilled counselors have knowledge of the potential bias in assessment instruments and use procedures and interpret findings keeping in mind the cultural and linguistic characteristics of the clients.

4. Culturally skilled counselors have knowledge of family structures, hierarchies, values, and beliefs from various cultural perspectives. They are knowledgeable about the community where a particular cultural group may reside and the resources in the community.

5. Culturally skilled counselors should be aware of relevant discriminatory practices at the social and community level that may be affecting the psychological welfare of the population being served.

C. Skills

1. Culturally skilled counselors are able to engage in a variety of verbal and nonverbal helping responses. They are able to send and receive both verbal and nonverbal messages accurately and appropriately. They are not tied down to only one method or approach to helping, but recognize that helping styles and approaches may be culture bound. When they sense that their helping style is limited and potentially inappropriate, they can anticipate and modify it.

2. Culturally skilled counselors are able to exercise institutional intervention skills on behalf of their clients. They can help clients determine whether a “problem” stems from racism or bias in others (the concept of healthy paranoia) so that clients do not inappropriately personalize problems.

3. Culturally skilled counselors are not averse to seeking consultation with traditional healers or religious and spiritual leaders and practitioners in the treatment of culturally different clients when appropriate.

4. Culturally skilled counselors take responsibility for interacting in the language requested by the client and, if not feasible, make appropriate referrals. A serious problem arises when the linguistic skills of the counselor do not match the language of the client. This being the case, counselors should (a) seek a translator with cultural knowledge and appropriate professional background or (b) refer to a knowledgeable and competent bilingual counselor.

5. Culturally skilled counselors have training and expertise in the use of traditional assessment and testing instruments. They not only understand the technical aspects of the instruments but are also aware of the cultural limitations. This allows them to use test instruments for the welfare of culturally different clients.

6. Culturally skilled counselors should attend to as well as work to eliminate biases, prejudices, and discriminatory contexts in conducting evaluations and providing interventions, and should develop sensitivity to issues of oppression, sexism, heterosexism, elitism and racism.

7. Culturally skilled counselors take responsibility for educating their clients to the processes of psychological intervention, such as goals, expectations, legal rights, and the counselor’s orientation.

The Case of Andrea

Andrea is a fourteen year old girl who lives with her parents and 17 year old brother in a small town. Because of Muscular Dystrophy Andrea is confined to a wheelchair. While Andrea can “wheel” herself to most of her classes, she is unable to open her classroom door because she cannot get out of her wheelchair. Andrea’s classmates open the classroom doors and the bathroom door for her because she is unable to work from her wheelchair to open the door. In meeting with her school counselor, Andrea says it is embarrassing to be so dependent on her classmates. In fact, Andrea says she almost had an “accident” because the student who was “wheeling” her to the bathroom began talking to another student, and Andrea barely made it to the bathroom. With Andrea’s permission, the school counselor discussed Andrea’s situation with the principal who, while expressing sorrow, said, “I am sorry but our school district cannot afford to provide accommodations to open the school doors.”

The more the school counselor thought about the situation, the more she became convinced that something must be done for Andrea. As she thought about Andrea’s situation, the school counselor concluded that she was the one who must advocate to help Andrea. With Andrea’s permission, the counselor talked with Andrea’s parents. She informed the parents, who are from another country and who do not speak fluent English, that the law states that the school must provide accommodations for Andrea. In talking with Andrea’s parents, it was evident that they were unaware of Andrea’s rights. The parents did thank the counselor for her help, and said they would talk with a friend who is an attorney. The counselor, attorney, and the parents attended a meeting with the principal and superintendent and discussed Andrea’s rights. Shortly after the meeting, accommodations were provided.
Countering the Conspiracy to Destroy Black Boys:

A Case Study

Dr. David Macintosh is a 62 year-old White male Vietnam veteran from New England. He is a Counseling Psychologist and a Licensed Psychologist, Licensed Professional Counselor who is currently supervising the supervision of Sherry Crockett, a 35 year-old White female doctoral student. Sherry identifies as a bisexual and bigender and as an East Texan Methodist. She is a LPC-Supervisor completing her doctoral internship hours in Counselor Education at her University Student Counseling Center located in a Predominantly White university in West Texas. She is supervising, Pham Nang, a 32 year old Vietnamese male master's student who is completing his last clinical internship class. Kim is an international student and second generation Christian who identifies as heterosexual.

Pham is counseling Jermaine, a 20 year-old Black male transfer student, who was raised in a middle-class African American neighborhood in Houston. He is an Engineering Student. His African parents are both professionals and both Muslims, even though his mom is Jewish by birth. In high school, he was an all around athlete and honor student and was aggressively recruited to play football. Currently, he is a member of The National Society of Black Engineers (NSBE) and he is a “Q Dog” (Omega Psi Phi).

Jermaine presents with mild depression that began during his first semester at this University. He has been having flashback memories of being in middle school and being teased for being too feminine. This semester his grade point average has dropped from a 4.0 to a 2.9 and he feels this might hurt his chances of going to graduate school at Harvard. He feels the low grades he received had a lot to do with his professors evaluating his work based on his being a Black male and his religion, rather than the quality of his work. Although he tries to participate in class, he rarely gets called on by his professors. He oftentimes feels excluded from the discussions; his White friends and classmates agree.