Accessible Counseling Entity (ACE)
Counseling Center

ACE
MANUAL

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TABLE OF CONTENTS

I. INTRODUCTION iii
II. MISSION STATEMENT iii
III. ACCESSIBLE COUNSELING ENTITY (ACE) - Counselor Statement 1
IV. AUTHORIZATION TO RELEASE/OBTAIN INFORMATION 2
V. ACE QUESTIONNAIRE 3
VI. INFORMED CONSENT 4
VII. RULES OF GROUP THERAPY 5
VIII. CONFIDENTIALITY STATEMENT 7
IX. CARING AND SHARING GROUP PROCEDURES 9
X. COUNSELING LABORATORY GENERAL REQUIREMENTS 10
XI. PROCEDURES FOR TERMINATING CASES 12
XII. LITERATURE SEARCH REQUEST CODES 15
XIII. INSTRUCTIONS FOR MAKING TAPES IN LABORATORY 17
XIV. GENERAL CONSIDERATIONS FOR THE INTAKE INTERVIEW 18
XV. INTAKE FORM COVER SHEET 19
XVI. REQUEST FOR SERVICES FORM 20
XVII. CONSENT TO AUDIO/VIDEO TAPE 23
XVIII. REPORT OF PSYCHOLOGICAL EVALUATION 25
XIX. QUALITY ASSURANCE 30
- A. Points to Remember. 30
- B. Responsibilities 30
- C. Case Review Checklist 31
- D. General Considerations 33

XX. INDIVIDUAL COUNSELING CASE LOAD RECORD 34
XXI. CASE STAFFING OUTLINE 35
XXII. PROCEDURES FOR HANDLING SUICIDE THREATS 36
XXIII COUNSELING CONTRACT 40
XXIV. PROCEDURES FOR HANDLING SUSPECTED CHILD ABUSE. 41
XXV. SYSTEMATIC DESENSITIZATION 43
XXVI. SCHOOL PROBLEMS 45
XXVII STUDY SKILLS 46
XXVIII ASSERTIVENESS 47
XXIX STRESS INOCULATION 49
XXX PROBLEM SOLVING-DECISION MAKING 50
XXXI TEST ANXIETY 52
XXXII GENERAL ASSESSMENT PROCEDURES 54
XXXIII FREQUENTLY USED TESTS 55
XXXIV CONFIDENTIALITY 57
XXXV. ETHICAL PRINCIPLES FOR PSYCHOLOGISTS 59
- A. Preamble 60
- B. General Principles 60

C. Ethical Standards 62
1. Resolving Ethical Issues 62
2. Competence 63
3. Human Relations 64
4. Privacy and Confidentiality 66
5. Advertising and Other Public Statements 68
6. Record Keeping and Fees 69
7. Education and Training 70
8. Research and Publication 72
9. Assessment 75
10. Therapy 78
XXXVI ACA CODE OF ETHICS AND STANDARDS OF PRACTICE 81
A. The Counseling Relationship 81
B. Confidentiality 84
C. Professional Responsibility 85
D. Relationship With Other Professionals 88
E. Evaluation, Assessment, and Interpretation 89
F. Teaching, Training, and Supervision 91
G. Research and Publication 93
H. Resolving Ethical Issues 95
XXXVII .RESOLVING ETHICAL ISSUES. 96
A. Familiarity With Ethical Codes 101
B. Confronting Ethical Issues 101
C. Conflicts Between Ethics and Organizational Demands. 101
D. Informal Resolutions of Ethical Violations 101
E. Reporting Ethical Violations 101
F. Cooperating With Ethics Committee 102
G. Improper Complaints 102
XXXVIII FREQUENTLY USED REFERRAL RESOURCES 103
XXXIX CHILD ABUSE/NEGLECT MISSISSIPPI CODE 104
XXXX REPORT OF SUSPECTED CHILD ABUSE/NEGLECT FORM 108

MISSION

The Accessible Counseling Entity (ACE) sponsored by the Department of School, Community and Rehabilitation Counseling at Jackson State University recognizes that the challenges that can accompany living in today's society can lead to personal problems, interpersonal difficulties, and emotional and psychological stress and distress. Counseling can support individuals in their experiences by promoting healthy and positive behaviors, views, relationships, and personal growth in a safe, confidential, professional, and supportive environment. At The Accessible Counseling Entity, we aim to provide the opportunity to foster this development to a culturally, socially, economically, religiously, and racially diverse community.

Vision Statement

The Accessible Counseling Entity will provide counseling services that we will hold to the highest professional and ethical standards as we work with and for the community and students of our university. The Counseling Center staff will be familiar with the issues facing a diverse college student body and population, and will contribute to student development, health, retention, and success by fostering and encouraging healthy decision-making and promoting coping skills. We will serve as a resource to the entire Jackson State University community by responding the faculty, staff, and student requests for information about community resources and referrals, and by consulting about issues affecting the success of our students. The Counseling Center will be a leader in the university's efforts to respond to critical incidents that affect the lives of our community, students and staff and the university's operations. By assisting and educating our community, promoting the use of our services for those affected by a disturbing event, and being available for debriefing and consultation, we will seek to lessen the impact of a critical incident.

Goals

ACE will accomplish our Mission and Vision by:

- ✦ Providing quality, professionally-delivered, counseling services to our community and students;
- ✦ Facilitating and supporting the personal and psychological growth and development of our community and students through individual, couples, and group counseling, as well as through prevention programming, education, and outreach;
- ✦ Promoting adjustment to college and, consequently, student retention
- ✦ Being available to students and the JSU campus and ACE community in the time of a crisis;
- ✦ Enhancing students' appreciation of diversity and individual differences;
- ✦ Promoting an environment of personal safety and respect ;
- ✦ Collaborating with faculty to promote well-being through outreach, prevention, and educational efforts.

Jackson State University
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Department of School, Community and Rehabilitation Counseling

Accessible Counseling Entity (ACE)
Counseling Center

I,______________________________, have read the Counseling laboratory Manual and understand the policies and procedures contained therein. I agree to see clients in the Counseling Laboratory only under those conditions.

Second, I,_________________________, have read the policies and procedures regarding confidentiality of client information and records and the Ethical Standards of Psychologists (APA). I am aware that client confidentiality is protected by Federal regulations and also aware of the penalties of non-compliance of these regulations while studying or employed at the Department of School Community and Rehabilitation Counseling at Jackson State University. I am also aware that these laws are applicable to me after termination of study or employment. I further understand that these policies must be followed to protect the welfare of the client and the university.

Third, I, ___________________________, acknowledge that I am personally liable while delivering counseling services to clients in the Counseling laboratory and in the field practicum/internship agencies.

____________________________________	____________________________________
Signature	Date
____________________________________	____________________________________
Witness	Date

Jackson State University
College of Education
Department of School, Community and Rehabilitation Counseling

Accessible Counseling Entity (ACE)

Counseling Center

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I, ________________________________ hereby authorize ______________________

____
Name of agency and agency's address

to release my medical records or information concerning my medical records to

________________________________ ________________________________
Specific agency or individual *Address of agency or individual*

for the specific purpose of ____
Use specific reason for the release of information

I specifically consent to the release of information or my medical records pertaining to

____
Nature and extent of information to be released

I understand that I may revoke this consent at any time except to the extent that the action has been taken thereon.

I further understand that this consent will expire upon ___________________________
Date six months from the date of client's signature

and cannot be renewed without my written consent.

________________________________ ________________________________
Signature of Client *Date*

________________________________ ________________________________
Signature of Legal Guardian *Date*

________________________________ ________________________________
Signature of Witness *Date*

________________________________ ________________________________
Authorized Signature of Program Representative *Date*

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Department of School, Community and Rehabilitation Counseling

Accessible Counseling Entity (ACE)

Questionnaire

Name: ______________________________ Date: ________________________

Current Address:____

Age: __________ Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Other ____________

Gender: ☐ F ☐ M Phone No(s): (   )________________ (   )__________

No in Family: Adults: ________ Children________

Previous Place of Employment: ______________________________________

On a scale of 1-7, please prioritize the following topics as # 1 most interested to # 7 least interested:

____________ Coping With Change

____________ Stress/Anger Management

____________ Coping With Feelings and Relapse Prevention
(Alcohol and Drug Abuse)

____________ Coping With Loss

____________ Conflict Resolution and Decision Making

____________ Play Therapy/Creative Problem Solving (*For Children*)

____________ Job Readiness/Employment Issues

Jackson State University

Department of School, Community and Rehabilitation Counseling

Accessible Counseling Entity (ACE)

INFORMED CONSENT

I, ____ agree to participate in the counseling sessions and workshops provided by the Department of School, Community and Rehabilitation Counseling at Jackson State University (JSU). I understand that participation is voluntary and will be provided free of charge by the faculty of the Counseling department and the Internship students in training at JSU.

I realize that all information regarding clients will be held in the strictest confidence. No information of any kind will be released to any external persons or agencies, by any counselor, without proper authorization from the client and/or the client's legal guardian and authorization from the laboratory director. Such confidential information includes acknowledging that a person of a particular name or description is or has been a client. Written consent of the client is required before information can be released to any third-party payor, including the Department of Public Welfare. Any request for information that may be of a confidential nature will be handled with an explanation that the information is confidential and cannot be released without the client's permission.

I hereby agree to the stipulations of this agreement and do give my consent:

________________________________	________________________________
Client's Signature	*Date*
________________________________	________________________________
Counselor's Signature	*Date*

Jackson State University

Department of School, Community and Rehabilitation Counseling

Accessible Counseling Entity (ACE)

RULES OF GROUP THERAPY

Group sessions are confidential. Every member of each therapy group at the Counseling Center is required to sign an agreement to adhere to the rules of confidentiality. In signing this agreement, group members make a personal pledge that nothing occurring in the group, including names of other group members, will be shared with anyone outside of the group. These rules are critical to the development of a safe, respectful, and trusting atmosphere which allows individuals to openly share their feelings.

If group is to be effective, your commitment to the following ground rules is essential:

- members should agree to keep each others' confidentiality;
- not attack each other verbally or physically;
- to actively participate in the group process, and to speak one at a time;
- if you are going to miss a session, let one of the leaders of the group know;
- the group meeting times have been set by the group leaders, and you are asked to adhere to those times;
- acting out your feelings is not acceptable whether you act them out upon yourself or another member of the group. The way we most respect ourselves and others is by experiencing feelings and then allowing ourselves to talk about them;

- it is the member’s responsibility to talk about your reasons for being in the group;
- the group sessions are confidential. You, other members, and the group leaders are bound ethically and legally not to disclose the contents of the group sessions; and if you decide that you have gained as much as possible from the group or that it isn't the most appropriate treatment method for you, we ask that you come to the group and say good-bye.

Jackson State University

Department of School, Community and Rehabilitation Counseling

Accessible Counseling Entity (ACE)

CONFIDENTIALITY STATEMENT

Confidentiality will be maintained at all times in regard to clients, client contacts, and client records. Clients are not to be identified nor discussed with individuals, groups, or agencies not directly affiliated with the Counseling Department at JSU, including spouses, relatives, and friends of counselors and clients. To maintain confidentiality, client's names are not discussed between or among counselors in public or quasipublic places such as restaurants, hallways, or offices in public areas of the counseling laboratory.

The counselor assigned to a particular client is responsible for maintaining the confidentiality of that particular case record. Access to the case record will be limited to the faculty and staff of the Department of Counseling at Jackson State University. Records will be stored in a locked cabinet at all times except when removed for the addition of new information..

Release of Client Information. The content of the information released from our records to other agencies/persons must be carefully considered in terms of the use to which other agencies/persons may put this information. For example, giving a teacher technical, medical/psychological diagnoses or treatment information regarding a client may not only be misused but may be misinterpreted and misunderstood. Any information leaving the laboratory must be considered in this light and should be tailored to the needs of the specific recipient. (Any information leaving the laboratory must first be approved by the director).

It is the responsibility of the counselor to see that appropriate consent forms are signed. Clearly, verbal and written information are never disclosed without written authorization from the client. A consent form must be obtained for each new piece of information required as consent forms are for specific information, are dated, and expire at the time indicated on the form. Consent forms are signed

as they are needed rather than routinely signed assuming that they will be used at some point in the future.

Jackson State University

Department of School, Community and Rehabilitation Counseling

Accessible Counseling Entity (ACE)

Sharing and Caring Groups

1. Know the group dynamics (Where, What, When, How, Why)
2. Group Icebreaker- (designed to plant trust among the members of the group)
3. What does the group have in common.
    a. What are some of the positive experiences shared by the group.
    b. What are some of the least positive experiences shared by the group.
4. Facilitate the process of sharing
    a. Have group members discuss short and long term goals.
    b. Look at ways of achieving goals
    c. What are the perceived resources needed for change
    d. Discuss avenues for change

COUNSELING LABORATORY

The following are general requirements for all counselors seeing clients in the Counseling Psychology Laboratory.

1. Personal conduct and dress should conform to professional standards reasonably expected of individuals offering counseling services.
2. Prior to seeing clients in the Laboratory, each counselor should read and understand the APA Ethical Standards.
3. All clients receiving services of the Counseling Laboratory will be recorded (audio and/or video). The counselor should be sure that a signed release form is properly executed and witnessed for each client. The counselor should check the counseling room, camera, and microphone prior to *the* counseling session. Also, a tape should be presented to the Control Room Operator 10 to 15 minutes prior to *the* session.
4. Items to be included in the client's file folder should appear in the following order:

- Intake Side (left side of folder, green sheets)
  Intake Forms Cover Sheet (top)
  Request for Services
  Intake Interview Report
  Counselor's Impressions
  Consent to Video & Audio Tape
  Consent for Release of Confidential Information (if applicable)
- Treatment Side (right side of folder, blue sheets)
  Case Summary
  Case Monitoring and Staffing Form
  Progress Charts (most recent information first, i.e., in reverse order)
  Treatment Plan
  Goal Attainment Scale Sheet (if applicable)
  Testing Report (if applicable)
  Tests, Self-Monitoring, Previous Treatment Records, and Profile Information

5. Counselors are to keep accurate records for each interview, completing pertinent forms and progress notes as soon as possible after each session, but not later than 24 hours after a session. Telephone and other contacts with clients and others regarding the client's case are to be logged in the progress notes. See the "Minimum Standards for Progress 'totes" and the progress note example in the blue section of the manual. At the end of the term, at

termination, or at referral, a Case Summary Form is to be prepared on each client.

6. If tests are administered, a Testing Report will be prepared for the client. Integrating testing and counseling data in order to provide an appropriate interpretation of test results, the Testing Report is prepared in an original and one copy (to be filed in the client's folder).
7. A Treatment Plan and Goal Attainment Scale for each client should be prepared by the end of the third session.
8. The Seminar Room is designed as a work station for counselors when it is not being used as a classroom. Please keep in mind that it is for work and hold the volume of your conversations down. The Control Room and Waiting Room are off-limits to counselors except when conducting business.
9. The Work Room (located at the South end of the doctoral students' study area) is available for monitoring of session tapes, informal conferences, studying, etc. Please be courteous to the doctoral students whose study area you must pass through in going to and from the Work Room.
10. NOTE: CONFIDENTIALITY IS TOUR RESPONSIBILITY. BREACHES WILL NOT BE TOLERATED. However, there are exceptions to the Rule of Confidentiality. Be sure to inform your clients that confidentiality must be broken under the following conditions:
    1. In cases where child abuse or neglect (including sexual abuse) are suspected.
    2. When a client threatens to harm self or others.
    3. If a client threatens to harm another, action must be taken to warn the potential victim.

See the appropriate sections of the Lab Manual for more information.11. If an emergency arises, the appropriate supervisor, instructor, the Lab Director or faculty member must be notified. Counselors will carry a reference card with the phone numbers of key persons to contact.

PROCEDURES FOR TERMINATING CASES

NOTE: For cases terminated DURING a semester, all items must be completed as indicated below EXCEPT those preceded by (End of Semester Only)

<u>Left Side of Intake Folder</u>

Intake Forms Cover Sheet

Request for Services

Intake Interview Report

Counselor Impressions

Consent to- Audio and/or Video Tape

Consent for Release of Confidential Information (when applicable)

<u>Right Side of Intake Folder</u>

Case Summary

Case Monitoring and Staffing Form Progress Notes - most recent information on top

Treatment Plan

Goal Attainment Scale

Tests, Self -Monitoring, Treatment History Information, etc. (when applicable)

Cases seen less than 4 times will require all the above completed forms EXCEPT a Goal Attainment Scale and Treatment Plan:

All pages of client file must have appropriate client number and counselor number where indicated or at the top of the page.

Counselor's supervisor is to sign and date the Termination Approval and the Case Summary Form.

Supervisors are to complete a Case Review Form for Quality Assurance on each case terminated.

Counselor's number should be written on file folder label.

If case was carried over from a previous semester, a new set of sheets in the above order should be placed on top of the sheets from the previous semester.

(END OF SEMESTER ONLY) : Each counselor completes only one of the End-of -Semester Report

Forms for all of his or her cases.

(END OF SEMESTER ONLY) : Counselors continuing a case into the next semester should indicate on the Case Summary that (1) they are registering for the next practicum course in their sequence, indicating that supervision for their "carryover" cases will be provided by the instructor/supervisors in the new course; or (2) the name of the faculty member who will be supervising the case

COUNSELING LABORATORY

Requirements:

In addition to the general requirements for all counselors seeing clients in the Counseling Psychology laboratory, the following requirements are required for completion of Counseling Laboratory :

1. The desired number of contact hours is 30 • This includes testing and interviewing.
2. Any Testing Reports given to clients are to be approved and signed by your instructor. Counselors need to show evidence of having written at least 1 test report during the term.
3. The student should have at least one interview per week monitored by his/her supervisor or instructor. It is the student's responsibility to ask the supervisor to monitor and to provide the supervisor with the case record and any competency forms to be evaluated.
4. Each student in Counseling Laboratory *I* should have at least three case staffing sessions with his laboratory group during the term.
5. All counselors will be expected to show evidence of being exposed to group work and consultation.

Competencies & Grading

The competencies are rated on a scale from on (1) to five (5), with three (3) being considered as minimal rating. It is important that you receive feedback on your progress in counseling. Therefore, you are encouraged to ask your supervisor to rate your performance frequently. Sane of the competency rating scales are quite appropriate for beginning sessions, so start early. It is your responsibility to ask to be rated on the competencies. While an attempt has been made to quantify the ratings as much as possible, there remains the element of subjective judgment. Your supervisor and professor will make that judgment based on their professional experience.

The two competencies "Theory and Practice Brought Together in Producing Client Change" and "Identifies Professional Role and Function and Integrates this as a Person" are quite important in the overall evaluation process.

Your overall rating will be determined from a composite of all the competencies.

LITERATURE SEARCH REQUEST CODES

A	
Abortion	ABOR
Acrophobia	ACRO
Adherence	ADHE
Adolescent Behavior Management	ADOL
Adult Foster Care	AFCX
Aggression	ACCR
Agoraphobia	AGOR
Alcoholism	ALCO
Anger	ANGE
Anorexia Nervosa	ANOR
Antabuse	DERX
Anxiety	ANXI
Assertiveness	ASSE
Asthma	ASTH
Attentive Behavior	ATTE
Autism	AUTI
B	
Back Pain	LBPX
Bereavement	BERE
Biofeedback	BIOF
Borderline Personality	BORD
Brain Damage	BRAI
Bruxism	BRUX
Bulimic Anorexic	BULI
C	
Cancer	CANC
Cannabis	CANA
Cardiovascular Disease	CARD
Child Abuse	CHAB
Child Gender Disturbances	CGDX
Child Management Problems	CHIL
Cigarette Smoking	CIGA
Classroom Behavior	CLAS
Cohabitation	COHA
Colitis	COLI
Communication	COM
Control Drinking	CODR
Cough,	COUG
Crisis Intervention	CRIS
D	
Dating Anxiety	DATE
Death	DEAT
Deindividualism	DEIN
Delusional Behaviaor	DELU
Dental Fears	DENT
Depression	DEPR
Dermatosis	PSDE
Developmental Problems	DEVE
Diabetes	DIAB
Disulfiram Ethanol Reaction	DERX
Divorce	DIVO
Driving Fears	SOLO
Drug Dependency	DRUG
Dysmorphophobia	DYSM
E	
Eczematous Dermatitis	ECZE
Emotional Disturbed	EMOT
Encopresis	ENCO
Enuresis	ENUR
Ethics	ETHI
Exhibitionist	EXHI
Extramarital Sexual Permissiveness	ESPX
F	
Family Disorders	FAMI
Fathering	FATH
Fears	FEAR
Fethishism	FETI
Foster Parents	FOST
G	
Gambling	GAMB
Gender Role Behaviors	GRBX
Geriatrics	GERI
Goal Attainment Scaling	GASX
Grief	GRIE
H	
Hallucinations	HALL
Handicapped	HAND
Headache	HEAD
Homicide Obsessions	HOMI
Homosexuality	HOMO
Hospitalization	HOSP
Hyperactive	HYPA
Hypertension	HYPT
Hysteria	HYST
I	
Impotence	IMPO
Impulsive	IMPU
Inhalent Abuse	INHA
Insomnia	INSO
Instruction Following	INFO
J	
Job Interview Skills	JISX
Juvenile Delinquency	JUVE
L	
Language Disorders	LANG

Learned Helplessness	LEHE
Life Planning	LIFE
Life Threatening Illness	LTIX
Low Back Pain	LBPX
M	
Manic	MANI
Manic Depressive	MADE
Marijuana	CANA
Marital Problems	MAPO
Masochism	MASO
Mastectomy	MASX
Masturbation	MAST
Menstrual Problems	MENS
N	
Nail Biting	NAIL
Negative Self-Statements	NSSX
Neurologic Disorders	NEUN
Neurosis	NEUX
O	
Obesity	WEIG
Obsessional Thinking	OBTX
Obsessive-Compulsive	OBCO
Oncology	ONOO
P	
Pain	PAIN
Paranoia	PARA
Parenting Skills	PAR
Vocational Indecision	VOCA
Pedophillic Behavior	PEDO
Phobia	PHOB
Pica	PICA
Pregnancy	PREG
Premarital Sexual Intercourse	PSIX
Premature Ejaculation	PREM
Prenatal Influences	PREN
Procrastination	PRCC
Psychoses	PSYX
Psychosomatic Dermatosis	PSDF
R	
Rape	RAPE
Remarriage	REMA
Renal Dialysis	REDI
Retarded	RETA
Rocking	ROCK
Ruminating Behavior	RUMI
S	
Sadism	SADI
Schizophrenia	SCEE
Seizures	SEIZ
Self Burning	SEBU
Self Injurious Behavior	SIBX
Self Talk (negative)	NSSSX
Sex Role Behavior	SRBX
Sexual Abuse	SEAB
Sexual Deviance	SEXD
Sexual Dysfunction	SEXU
Sleep Disorder	SLEE
Snoring	SNOR
Social Skill Deficit	SSTX
Social Anxiety	SOAN
Spasm	SPAS
Speech Anxiety	SPEE
Spinal Cord Injury	SCIX
Spouse Abuse	SPAB
Stealing	STEA
Stress Management	STCO
Student Behavior	CLAS
Study Skills	STSK
Stuttering	STUT
Suicide	SUIC
T	
Tardive Dyskinesia	TARD
Tension	TENS
Test Anxiety	TEST
Thumb Sucking	THSU
Tics	TICS
Toilet Training	TOIL
Trichotilloniania	TRIG
U	
Urination	URIN
V	
Vaginismus	VAGI
W	
Weight Control	WEIG
Withdrawal	WITH
Women's Role	WOME
Work Adjustment	WORK
Writer's Cramp	WRIT

NOTE: The number of references within each problem area will vary. Only references appear on the printout abstracts are not provided.

Instructions for Making Tapes in the Laboratory

- All counseling sessions in the laboratory must be audio and/or video taped.
- About 15 minutes before the session, counselors should complete a tape request form. These forms are located in the records office.
- Attach the form to the tape with a rubber band and place both in the plastic "in receptacle on the control room door at least 15 minutes before the time of your session. Do not disturb the control room operator to give him/her a tape.
- Check the cubicle to make sure all equipment is in place before taking client in.
- When doing an intake, the counselor should get the Consent to Audio and/or Video Tape form signed before taping. When this form is signed, alert the control room operator that taping may begin. NOTE: Taping cannot begin until the consent form is signed.
- After finishing the session the control room operator will place the tape back in the "out" receptacle on the door. Please pick up your tapes immediately after your session. Tapes left in "out" bin constitute a threat to confidentiality.
- Keep tapes of sessions no more than one week. Erase them at the end of this time, if not sooner. (A bulk tape eraser is available in the supply closet in the waiting room.)

GENERAL CONSIDERATIONS FOR INTAKE INTERVIEW

- Develop a working familiarity with the intake form.
- Let the interview flow smoothly; use the intake form, don't let it use you.
- Try to ask questions in an open-ended fashion give the client a chance to speak freely (exception: severely disturbed clients).
- Try to move from general (open-ended) questions to more specific (less global) questions within a given topic area.
- Use the questions from the Intake Interview Form that are appropriate to the client's problems; depending on the nature of the problem, some of the questions/sections may or may not be needed.
- Allow for limited catharsis—REMEMBER: The intake interview is an information-gathering session, not a therapy session.
- Allow or promote a positive expectancy about receiving help, but make it clear that you won't necessarily be the client's regular counselor.
- Be sure to inform client of confidentiality and the limits of confidentiality (ie. threats of harm to self or others)
- REMEMBER: Be clear and write legibly on all forms.
- Each intake session <u>must</u> be audiotaped or videotaped.

NOTE: Copies of a format for the Mental Status Exam are located in the Assessment Lab if needed.

COUNSELING LABORATORY
INTAKE FORMS COVER SHEET

_______ Request for Services (signed, witnessed, dates, and times when client is "available)

_______ Confidentiality Agreement Form (signed, witnessed, and dated)

_______ Intake Interview Report and Counselor Impressions and Recommendations "forms completed (including Intake Counselor's signature)

_______ Authority to Release/Obtain Information (Request for information from "other agencies, if appropriate)

_______ CPY Hourly Fee Schedule (Identify the amount to be billed)

_______ Amount to be Billed per Session: $_________

______________________________ ______________________________
Signature of Intake Counselor *Date*

_________Record is complete______________________ ______________________________
Signature of Case Record Coordinator *Date*

★★

Case Assignment

________ Intake approved for assignment to Counseling Lab Group

____

____

______________________________ ______________________________
Signature of Director *Date*

COUNSELING LABORATORY

Request for Services
(Individuals)

Your cooperation in completing this questionnaire will be helpful in planning our services for you. Please answer each item carefully. If you have any questions, please ask the desk personnel for assistance. NOTE: Please complete the following information for the person who will be receiving our services. If the client is a child, complete all information as it pertains to the child except for the phone numbers which should be those of the parent/guardian.

FULL NAME:________________________________ TODAY'S DATE:__________________________

ADDRESS____

PHONE (LOCAL OR CAMPUS): _______________________ (BUSINESS):____________________

AGE:________ DATE OF BIRTH:_______________ SEX:_______ MARITAL STATUS:____________

HIGHEST LEVEL OF EDUCATION COMPLETED:____________________ CURRENTLY IN SCHOOL?

_______YES ______NO IF YOU ARE A JSU STUDENT, ARE YOU RECEIVING CLASS CREDIT FOR

ATTENDING COUNSELING SESSIONS? _____YES ____NO

WHERE EMPLOYED?____

FOR HOW LONG?_________________JOB TITLE?____

_______ I am a student at JSU.

______ I am not associated with JSU

.

______ I am being referred by the courts, Welfare Dept., or other agency: Which one?
____

PLEASE INDICATE THE DAYS AND THE TIMES EACH DAY YOU ARE AVAILABLE FOR COUNSELING SESSIONS:

MONDAY______________ TUESDAY ____________ WEDNESDAY____________

THURSDAY____________ FRIDAY ______________

____ ____________________________________

COUNSELOR # CLIENT #

FAMILY MEMBERS:

NAME	AGE	RELATIONSHIP	WHERE RESIDING?

HOW DID YOU FIND OUT ABOUT OUR SERVICES? ____

ARE YOU NOW RECEIVING OR HAVE YOU EVER RECEIVED COUNSELING OR THERAPY SERVICES?____YES ____NO IF YES, PLEASE LIST COUNSELOR/THERAPIST'S NAME, NAME AND ADDRESS OF AGENCY, AND DATES OF COUNSELING:____
____

HAVE YOU HAD OR DO YOU NOW HAVE ANY MAJOR HEALTH PROBLEMS? ______ YES______ NO
IF YES, PLEASE DESCRIBE:____

PLEASE LIST ANY MEDICATIONS (BOTH PRESCRIBED AND OVER-THE-COUNTER) CURRENTLY BEING TAKEN AND THE PHYSICIAN WHO PRESCRIBED THEM (IF THERE IS ONE):
____
____

IN YOUR OWN WORDS, BRIEFLY DESCRIBE THE MAIN CONCERN WHICH PROMPTED YOU TO SEEK COUNSELING. ____
____

WHAT LED YOU TO SEEK COUNSELING AT THIS TIME? ________________________________
____

PLEASE INDICATE (BY NUMBER) YOUR CURRENT LEVEL OF GENERAL SATISFACTION WITH LIFE (ON A 1-10 SCALE WITH 1 AS TOTALLY DISSATISFIED, 5 AS MODERATELY SATISFIED, AND 10 AS TOTALLY SATISFIED):____________________________________

I WOULD LIKE TO REQUEST SERVICES FOR MYSELF (MY CHILD).

_____________________________ _____________________________ __________________
Signature of Client *Signature of Witness* *Today's Date*

____
Signature of Legal Guardian

INSTRUCTIONS FOR COMPLETING CONSENT TO AUDIO/VIDEO TAPING

In completing this consent form, attention should be given to the following:

- ♦ When couples are being treated, both must sign a form.
- ♦ In therapy with a child, parents must 'sign a form for the child to be taped.
- ♦ When parents are being seen with a child, parents must sign forms.
  - * The key to remember: All persons in the session must have signed a consent to audio/video tape

COUNSELING LABORATORY

JACKSON STATE UNIVERSITY

CONSENT TO AUDIO AND/OR VIDEO TAPE

The Counseling Psychology Laboratory is a teaching facility for counselors. Consequently, all counseling sessions in the Laboratory are audio and/or video taped. These recordings are used by the teaching staff to insure that you receive the services you requested and to provide supervision of your counselor by faculty. Faculty supervisors are licensed psychologists.

The contents of your counseling sessions will be held in strictest confidence and will not be revealed to any person or agency except under the following circumstances:

1. If you (or, if you are a minor, your parents) give written permission to release information.
2. If you are involved in a bonafide medical emergency, information may be given to medical personnel.
3. If research, management audits, financial audits, or program evaluations are conducted, information may be revealed but you will not be identified either directly or indirectly.
4. If an appropriate court order is received by the Director of the Counseling Laboratory.
5. If you reveal information which, in your counselor's judgement, indicates that you intend to harm yourself or someone else.
6. If you reveal information that indicates the existence of past or present child abuse, as required by Mississippi Code of 1972: Sections 43-21-353 and 43-21-355.

I have read and understand the above statements and I agree to the following:

1. Counseling sessions will be audio and/or video taped. Tapes will be erased after supervisory review or at termination of counseling.
2. Teaching staff and the staffing group may listen to and/or view the tapes.
3. Information revealed during counseling sessions will be held in strict confidence except in the circumstances described in items one through six above.
4. Testing may be conducted if my counselor and I determine that it would be helpful to me.

5. The case records maintained with regard to my counseling will be kept in a confidential file. They will be destroyed four years after the termination of counseling and all other records of my having received services in the Counseling Laboratory will be destroyed after seven years.

______________________________	______________________________
Witness's Signature	*Client's Signature*
______________________________	______________________________
Date	*Parent's Signature* *(if appropriate)*

COUNSELOR # ______________ CLIENT #______________

Report of Psychological Evaluation

Confidential Information

Name: ________________________________ Examiner: __________________________________

Date of Evaluation:________________________ Age: ______________________________________

Referral Question:

_____ was referred to the JSU. Counseling Lab for psychological evaluation by his first grade teacher, Ms. _____, who sent a packet of examples of ____'s classroom work. In an accompanying note, she reported that he has great difficulty staying on task and often does not complete assignments even when allowed to work on them all day. When he does complete them, they are, in her words, "... far below expected standards." She reports that he has the most difficulty with writing and copying from the board. He has trouble as well with reading, but is mastering vocabulary and phonetic skills. ____ is retained in the first grade this year.

Intellectual evaluation was requested to help determine the source of _____'s academic difficulties and to assist in planning a curriculum for him.

Behavioral Observations

At first encounter, _____ appeared to be an outgoing and friendly young man. He readily accompanied the examiner to the testing cubicle and, once there, it was easy to converse with him and to begin to establish rapport. He readily shared information about himself and about school, saying that he liked school and his teacher although he found some subjects hard.

For the most part _____ was easily engaged in the tasks of the WISC-R, although he seemed to be less able to concentrate on tasks with which he had difficulty although he responded well to encouragement and praise and was able to get back on task. Although the testing session was not inordinately long, later on _____ had greater difficulty concentrating even for shorter periods of time. He became more active and his attention wandered. On a couple of occasions he got up out of his chair and attempted to walk around the room or to crawl up under the table. However, on the insistence of the examiner, he would sit properly in the chair and focus his attention on the test items. He seemed to concentrate well for a period of time on the promise of a short break after so many subtests were completed, for example.

Regardless of_____'s sometimes short attention span, rapport was good with him and he responded well to the examiner throughout the session. Hence, it is assumed that the test results reported here represent valid estimates of 's current abilities.

Tests Administered:

Weschler Intelligence Scale for Children-Revised (WISC-R)

Test Results:

Verbal Scale IQ: 59 Performance Scale IQ; 80 Full Scale IQ: 68Verbal Tests

Performance Tests

Verbal Test		**Performance Test**	
Information	3	Picture Completion	5
Similarities	4	Picture Arrangement	11
Arithmetic	3	Block Design	7
Vocabulary	2	Object Assembly	7
Comprehension	5	Coding	5

Wide Range Achievement Test (WRAT)

Test Results:

Standard Subtest	**Grade Level**	**Standard Score**	**Percentile**
Reading	2.1	77	6
Spelling	1.4	69	2
Arithmetic	2.3	82	12

Interpretation of Test Results:

The WISC-R full scale IQ score indicates that is currently functioning in the borderline to slightly mentally deficient range of intellectual functioning. The full scale IQ is composed of two other IQ scores, one of which is an estimate of verbal ability and a second which is an estimate of performance or visual motor functioning. Part of the reason for his relatively low full scale IQ score was due to a large, statistically significant difference between the verbal and performance IQ scores, the verbal score being lower. The verbal IQ score suggests that ____ is currently functioning in the retarded range of ability for verbally-related tasks. A score of this magnitude

indicates that with regard to verbal ability, over 99% of the population of children of the same age as_scored higher than him. Although the subtest scores that compose the verbal IQ scale were all very similar, one score suggested a relative strength in the area of comprehension. The Comprehension subtest of the WISC-R measures practical knowledge, the ability to interpret social situations and formulate logical solutions to everyday problems. In the verbal area, ____ had the greatest difficulty defining orally-presented vocabulary words.

______'s IQ score for the performance part of the WISC-R indicates that he is functioning with regard to visual-motor related tasks in the low average range. The subtest scores that compose this IQ score were, likewise, fairly homogeneous, with the exception of the Picture Arrangement subtest score where _____ scored within the average range. The Picture Arrangement subtest requires the child to arrange in a.logical sequence a series of cartoon-like pictures so that they tell a story that makes sense. As such, it is a measure of logical sequencing, alertness to visual detail and the ability to interpret social situations. As mentioned, _____ Performance IQ score was significantly higher than his verbal. It must be noted that differences of this magnitude are considered to be "soft" signs or at least suggestive that organic impairment on some level may be present. If____ experiences severe impairment in functioning in areas other than academic, further specialized assessment of brain functioning may be advisable.

Although it is assumed that the IQ scores reported here are considered to be valid estimates of ______'s current ability, it must be remembered that there is a margin of error inherent in any standardized test. Considering the standard error of measurement in the WISC-R, the actual full scale IQ score probably lies within a range of about 65 to 72.

In addition to the WISC-R, the WRAT was administered. The WRAT is an achievement test designed to measure current knowledge and skills in the school subject areas of reading, spelling and arithmetic. Scores on the WRAT indicate that is achieving in the areas of reading and arithmetic at a level of the beginning second grade. This is a level of achievement beyond his current grade placement, but, considering he is repeating the first grade, this is a level of achievement less than what would be expected of a child his age at this point in the school year. Of these two subject areas, _____ showed the highest achievement in arithmetic. On that subtest he

was able to count 15 dots, to recognize the larger of two numbers and solve one orally-presented addition problem and one orally-presented subtraction problem and successfully solve two-digit written addition and subtraction problems. He was unable to solve problems more complex than these. In addition, his performance was erratic in that he missed some of the easiest pre-arithmetic items such as recognizing numbers by sight. He reported "17" to be "70" and "41" to be "40." He said he did not know the answer to an orally-presented problem requiring the subtraction of 3 from 9.

On the reading subtest, _____was able to read only the simplest one-syllable words. When encouraged to do so, he attempted to sound out many more and showed some good ability to do so. However, he was consistently unable to put together or close up the individual sounds to form the whole word. Hence, "work" became "rock," "eat" was "at" and "spell" was "bill." In other cases where he did not recognize the word and his efforts to sound out failed, he just said any word in order to go on.

______'s poorest achievement is in spelling where not only his poor spelling but also his lack of eye-hand coordination was evident. On the pre-spelling portion of the subtest where the child is required to copy a series of symbols, several could not be scored because of failure to make precise, sharp right angles. The quality of his printing was equally irregular; he initially omitted the "e" in _______. On the actual spelling portion of the test, _____was able to correctly spell only four words: "go," "and," "will" and "must." With encouragement he did go on and attempt other words and showed some good ability to sound out words. Hence, "cat" was "kit," "make" became "mak" and "cook" was "kuk." His attempts to spell more difficult words were more crude.

Summary:

______is a barely eight year old young nan who was referred for intellectual evaluation due to poor performance in the first grade which he is repeating. He was friendly and outgoing on first encounter and rapport was easily established although he was distractable during the testing session. The WISC-R full scale IQ indicates that he is currently functioning within the borderline or high level mentally deficient range of intelligence. There was a significant discrepancy between the verbal and performance IQ scores, with performance higher. He showed relatively good ability for

logical sequencing of events.

WRAT scores indicate that______ is achieving in arithmetic and reading at the early second grade level. In spelling he is achieving at the early first grade level. His achievement levels with regard to arithmetic and reading are commensurate with his WISC-R performance IQ.

Recommendations:

1. Due to the significant discrepancy between the verbal and performance IQ scores on the WISC further evaluation may be advisable if there is any evidence of impairment in functioning in any areas of _______'s life other than academic, or if there is any drastic change in his academic performance.
2. Depending on the criteria, ______may be eligible for special help in school, especially in arithmetic, the area where he is progressing slowest. It is apparent considering _____'s current level of intellectual functioning and his achievement levels that he has responded to the special attention and encouragement he has received from his teacher this year, and will probably require additional special help to keep from falling behind.
3. ______should be retested later in the summer to determine his intellectual functioning and achievement levels at that time to make sure the most advantageous educational decisions are made for him before he enters the next grade.

Examiner Name: _____________________________ Director: __________________________

Examiner # _________________________

Quality Assurance (QA)

The goal of Quality Assurance (QA) is to enhance the ability of clinicians and the agencies with which they are affiliated to provide clients with the best possible services available. To assure that this goal is being met in the Counseling Psychology Laboratory/ frequent QA audits will be conducted throughout the semester. All QA audits will reflect the minimum standards of client care as defined in the Counseling Psychology laboratory Manual.

It is the responsibility of all clinicians in the laboratory to adhere to these standards. Doctoral students will provide training in policies, procedures and proper case records management which are fully explained in the lab manual for all labs. However, it remains the clinician's responsibility to assure that all his/her case records meet those minimum standards.

Points to Remember Regarding QA

1. That QA is a part of clinical training 'in the Counseling Psychology Laboratory.
2. That QA is a fact of life. All community agencies, both private and non-private have QA audits.
3. That the Laboratory Manual is considered the policy and procedure manual for the Counseling Psychology Laboratory and answers to any questions regarding minimum standards can be found in the current edition.
4. That each clinician is responsible for his/her case records and correcting all deficiencies. Additions and corrections are recorded in the case progress notes using the current date and should refer to the item corrected and date of original entry.

Q. A. Responsibilities

A. ***Counselors are responsible for:***

1. Correcting all deficiencies within one week.
2. Learning and understanding correct case records management practices
3. Consulting with supervisor (Labs I & II) or Case Recorders Manager (Lab III & Special Problems) and returning QA Checklist to them when corrections are made and recorded.

B. ***Supervisors & Instructors are responsible for:***

1. Training all assigned clinicians in proper case records management.
2. Conducting two formal QA audits with those they supervise in 1>h I & Lab II during the semester.
3. Keeping copies of QA Checklist in confidential supervisor's folder.

C. ***Case Records Manager and Administrative QA Team are responsible for:***

1. Training instructors, supervisors and counselors (Lab III and Special Problems) in proper case records management.
2. Conducting two formal QA audits with all counselors.
3. Place copies of QA Checklist in confidential supervisors file for Lab III & Special Problems.
4. Report any problems with QA to Director of Counseling Psychology Laboratory.85 Case Review for Quality Assurance Checklist

CASE Review for Quality Assurance Checklist

Instructions: Review record and check all items that meet minimum standards.

(Code=NA not applicable (✓) meets standards (No) does not meet standard

A **Treatment Plan**

_____ 1. Includes problem definition, measurable goals, and treatment activities.

_____ 2. Treatment plan specifies overall service strategies and projected time tables or number of sessions required to complete treatment.

_____ 3. Treatment plan includes, client's assets & deficiencies relevant to maintenance and remediation of the problem, including family involvement in case or other social support system.

_____ 4. Treatment plan specifies an appropriate theoretical orientation for treatment of client's problem.

_____ 5. Counseling activities relate to treatment goals which indicates that the treatment plan is being followed..

_____ 6. The methods of evaluation are specified.

______ 7. Follow-up plans are specified.

B. **Goal, Attainment Scale**

______ 1. Goals and strategies on GAS relate to the treatment plan.

______ 2. GAS containing all necessary client information (i.e. session number, date of implementation etc).

______ 3. Counselor signed GAS.

______ 4. There is evidence that client agreed with stated goals (i.e. client signed GAS).

C. **Progress Notes**

______ 1. Progress chart entries are legible and understandable.

______ 2. Progress chart entries are brief & adequate (goal & progress oriented)

______ 3. Documentation of progress/lack of progress towards defining treatment goals or documentation of client's progress/lack of progress toward achieving goals.

______ 4. Counselor initialed progress chart entries (supervisor initialed all entries for Lab I).

______ 5. Session number, date of session & number of minutes in session indicated for all progress chart entries.

______ 6. Indication of plans for future sessions.

D. **Client's Rights/Informed Consent**

______ 1. There is documentation that client was informed and participated in all treatment decisions (i.e. client signature on GAS),

______ 2. Client confidentiality has been maintained (signed release for every outside contact),

______ 3. Copies of all release of information forms in file,

______ 4. There is documentation of reason for referrals,

______ 5. There is evidence of follow-up plans for referrals.

E. Testing (if applicable)

______ 1. Tests selected were appropriate to goals established. (Justification noted in treatment plan or progress notes).

_____ 2. Documentation of explanation of test results to client.

_____ 3. A copy of test report is in client file.

_____ 4. Testing results are integrated into progress chart entries.

_____ 5. Testing is appropriate to therapist's demonstrated competencies or there is evidence of appropriate supervision during testing.

F. General Considerations

_____ 1. Counselor & client number on file tab. client and counselor number (Both intake and treatment side).

_____ 2. All material in file has

_____ 3. Client file is maintained in proper order (i.e. all items are secured in file).

_____ 4. Evidence of client contact every two weeks.

_____ 5. Evidence of staffing with supervisor or instructor (initials on case monitoring and staffing

Corrections needed in this record:

1. ____

2. ____

3. ____

4. ____

5. ____

Corrective Action taken by therapist

____

____

____

____

______________________	______________________
Therapist	*Certified by Instructor or Supervisor Supervisor (Must be completed within one (1) week of receipt.*
______________________	______________________
Counselor Name	*Client Number*

Name :__________________________CO #:__________________________

INDIVIDUAL COUNSELING CASE LOAD RECORD

Client #	# of Contacts	# of Test	Hours of Interaction	Hours of Testing	Hours Staff	Hours Prep	Total Hours	Case Disposition	Counseling Code	Lab #

CASE STAFFING OUTLINE

1. Identifying Information; Name (first name only), age, sex, referral source, mental status.
2. Presenting Problem: Client's description of the problem. (Why is the client here?)
3. Background Information; Information relevant to the presenting problem-and including present circumstances.
4. Treatment Plan;
   A. Assessment; Therapist's definition of the problem based on information obtained during sessions and from specific assessment techniques and instruments.
   B. Treatment Goals; Short-range and long-range goals stated in terms of expected and ideal levels of outcome. (How will the client change for the better?)
   C. Evaluation; Criteria for determining whether the treatment goals have been met and how these criteria will be assessed.
   D. Literature Search; What does the literature have, to say about the treatment of the presenting problem(s)?
   E. Intervention; Specification of the treatment plan, including steps to be followed and techniques to be used.
   F. Rationale; Why did you use this approach? How was the procedure modified to meet the individual needs and goals of this client?
   G. Consultations; Whom did you consult for assistance on this case (if appropriate)?
5. Ethical Considerations; Which of the ethical principles for psychologists are relevant to this case and how have they been resolved?
6. Summary; Brief review of presenting problem and treatment plan. Also give DSM-III-R diagnosis, expected length of treatment, and prognosis.

PROCEDURES FOR HANDLING OF SUICIDE THREAT AND SUSPECTED CHILD ABUSE/NEGLECT

I. **DEFINITION**: A suicide threat is an expression that life is hopeless and a desire to end one's own life.

II. **PREVALENCE**: Threats are not common in the Laboratory; however, one or two do occur each term.

III. **DESCRIPTION**: A suicide threat may range from a casual reference to death, usually expressed with disgust about the conditions of one's life, to a specific planned method, time, and place for the event to occur.

IV. **TREATMENT PROCEDURE**:

A. **Assessment phase:** With the possible exception of the one item, i.e., having a very lethal and specific plan for suicide, no single criterion should be alarming. Rather the evaluation of the suicidal potential should be based on the general pattern within the framework of the fourteen criteria which follow:

Step #1: **Age and Sex.** Suicidal communications from males are usually more dangerous than from females. The older the person, the higher the probability of suicidal intention. Both age and sex should be considered. A communication from an older woman is more dangerous than one from a younger boy. Note, however, that younger people do make attempts, even if the aim is to manipulate and control people.

Step #2: **Mood.** If the caller sounds tired, depressed, "washed out", then the suicidal risk is higher than if he/she seems to be in control of himself/herself. Exuberance, flight of ideas, screaming and yelling are to be considered ominous signs, also. Strong denial of suicidal intention should be considered a definite danger signal. If the caller's mood undergoes marked change for the better during the conversation, this is an important positive sign of suicidal potentiality.

Step #3; **Prior attempts or threats**. Recent studies show that in about 75% of actual suicides, there have been previous attempts.

Step #4: **Acute or chronic situation.** An acute situation is a sign of greater immediate danger than would be chronic recurring situations. An acute event, although a sign of immediate danger, has a better prognosis for improvement (once the crisis has been dealt with) than is true of chronic, recurring situations. When did the problem develop?

Step #5: **Means of possible self-destruction**. The most deadly means are shooting, hanging, and jumping. If the caller has used or is threatening to use any of these methods, and the means are available, you must consider the threat to be serious and that the suicidal danger is high. Other methods can be lethal and should not be discounted because they appear to be slower and less dangerous, such as barbiturate ingestion, carbon monoxide poisoning, and wrist cutting.

Step #6: **Specific details of the method.** If the caller not only has specifically named the method he intends to use, but also goes on to give details about time and place, he should be considered to be in danger.

Step #7: **Recent loss or separation from loved one.** If death of a loved one and/or divorce and separation come into the picture, the danger goes up. The separation need not have already taken place, but he/she may feel that is impending and he is therefore depressed. If there is any actual or pending loss of a loved one, suicidal danger rises.

Step #8: **Medical symptoms:** If such facts as unsuccessful surgery, chronic debilitation, cancer or fear of cancer, asthma, fatigue, impotence, loss of sexual desire or any medical symptom come into the picture, the suicidal danger goes up. This is especially true in older person who may be fearful they will never be well again. They may be lonely and feel that nobody cares for them, which will help to exaggerate the importance of their physical ailments.

Step #9: **Diagnostic impressions.** Making a psychiatric diagnosis is a professional task; however, record any symptoms. given you so that a professional evaluation may be made,, later. Obvious signs such as hallucinations, delusions, loss of "contact with reality", will reveal a disoriented state. If such states as depression, anxiety, alcoholism, homosexuality enter into the picture, then the suicidal danger rises.

Step #10: **Resources**. If the caller is under financial stress, if he/she has no friends, or if he/she is all alone and has few or no social contacts, then the suicidal danger is high.

Step #11: **Living arrangements.** The greater the satisfaction of the client in this area, the lower the risk. Four questions are useful: who is the person(s) the client is (are) living with in the same dwelling at the present time? What is the quality and quantity of their relationships? Is the client satisfied? Are these arrangements , economically, emotionally, and socially adequate and supportive for the client at the present time? Callers who live alone, have few friends or other support systems or are unhappy in their living arrangements are greater risks.

Step #12: **The client's perceptions of his problem**. The client who feels his/her situation is hopeless and/or he/she is helpless to deal with the problem is a higher risk. How realistic are the client's perceptions of the situation. Are they accurate, distorted, or confused? Remember, Suicide is often an emotional decision, not a rational.

Step #13: **Disruptive of daily living patterns**. The client who is not going to work, who is not eating well, who has lost weight and who is not able to carry on daily routine is a higher risk than one who is not so affected.

Step #14: **Coping strategies and devices**. How has the client dealt with crisis in past times? Have formerly used coping methods been tried? If so, and they have proven ineffective, why are they not working now? *Is* the client impulsive? Does the client habitually

recourse to excessive drinking or misuse of drugs or violent acting out against self or others?

B. **Treatment phase**:

Step #1: The counselor becomes aware of the steps to take in working with and in assessing of suicidal potential.

Step #2: The counselor remains calm during the session in which the threat occurs. The counselor does not become distressed or excited by the threat.

Step #3: The counselor listens to what the client is saying, asks questions appropriate to determine lethality of threat, and reviews the "Criteria for Assessment of Suicide" in his/her own mind, during the session, to determine if the threat is serious.

Step #4: Prior to the client leaving the Laboratory, if possible, the counselor discusses the situation with his/her supervisor. The supervisor helps the counselor determine if there is a need for specific action at this time while the client is still in the laboratory, (a) The counselor (or in some cases the supervisor) continues the session until such time as it is felt that the danger of suicide is no longer present. (b) The counselor enters into a "No--Suicide Contract" with the client to extend beyond the next scheduled counseling session. Have the client repeat "I promise not to do anything self -destructive intentionally or unintentionally until _____ (specify time limit). The client must repeat your exact words, (c) The counselor and supervisor decide whether to refer the client to another agency immediately. (This action is taken upon consultation with the Director.)

Step #5: Upon completion of the session, the counselor, supervisor, and instructor review the audio/video tape together and determine what specific action is appropriate. . In all cases, the director of the Laboratory is informed and with consultation determines the next step.

Step #6: The Dir^tor, at his discretion, notifies the Department Chairperson if it is felt that there was a "real" threat. The chain of notification continues in the following manner as appropriate: 1.Chairperson, Vice President for Student-Affairs, Campus Security, Police""or 2. Department Chairperson, Dean of College,, Vice-President"for Academic Affairs, Police.)

Source: "Criteria for Assessment of Suicidal Potentiality", (adapted from Sliaken, 1979, and Hatton, Valente, and Rink, 1977).

DECISION TREE FOR HANDLING SUICIDAL/HOMICIDAL THREAT OR IDEATION

- Client reports to Lab..
- Counselor becomes aware of suicidal/homicidal threats thru client's report of suicidal/homicidal ideation or report by client or other of suicidal/homicidal gesture
- Counselor stays calm and thinks through the steps he/she will need to take
- Counselor listens to what client is saying and mentally determines if client's report indicates seriousness of intent
- Homicide: Co. asks Cl. the name, address, & phone # of intended victim(s); plan; and inquires about access to means.
- Suicide: Co. asks Cl. about his/her plan; his/her access to means; and name, address, & phone # of a supportive friend.

A judgment is made that the threat is serious

NO

Counselor conducts session as usual

Counselor with supervisor, instructor and/or director take emergency action as needed.

Session is concluded.

Routine sessions or follow-up pursued.

Counselor, supervisor and instructor review tapes of session to determine what specific action is needed.

Director of Lab is notified

Director determines that threat was genuine

Director notifies the appropriate University and Law Enforcement Agency and the potential Victim(s)

YES

Counselor immediately discusses situation with supervisor, instructor or director.

Counselor keeps session going until the crisis is over

"No Suicide/No Homicidal" contract is made with the client that extends beyond next scheduled session.

Session is concluded

Routine sessions or follow-up pursued.

Director notifies the appropriate University and Law Enforcement Agency and the potential Victim(s)

Jackson State University
College of Education
Department of School, Community and Rehabilitation Counseling

Accessible Counseling Entity (ACE) Counseling Center

Counseling Contract

I____ agree not to do anything destructive intentionally or unintentionally to myself, to others or to property until after my next counseling session at the Jackson State University Counseling laboratory. I am aware that my next scheduled appointment is____________________.

I agree that if I begin to feel as if I will harm myself or someone else, I will call my counselor at the Jackson State University Counseling Laboratory.

_______________________________________ _____________________________
Client *Date*

_______________________________________ _____________________________
Counselor *Date*

PROCEDURES FOR HANDLING SUSPECTED CHILD ABUSE/NEGLECT CASES

I. Assessment. When the client reports to the lab, and the counselor, whether by report of the parent or caregiver or by observation of the child, suspects abuse or neglect, steps must be taken immediately to report the suspected abuse/neglect. Observation of the child might reveal cuts, bruises, abrasions or other injuries that may appear out of the ordinary for a child of that age. The counselor may observe a "failure to thrive" or excessive fear, withdrawal or "helpless" attitude in the child which may suggest abuse or neglect. The reports of the parent or caregiver may indicate excessive physical or psychological punishment or discipline.

II. Intervention. Once abuse or neglect is suspected, the counselor is required by law to enact a series of steps to report the suspected abuse/neglect.

A. The counselor has the client remain at the Lab while the subsequent steps are undertaken.

B. The counselor informs the Director of the situation and the reasons why abuse or neglect are suspected. If the Director is not available at the time, the usual chain of notification is followed until the person serving in place of the Director is alerted and action can be taken.

C. The Director then determines whether or not the counselor's suspicion is likely. If he or she feels that it is not, then the counselor conducts the session as usual. If, on the other hand, he/she feels that the suspicion is warranted, he or she immediately calls Department of Public Welfare to report the case.

D. The Director, at his or her discretion, or at the request of the Department of Public Welfare, may take polaroid pictures visible injuries. This often expedites legal proceedings to remove the child from the abusive situation if, in fact, the child is actually in danger.

E. The Director is then required to submit a Written report of the incident to the Department of Public Welfare as soon as possible.

F. The counselor then conducts the session as usual. Of course this may be difficult if the client feels that trust has been broken by the reporting of the incident. In many cases, however, the client can be convinced that he or she has done the right thing and that remaining in therapy can be helpful to both the suspected abuser and the child.

Regardless of how difficult or uncomfortable it may be to report abuse, we are obligated under the law to do so.

DECISION TREE FOR HANDLING SUSPECTED CHILD ABUSE/NEGLECT

Client reports to Lab for intake or appointment:

__**YES**__ Counselor notes presence of bruises, cuts, abrasions, contusions or other injuries on child that appear out of the ordinary.

NO

__**YES**__ Counselor suspects malnutrition, "failure to thrive", or observes excessive fear, withdrawal or "helpless" attitude in child

NO

__**YES**__ Counselor, via report of parents or other care giver, hears of abuse neglect or excessive physical or psychological punishment

NO

Counselor has clients remain at the lab
Counselor informs Director of situation
Director suspects that abuse or neglect is likely **NO**

YES

Director immediately calls Department of Public Welfare to report the case

Polaroid photograph of injuries taken at Director's discretion

Director submits written report of incident to Department of Public Welfare as soon as possible

Counselor conducts session .as usual.

SYSTEMATIC DESENSITIZATION

I. **DEFINITION;** Systematic desensitization is an anxiety-reduction strategy that is appropriate when a client has the ability to handle a situation or perform an activity but avoids that situation or performs less than adequately because of anxiety or fear.

II. **DESCRIPTION;** Systematic desensitization is a technique which pairs physiological states, which are incompatible with anxiety or fear, with a weak anxiety response to a stimulus. This procedure is continued until the weak response is eliminated. This same technique is then repeated with progressively stronger anxiety producing stimulus until they are eliminated.

III. **TREATMENT PROCEDURE;**

Step 1: Verbal set - present to the client a rationale and an overview of the desensitization procedure. The self-control model teaches the client to cope with less stressful situations before moving on to more difficult ones with the aid of relaxation techniques.

Step2; Identify Themes - the emotion-provoking situations are defined idiosyncratically by the client. Three methods used for assessment include interview, client self-monitoring and client self-report.

Step #3: Hierarchy Construction - a hierarchy is a list of stimulus situations which the client reacts to with a graded amount of emotional response. Hierarchies can be constructed based on time, distance, components of feared objects or activities relating to a specific individual or event. The exact number of hierarchies is mutually determined by client and counselor.

Key Components of Hierarchy Construction;

a) Identification of Hierarchy Items - criteria include concrete and specific items that represent actual situations for the client. Items should be able to elicit a range of emotional responses from the client (i.e., high to low intensity).
b) Identification of Control Items - control or neutral items are used at the bottom of the hierarchy to test the client's ability to assume an "anxiety-free" state.
c) Ranking and Spacing of Hierarchy Items - items are placed in increasing order of difficulty, stress or emotional arousal.
d) Selection of a Coping Response - client and counselor work to identify a coping response to be employed that counter-conditions the arousal of the hierarchy item. Reported coping responses include deep muscle relaxation, emotive imagery, meditation, assertion training, thought stopping, etc.
e) Imagery Assessment - the administration of desensitization is dependent upon the client's ability to imagine each item in the hierarchy construction.

Step #4: Presentation of Hierarchy: Each scene presentation is paired with a counter conditioning response to decrease client's emotional arousal. Scene presentation usually lasts 15 to 20 minutes and follows a certain format. One method is to remove or stop the stimulus item when the client reports feelings of anxiety or other emotional responses. The client is then instructed to employ the coping mechanisms.

Client and counselor decide on a signaling system to communicate when the client

feels anxious or calm. This will indicate to the counselor the rate of progression for successive scene presentation.

Each presentation session should end with a stimulus situation that evokes little or no emotional response. Systematic desensitization is usually conducted over several sessions.

Step #5: Homework is an important aspect of the systematic desensitization procedure. The client is instructed to practice relaxation techniques and the items covered in the session. A practice tape can be used for homework assignment. Gradually, the client will be expected to participate in real life situations to facilitate generalizations from the counseling sessions.

IV. SOURCE:

Cornier, W.H. & Cormier, L.S. (1979). Interviewing Strategies for Helpers. A Guide to Assessment, Treatment, and Evaluation. California: Brooks/Cole Publishing Company.

Goldfried, M.R. & Davidson, G.C. (1976). Clinical Behavior Therapy. New York: Holt, Rinehart, & Winston.

Small, L. (1971). The Briefer Psychotherapies. New York: Bruner/Mazel, Publishers.

SCHOOL PROBLEMS

I. **DEFINITION:** A child or adolescent with learning problems is one who is performing poorly in school because of one or several handicaps, physiological or environmental influences, or adjustment or motivation problems.

II. **PREVALENCE:** While less than 10% of the school age population is considered by the school to be handicapped, any child may experience transient or situational problems at any point during his/her school career.

III. **DESCRIPTION**: Learning problems may be attributable to one or several handicaps, (e.g., speech problems, learning disabilities, mental retardation, behavior or emotional problems), socioeconomic or cultural differences, motivation or adjustment problems, or medical problems.

IV. **TREATMENT PROCEDURE:**

Assessment phase:

Step # 1: Family, school, social history from child and parents.

Step # 2: Have physician complete physical to rule out organicity.

Step # 3: Send for child's school records and psychological information (if any).

Step # 4: Telephone interview with child's school principal, regular and special education teachers, and/or counselor regarding school performance.

Step # 5: A more in-depth psychological/educational assessment may be indicated.

Step # 6: Compile information from all sources to determine etiology of problems.

Treatment Phase: Treatment phase may include any of the following as indicated:

Step # 1: Providing information to parents, a) regarding expected levels of development and achievement of the child; b) regarding services and agencies in the community which will assist them; c) regarding parenting groups where management skills are learned.

Step #2: Counseling: a) facilitating parents as they learn to accept the child's diagnosis and prognosis for the future; b) behavior management; c) stress management; d) bibliotherapy - books on information for parents, descriptions of similar cases, etc.

Note 1: The Physician will become involved with families who have children with medical conditions which will interfere with a child's school functioning.

Note 2: A comprehensive approach to dealing with school problems should include educating and informing parents about what to expect from the child, supportive counseling along with behavior and stress management for parents and/or families, providing information, and possibly coordinating with the schools in planning educational programs for the child.

V. SOURCE:

Alien, J.E., Guruaj, V. J., and Russo, R.M. Practical points in pediatrics. (2nd ed.), New York: Medical Examinations Publishing Co., 1977.

Rosen, M. and Arsht, E.D. Psychological approaches to family practice. Baltimore: University Park Press, 1979.

STUDY SKILLS

I. **DEFINITION**: Study skills pertain to the systematic method of knowledge acquisition. More succinctly, it focuses on how to study.

II. **PREVALENCE**: Deficits in study skills are a major problem among college students today.

III. **DESCRIPTION**: Study skills training is utilized with the desire to improve academic performance. It is designed to eliminate "cramming" as the client implements a daily routine of study behavior. Behavioral methods of self-observation, stimulus control and contingency management can be used for the adaptation of more effective study skills.

IV. **TREATMENT PROCEDURE:**

Step #1: **Self-Observation**; For the first week client is instructed to keep a daily written record of study time and place. This is used as a baseline against which to evaluate change in study behavior.

Step #2: **Stimulus Control;** Where to study may have an effect on the quality of study time. Suggestions on how to improve where to study include: a) choose a quiet place, free from distractions and interruptions; b) study at a desk with adequate lighting; c) clear desk of all items not essential to studying; d) set up a schedule to study at the same time and the same place.
Self-observation may indicate that the client studies more effectively during certain times of the day and/or in specific areas. An accurate assessment of environmental stimuli will help to identify key areas to modify and/or change.

Step #3: **Educate** the client in how to study the PQRST Method:
l listed below is one system of doing this: a) go through reading assignments and underline anything that appears to be highlighted in the chapter (i.e. italicized words, quotes, bold headings, graphs, etc.); b) try to get an idea of the organization of the chapter. Focus on headings and sub-headings to determine the purpose and sequence of the material. Read chapter summaries before reading the chapter; c) read actively. After 3 or 4 sentences, paraphrase what the author has written, d) review sub-headings and recall what has been read without referring to the material; e) test your comprehension by making up questions pertaining to the readings.

Step #4: **Contingency Management**: Client and counselor identify specific reinforcements to be applied following the implementation of preselected study skill behaviors. Self-monitoring procedures are used to assess client improvement of the identified behaviors. Client and counselor develop a contract agreement that include the method of improving study skills; the type of monitoring procedures to be used; and the specific positive and negative reinforcements designed for contingency management.

V. SOURCES:

Harris, A.J. Everything You've Ever Wanted To Know About Good Study Habits (And Were Afraid To Ask). Unpublished Manual located in USM Counseling Center.

Krumboltz, J.D., & Thorensen, C.E. 1976. Counseling Methods. New York: Holtz, Rinehart & Winston.

ASSERTIVENESS

I. **DEFINITION:** Assertiveness is a socially appropriate behavior that is likely to~be effective in eliminating obstacles interfering with an individual's goals. This also includes the expression of positive and negative feelings.

II. **DESCRIPTION**: The literature appears to indicate that behavioral approaches are the most effective means of increasing assertive behavior in clients. The treatment described below, behavior rehearsal, is the most commonly used method. However, treatment may also include other components, such as cognitive restructuring, desensitization, and relaxation.

III. **TREATMENT PROCEDURE;**

A. **Assessment phase;** Assessment is extremely important in terms of determining the most appropriate means of increasing assertive behavior. Specific areas of deficit will determine the treatment to be used. Areas which need to be assessed and treatment which are most appropriate for the specific deficits are: (1) absence of information - the client does not know what to say to do (behavior rehearsal), (2) behavioral deficit - the client does not know how to say it (behavior rehearsal), (3) anticipatory anxiety - anxiety is inhibiting behavior which the client possesses (relaxation or desensitization), (4) unrealistic concerns that something bad will happen if they are assertive (cognitive restructuring), and (5) moral or ethical beliefs that assertive behavior is not proper[1]. It is also important to assess the specific types of situations in which the person is not assertive. The "Adult Self Expression Scale" can be used for this purpose.

B. **Treatment phase;** Preparing the client for treatment.

Step #1: The client must be helped to recognize the need for learning new behavior patterns as well as the idea that behavior rehearsal is an appropriate method for increasing assertive behavior. Other issues that may need to be dealth with during this stage of treatment include; concern by the client as to whether assertiveness is appropriate behavior, the idea that individual's have certain rights, and the difference between assertive and aggressive behavior. It is also important to prepare the client for possible responses they might receive from others as a result of being assertive.

Step #2: Selecting target situations: A hierarchy of situations is developed. The situations, as selected by the client, should range from the relatively simple to the more complex.

Step #3: Behavior rehearsal: Behavior change should include not just what the client should say, but also nonverbal aspects such as eye contact and voice tone. However, there should not be an attempt to develop all behaviors at once. It is more effective to start with a few simple behaviors and, as the sessions progress, additional behaviors can be added. For clients who

have especially significant behavioral deficits, it may be appropriate for the counselor to first model appropriate behavior. However, the counselor should not be too perfect a model. The client should then role play the appropriate situations. Both overt and covert rehearsal can be used. Feedback should be provided to the client by the counselor and by video feedback. The client should also be asked to evaluate his or her role play. The counselor can also, if necessary, coach the client on more appropriate behavior. Once the client has mastered specific behaviors, they can be combined into more complex behaviors. In addition, the client can progressively role play more difficult situations.

Step #4: In vivo practice: The clients should finally try out the behaviors they have learned in order to determine if learning has occurred or if further training is still needed. Homework assignments, as in practicing new behaviors, should be given. It is important for the client to keep a record of situations calling for assertive behavior and the manner in which the client responded.

V. SOURCES:

Alberti, R. (Ed.) 1977. Assertiveness; Innovation, applications, issues. San Luis Obispo, California: Impact Publishers, Inc.

Goldfried, M. & Davidson, G. 1976. Clinical behavior therapy. New York: Holt, Rinehart, and Winston.

STRESS INOCULATION

I. **DEFINITION**: Stress inoculation is an approach to teaching both physical and cognitive coping skills. Stress inoculation has been used in management of anxiety reactions, anger control training for abusive clients, anger management for law enforcement personnel, pain management, and to relieve tension headaches.

II. **PREVALENCE**: Stress related problems affect a large portion of today's society.

III. **DESCRIPTION**: Stress inoculation functions much the same way as medical inoculation (i.e. resistance is created by exposing the individual to a stimulus strong enough to arouse body defenses but not strong enough to overwhelm them). Similarly, stress inoculation provides psychological protection by giving the individual skills and strategies to deal with future stressful situations.

IV. **TREATMENT PROCEDURE**: The treatment procedure for stress inoculation involves four major steps:

Step #1: Educate the client about stressful reactions and also briefly review the procedures for stress inoculation with them.

Step #2: Introduce and rehearse direct action coping strategies. Examples of direct action coping are identification of escape route, mental relaxation techniques, and physical relaxation techniques. The client should be allowed to choose which strategy he/she feels is most appropriate.

Step #3: Educate the client in the four phases of cognitive coping:

a) preparing for the situation
b) confronting and handling the situation
c) coping with critical moments
d) reinforcing oneself after the situation

In acquiring the cognitive strategies it is helpful for the counselor to model coping thoughts. It is also important for the client to select and practice appropriate coping thoughts.

Step #4: The final step involves the application of all coping strategies to the problem situation. This may be initiated through several techniques. Some of them are modeling, role playing, and homework assignments.

V. SOURCES;

Cormier, William H., and Cormier, L.S. 1979. Interviewing Strategies for Helpers. Monterey, California: Brooks/Cole Publishing Company, pp. 374-400.

PROBLEM SOLVING - DECISION MAKING

I. **DEFINITION:** Problem solving is defined as a process, overt or covert, which provides a variety of potentially effective responses to problem situations and increases the likelihood of selecting the most effective responses from among the various alternatives

II. **PREVALENCE**: Decision making is an integral part of many counseling situations.

III. **DESCRIPTION** The approach to be described below appears to be the most effective one and involves the teaching of specific problem solving skills. The basic goals of this approach are to improve general effectiveness in independent functioning and effectiveness in coping with problem situations. This should serve to increase the individual's ability to cope effectively in a wide variety of situations.

IV. **TREATMENT PROCEDURE**:

Step #1: General Orientation—Treatment begins with a basic discussion of the rationale and anticipated benefits of treatment. This includes introducing to the client a cognitive set that (a) problem situations are a normal part of life and that they can be coped with, (b) that it is important to be able to identify problem situations when they occur, and (c) it is also important to learn to inhibit one's tendency to respond with the first impulse in a problem situation. This basically involves creating in the client the expectation that they can solve problems. Cognitive restructuring is one possible means of helping the client develop such a set. In order to help the client become sensitized to identifying problem situations, homework assignments (involving self-monitoring of daily living situations) should be given

Step #2: Problem Definitions and Formulations—In this stage, the client learns to define external situations and internal factors, such as thoughts, which are involved in the client's problems. The client must also identify specific goals and the obstacles to reaching those goals.

Step #3: Generation of Alternatives—Brainstorming is the key to this process. There are four basic rules to follow when employing brainstorming: (a) criticism is ruled out—advance judgment of ideas is withheld until later, (b) no alternative should be rejected, no matter how wild it seems, (c) the greater the number of ideas, the better, and (d) combining and improving earlier ideas is the final goal.

Step #4: Decision making—The client determines which of the alternatives is worth pursuing by (a) predicting likely consequences and (b) considering the utility of the consequences. Once a strategy is chosen, it is necessary to develop as many alternative ways as possible of carrying out the strategy by returning to the brainstorming process.

Step # 5: Verification—The client most act on the decision so as to verify the actual effectiveness of the choice. If the strategy is not successful, it

may be because the client does not have the necessary skills to carry it out and a skills training program then becomes necessary. It may also be necessary, if not successful, to return to brainstorming to develop another strategy. Homework assignments should be given which involve having the client practice problem solving.

V. SOURCE:

Goldfried, M. & Davidson, G. 1976. *Clinical Behavior Therapy,* *New-York: Holt, Rinehart, and Winston.*

TEST ANXIETY

I. **DEFINITION**: Decreased performance in test situations generally thought to result from an excessive level of anxiety. Recent research, however, suggests that test anxiety results not from too much anxiety, but rather from a lack of skills which lead to ineffective test-taking behavior.

II. **PREVALENCE:** Text anxiety is common among high school and college students.

III. **DESCRIPTION:** Text anxious students have been shown to (1) label their physiological arousal as debilitating; (2) make a greater proportion of off-task (not relating to the test) or negative statements before and during the test; and (3) use task-irrelevant statements as a means of inhibiting arousal.

IV. **ASSESSMENT:**

Step #1: Assess current study skills. In addition to self report, one instrument which can be used is Brown's Effective Study Test.

Step #2: Assess for prior academic performance in relation to present expectations to measure the client's use of facilitative versus debilitative anxiety. One possible instrument would be Alpert and Habers[1] Achievement Anxiety Test (AAT).

Step 13: Assess for levels of general anxiety (possible instrument: Sarason's General Anxiety Scale) and anxiety in testing situations (Possible instrument: Sarason's Test Anxiety Scale).

V. **TREATMENT:** This treatment protocol focuses on (1) developing effective test taking strategies; (2) utilizing adaptive self-instructional statements; and (3) developing attentional control skills. It is designed for five sessions.

Session #1: Rationale and Test-Taking Strategies.

Educate the client in the rationale for the skills acquisition approach to treating test anxiety, emphasizing that the problem is one of too few skills rather than too much anxiety. Explain that the treatment will focus on acquisition of skills for effective test-taking with no relaxation training under the assumption that, with the new skills, their arousal will actually aid in improving their test performance. Also address the client's learning of effective test-taking strategies including:

1. Reading all test directions completely.
2. Surveying the length of the test.
3. Surveying the test to see if certain sections require more time than others.
4. Budgeting your time (e.g., on a test with 80 items and 40 minutes, plan for two items par minute).
5. Surveying essay exams to get the overall picture before answering individual questions.
6. Outlining answers for essay exams.
7. Working on only one problem at a time.
8. Marking harder items to return to later.
9. Trying to predict general questions on a test when studying.

10. Outlining lecture and reading notes.
11. Asking the instructor about the type and coverage of exams.

Emphasize that using these strategies in actual test situations is the goal and that knowledge of their use will enable the client to more effectively use his arousal.

Session 2: <u>Review Rationale and Self Instructional Training</u>

Review previously presented strategies and assess the client's understanding of how acquisition of effective test-taking skills is the most direct route to improved test performance. Reemphasize points as needed. Explain to the client how something that he already does -talking to himself - can aid in his becoming a more effective test taker. Ask the client to tell you some of the statements he tells himself before and during a test. Discuss these statements in terms of off-statements (not relating to the task), on-statement -(dealing directly with the task), negative self-evaluations ("Everyone's smarter than me", etc.), and positive self-evaluations ("I know I can do well because I've studied hard".). Explain the purpose of self-instructional training as working to increase the frequency of on-statements and positive self evaluations while decreasing the frequency of off-statements and negative self-evaluations, have the client generate a list of on-task and positive self-evaluation statements which he can utilize.

Session #3: <u>Review of Rationale and Attentional Training</u>
Review the rationale for self-instruction (to increase the client's attention to the task and to clear his mind of irrelevant information). Review categories of self-statements. Model for the client how specific self-instructions can increase attention to the test-taking task. Close by having the client summarize the information presented to this point and reemphasize points on which client is unclear.
Session #4: <u>Review and Practice</u>

Summarize material covered previously. Emphasize that skills must be practiced to be learned. Before the client arrives, prepare a timed test with items of sufficient difficulty to challenge the client. Simulate a testing situation as much as possible. Reemphasize the requirement to practice the skills.

Session #5: <u>Review and Practice</u>

Briefly review the skills. Discuss how the skills worked for the client in the Session #4 test situation and discuss strategies for dealing with any difficulties encountered. Present a second timed test for the client to practice his new skills. Close the session by talking through how the client will use these skills in an actual test situation he will soon encounter.

<u>Sources:</u>

This treatment protocol is a summary of the following document which is available in the USM Counseling Psychology Laboratory; Gordon, D.H., Hollandsworth, J.G., and Kirkland, K. (1981). Treatment manual for ineffective test-taking. Unpublished manuscript, University of Southern Mississippi, Department of Counseling Psychology, Hattiesburg.

GENERAL ASSESSMENT LABORATORY PROCEDURES

The Counseling Assessment Lab contains a variety of test and evaluation instruments and testing resources for use by the Counseling Psychology staff and students. The Assessment Lab maintains a listing of currently available instruments, and assessment lab staff will assist in the selection, administration, and scoring of assessment instruments given in the laboratory.

A major function of the Assessment Laboratory is for the testing of clients that are seen by counselors in the Counseling Psychology Lab. However, the lab is also utilized for other assessment-related purposes. Importantly, some assessment instruments must be administered by a qualified examiner or by individual administration, and hence, may not be able to be administered by routine Assessment Laboratory procedures. If a counselor is unsure if an assessment instrument requires special procedures, he or she must check with assessment lab staff. To circumvent scheduling problems, counselors must coordinate with assessment lab personnel before an appointment for such tests or assessment is made.

Counselors are requested to have clients call the Counseling Psychology Lab as soon as possible in the event that a scheduled assessment appointment cannot be kept. (The Counseling Lab receptionist will advise the Assessment Lab.)

On occasion, assessment instruments and resources can be checked out to Counseling Psychology graduate students for twenty-four (24) hour periods.

A complete description of Assessment Laboratory Procedures, hours of lab operation, and openings for appointments is available in the Assessment Lab. Also, Counseling Psychology faculty and Counseling lab supervisors have current copies of the complete description of procedures.

COUNSELING LAB

Frequently Used Tests By Category

DIRECTORY

ABILITY

- SRA Verbal & Nonverbal
- Slosson Intelligence Test
- Otis Lennon Mental Ability Test
- Peabody picture Vocabulary Test (Res)
- Wechsler Adult Intelligence Test (Res)
- Wechsler Intelligence Scale for Children (Res)
- Wechsler Pre-School & Primary Scale of Intelligence (Res)
- Stanford-Binet Intelligence Scale

ACHIEVEMENT & ACADEMIC DIAGNOSTIC

- Wide Range Achievement Test
- Peabody Individual Achievement Test (Res)
- Woodcock Reading Mastery Tests (Res)
- Key-Math Diagnostic Test
- Nelson-Denny Reading Test
- Illinois Test of Psycho Linguistic Ability

INTEREST

- Kruder Perferenos Record
- How Well Do You Know Yourself
- Strong Campbell Interest Inventory
- Hall Occupational Orientation Inventory
- Educational Interest Inventory
- Self Directed Search
- Vocational Interest Inventory

PERSONALITY

- How Well Do You Know Yourself
- Gordon Personal Profile
- Kuder Personal Preference Record
- Mooney Problem Check Lists
- Sixteen Personality Factors
- Tennessee Self Concept
- California Psychological Inventory
- Edward Personality Inventory
- Edward Personal Preference Inventory
- Personality Research Form
- Myers-Briggs Type Indicator
- Rokeach Value Survey
- Minnesota Multiphasic Personality Inventory (Res)

MARITAL & FAMILY

- Pair Attraction Inventory
- Marital Roles Inventory
- Family Environment Scale

MISCELLANEOUS

- Survey of Study Habits & Attitudes
- Classroom Environment Scale
- Bender Visual-Motor Gestalt Test (Res)
- Adult Self-Expression Scale
- Interpersonal Behavior Survey

NOTE: Tests are located in the Assessment Lab. The Lab also has a complete listing of tests. Restricted (Res) tests are those instruments which the counselor must receive specified training in order to be able to administer.

CONFIDENTIALITY

It is the policy of the Counseling Psychology Laboratory that all information regarding clients will be held in the strictest confidence. No information of any kind will be released to any external persons or agencies, by any counselor, without proper authorization from the client and/or the client's legal guardian and authorization from the laboratory director. Such confidential information includes acknowledging that a person of a particular name or description is or has been a client.

The counselor assigned to a particular client is responsible for maintaining the confidentiality of that particular case record. Access to the case record by other staff members will be limited to the quality Assurance Committee. Records will be stored in a locked cabinet at all times except when removed for the addition of new information.

Confidentiality will be maintained in regard to clients, client contacts, and client records. Clients are not to be identified nor discussed with individuals, groups, or agencies not directly affiliated with the Counseling Psychology Laboratory including spouses, relatives, and friends of counselors and clients. To maintain confidentiality, it is important that client's names are not discussed between or among counselors in public or quasipublic places such as restaurants, hallways, or offices in public areas of the laboratory. Difficulties that may arise should be referred up the supervisory channel.

Release of Client Information.

The content of the information released from our records to other agencies/persons must be carefully considered in terms of the use to which the other agency/person may put this information. For example, giving a teacher technical, medical/psychological diagnoses or treatment information regarding a client may not only be misused but may be misinterpreted and misunderstood. Any information leaving the laboratory most be considered (Any information leaving the laboratory must first be approved by the director).

It is the responsibility of the counselor to see that appropriate consent forms are signed. Clearly, verbal and written information are never disclosed without written authorization from the client. Consent forms are signed as they are needed rather than routinely signed assuming that they will be used at some point in the future.

The 'Consent for Release of Information' form used by the Laboratory is in compliance with all current applicable state and federal standards. It should, therefore, be accepted by any other agency from whom **we** request records. This form or its specific equivalent must be completed and received before any records or information is released to any other agency or person. The counselor assigned to the case has the responsibility for completing all necessary paperwork involved in sending or requesting client information. The 'Consent for Release of Information1 has the following elements, all of which must be completed:

1. The name of the program, agency, or individual being authorized to release information.
2. The full name of the client on whom information is being released.
3. The name of the program, agency, or individual who will be authorized to receive information.
4. The purpose or need for the release or information.
5. The specific nature and extent of information to be released.
6. The condition or date on which the release will automatically expire.
7. The client's original signature (and/or that of the parent or legal guardian if the client is a minor.)
8. The date the client signed the form.
9. The signature and date of one witness to the signature of the client.

In all cases, the counselor asking the client to authorize release of information will

complete all required information and allow the client to read the consent form or will read it to the illiterate client before requesting the client to sign. (Any information leaving the laboratory must first be approved by the director of the lab.),

Disclosure to medical personnel is authorized without the consent of the client when and to the extent necessary to meet a bona fide medical emergency, i.e., when the life or health of a client may be endangered by an error in the manufacture or packaging of a drug, when the client is incapacitated and treatment and information concerning the treatment being given by a person is necessary to make a sound determination of emergency treatment needed, or for notification to family or others when the individual is suffering from a serious medical condition receiving treatment. The treating counselor may in such cases give notification of such a condition to a member of the individual's family or a physician. Any individual making an oral disclosure under authority of this section shall make a written entry into the case record showing the client’s name, case number, the date, some indication of the nature of the emergency, information disclosed and to whom it was disclosed. Very few medical emergencies will exist in the course of involvement with laboratory clients. Should this situation arise, it should be cleared with the director of the laboratory before any action is taken.

Ethical Principles of Psychologists
INTRODUCTION

The American Psychological Association's (APA's) Ethical Principles of Psychologists and Code of Conduct (hereinafter referred to as the Ethics Code) consists of an Introduction, a Preamble, six General Principles (A - F), and specific Ethical Standards. The Introduction discusses the intent, organization, procedural considerations, and scope of application of the Ethics Code. The Preamble and General Principles are aspirational goals to guide psychologists toward the highest ideals of psychology. Although the Preamble and General Principles are not themselves enforceable rules, they should be considered by psychologists in arriving at an ethical course of action and may be considered by ethics bodies in interpreting the Ethical Standards. The Ethical Standards set forth *enforceable* rules for conduct as psychologists. Most of the Ethical Standards are written broadly, in order to apply to psychologists in varied roles, although the application of an Ethical Standard may vary depending on the context. The Ethical Standards are not exhaustive. The fact that a given conduct is not specifically addressed by the Ethics Code does not mean that it is necessarily either ethical or unethical.

Membership in the APA commits members to adhere to the APA Ethics Code and to the rules and procedures used to implement it. Psychologists and students, whether or not they are APA members, should be aware that the Ethics Code may be applied to them by state psychology boards, courts, or other public bodies.

This Ethics Code applies only to psychologists' work-related activities, that is, activities that are part of the psychologists' scientific and professional functions or that are psychological in nature. It includes the clinical or counseling practice of psychology, research, teaching, supervision of trainees, development of assessment instruments, conducting assessments, educational counseling, organizational consulting, social intervention, administration, and other activities as well. These work-related activities can be distinguished from the purely private conduct of a psychologist, which ordinarily is not within the purview of the Ethics Code.

The Ethics Code is intended to provide standards of professional conduct that can be applied by the APA and by other bodies that choose to adopt them. Whether or not a psychologist has violated the Ethics Code does not by itself determine whether he or she is legally liable in a court action, whether a contract is enforceable, or whether other legal consequences occur. These results are based on legal rather than ethical rules. However, compliance with or violation of the Ethics Code may be admissible as evidence in some legal proceedings, depending on the circumstances.

In the process of making decisions regarding their professional behavior, psychologists must consider this Ethics Code, in addition to applicable laws and psychology board regulations. If the Ethics Code establishes a higher standard of conduct than is required by law, psychologists must meet the higher ethical standard. If the Ethics Code standard appears to conflict with the requirements of law, then psychologists make known their commitment to the Ethics Code and take steps to resolve the conflict in a responsible manner. If neither law nor the Ethics Code resolves an issue, psychologists should consider other professional materials

The procedures for filing, investigating, and resolving complaints of unethical conduct are described in the current Rules and Procedures of the APA Ethics Committee. The actions that APA may take for violations of the Ethics Code include actions such as reprimand, censure, termination of APA membership, and referral of the matter to other bodies. Complainants who seek remedies such as monetary damages in alleging ethical violations by a psychologist must resort to private negotiation, administrative bodies, or the courts. Actions that violate the Ethics Code may lead to the imposition of sanctions on a psychologist by bodies other than APA, including state psychological associations, other professional groups, psychology boards, other

state or federal agencies, and payors for health services. In addition to actions for violation of the Ethics Code, the APA Bylaws provide that APA may take action against a member after his or her conviction of a felony, expulsion or suspension from an affiliated state psychological association, or suspension or loss of licensure.

PREAMBLE

Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness. This Ethics Code provides a common set of principles and standards upon which psychologists build their professional and scientific work.

- This Ethics Code is intended to provide specific standards to cover most situations encountered by psychologists. It has as its goals the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students, and the public regarding ethical standards of the discipline.

The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees, and colleagues; and to consult with others concerning ethical problems.

GENERAL PRINCIPLES

This section consists of General Principles. General Principles, as opposed to Ethical Standards, are aspirational in nature. Their intent is to guide and inspire psychologists toward the very highest ethical ideals of the profession. General Principles, in contrast to Ethical Standards, do not represent obligations and should not form the basis for imposing sanctions. Relying upon General Principles for either of these reasons distorts both their meaning and purpose.

Principle A: **Beneficence and Non-maleficence**

Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work

Principle B: **Fidelity and Responsibility**

Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities

to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues' scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.

Principle C: Integrity

Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.

Principle D: **Justice**

Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices.

Principle E: **Respect for People's Rights and Dignity**

Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

ETHICAL STANDARDS

1. Resolving Ethical Issues

1.01 Misuse of Psychologists' Work
If psychologists learn of misuse or misrepresentation of their work, they take reasonable steps to correct or minimize the misuse or misrepresentation.

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority
If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to the Ethics Code and take steps to resolve the conflict. If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing legal authority.

1.03 Conflicts Between Ethics and Organizational Demands
If the demands of an organization with which psychologists are affiliated or for whom they are working conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and to the extent feasible, resolve the conflict in a way that permits adherence to the Ethics Code.

1.04 Informal Resolution of Ethical Violations

When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved. (See also Standards 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority, and 1.03, Conflicts Between Ethics and Organizational Demands.)

1.05 Reporting Ethical Violations
If an apparent ethical violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution under Standard 1.04, Informal Resolution of Ethical Violations, or is not resolved properly in that fashion, psychologists take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, to state licensing boards, or to the appropriate institutional authorities. This standard does not apply when an intervention would violate confidentiality rights or when psychologists have been retained to review the work of another psychologist whose professional conduct is in question. (See also Standard 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority.)

1.06 Cooperating With Ethics Committees
Psychologists cooperate in ethics investigations, proceedings, and resulting requirements of the APA or any affiliated state psychological association to which they belong. In doing so, they address any confidentiality issues. Failure to cooperate is itself an ethics violation. However, making a request for deferment of adjudication of an ethics complaint pending the outcome of litigation does not alone constitute non-cooperation.

1.07 Improper Complaints
Psychologists do not file or encourage the filing of ethics complaints that are made with reckless disregard for or willful ignorance of facts that would disprove the allegation.

1.08 Unfair Discrimination Against Complainants and Respondents
Psychologists do not deny persons employment, advancement, admissions to academic or other programs, tenure, or promotion, based solely upon their having made or their being the subject of an ethics complaint. This does not preclude taking action based upon the outcome of such proceedings or considering other appropriate information.

2. Competence

2.01 Boundaries of Competence

(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard.

(c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

(d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.

(e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.

(f) When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles.

2.02 Providing Services in Emergencies

In emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied. The services are discontinued as soon as the emergency has ended or appropriate services are available.

2.03 Maintaining Competence

Psychologists undertake ongoing efforts to develop and maintain their competence.

2.04 Bases for Scientific and Professional Judgments

Psychologists' work is based upon established scientific and professional knowledge of the discipline.

2.05 Delegation of Work to Others
Psychologists who delegate work to employees, supervisees, or research or teaching assistants or who use the services of others, such as interpreters, take reasonable steps to (1) avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity; (2) authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided; and (3) see that such persons perform these services competently.

2.06 Personal Problems and Conflicts
(a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.

(b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties.

3. Human Relations

3.01 Unfair Discrimination
In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law.

3.02 Sexual Harassment
Psychologists do not engage in sexual harassment. Sexual harassment is sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with the psychologist's activities or roles as a psychologist, and that either (1) is unwelcome, is offensive, or creates a hostile workplace or educational environment, and the psychologist knows or is told this or (2) is sufficiently severe or intense to be abusive to a reasonable person in the context. Sexual harassment can consist of a single intense or severe act or of multiple persistent or pervasive acts.

3.03 Other Harassment
Psychologists do not knowingly engage in behavior that is harassing or demeaning to persons with whom they interact in their work based on factors such as those persons' age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status.

3.04 Avoiding Harm
Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

3.05 Multiple Relationships

(a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.

(b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.

(c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur.

3.06 Conflict of Interest

Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation.

3.07 Third-Party Requests for Services

When psychologists agree to provide services to a person or entity at the request of a third party, psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations involved. This clarification includes the role of the psychologist (e.g., therapist, consultant, diagnostician, or expert witness), an identification of who is the client, the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality.

3.08 Exploitative Relationships

Psychologists do not exploit persons over whom they have supervisory, evaluative, or other authority such as clients/patients, students, supervisees, research participants, and employees.

3.09 Cooperation With Other Professionals

When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately.

3.10 Informed Consent

(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code.

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.

(d) Psychologists appropriately document written or oral consent, permission, and assent.

3.11 Psychological Services Delivered To or Through Organizations

(a) Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about (1) the nature and objectives of the services, (2) the intended recipients, (3) which of the individuals are clients, (4) the relationship the psychologist will have with each person and the organization, (5) the probable uses of services provided and information obtained, (6) who will have access to the information, and (7) limits of confidentiality. As soon as feasible, they provide information about the results and conclusions of such services to appropriate persons.

(b) If psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of the service.

3.12 Interruption of Psychological Services

Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability, relocation, or retirement or by the client's/patient's relocation or financial limitations.

4. **Privacy And Confidentiality**

4.01 Maintaining Confidentiality

Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established

by institutional rules or professional or scientific relationship.

4.02 Discussing the Limits of Confidentiality

(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities.

(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

(c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.

4.03 Recording

Before recording the voices or images of individuals to whom they provide services, psychologists obtain permission from all such persons or their legal representatives.

4.04 Minimizing Intrusions on Privacy

(a) Psychologists include in written and oral reports and consultations, only information germane to the purpose for which the communication is made.

(b) Psychologists discuss confidential information obtained in their work only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

4.05 Disclosures

(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.

(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose.

4.06 Consultations

When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the

consultation.

4.07 Use of Confidential Information for Didactic or Other Purposes
Psychologists do not disclose in their writings, lectures, or other public media, confidential, personally identifiable information concerning their clients/patients, students, research participants, organizational clients, or other recipients of their services that they obtained during the course of their work, unless (1) they take reasonable steps to disguise the person or organization, (2) the person or organization has consented in writing, or (3) there is legal authorization for doing so.

5. Advertising and Other Public Statements

5.01 Avoidance of False or Deceptive Statements

(a) Public statements include but are not limited to paid or unpaid advertising, product endorsements, grant applications, licensing applications, other credentialing applications, brochures, printed matter, directory listings, personal resumes or curricula vitae, or comments for use in media such as print or electronic transmission, statements in legal proceedings, lectures and public oral presentations, and published materials. Psychologists do not knowingly make public statements that are false, deceptive, or fraudulent concerning their research, practice, or other work activities or those of persons or organizations with which they are affiliated.

(b) Psychologists do not make false, deceptive, or fraudulent statements concerning (1) their training, experience, or competence; (2) their academic degrees; (3) their credentials; (4) their institutional or association affiliations; (5) their services; (6) the scientific or clinical basis for, or results or degree of success of, their services; (7) their fees; or (8) their publications or research findings.

(c) Psychologists claim degrees as credentials for their health services only if those degrees (1) were earned from a regionally accredited educational institution or (2) were the basis for psychology licensure by the state in which they practice.

5.02 Statements by Others

(a) Psychologists who engage others to create or place public statements that promote their professional practice, products, or activities retain professional responsibility for such statements.

(b) Psychologists do not compensate employees of press, radio, television, or other communication media in return for publicity in a news item.

(c) A paid advertisement relating to psychologists' activities must be identified or clearly recognizable as such.

5.03 Descriptions of Workshops and Non-Degree-Granting Educational Programs
To the degree to which they exercise control, psychologists responsible for announcements, catalogs, brochures, or advertisements describing workshops, seminars, or other non-degree-granting educational programs ensure that they accurately describe the audience for which the program is intended, the educational objectives, the presenters, and the fees involved.

5.04 Media Presentations

When psychologists provide public advice or comment via print, Internet, or other electronic transmission, they take precautions to ensure that statements (1) are based on their professional knowledge, training, or experience in accord with appropriate psychological literature and practice; (2) are otherwise consistent with this Ethics Code; and (3) do not indicate that a professional relationship has been established with the recipient.

5.05 Testimonials

Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence.

5.06 In-Person Solicitation

Psychologists do not engage, directly or through agents, in uninvited in-person solicitation of business from actual or potential therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence. However, this prohibition does not preclude (1) attempting to implement appropriate collateral contacts for the purpose of benefiting an already engaged therapy client/patient or (2) providing disaster or community outreach services.

6. Record Keeping and Fees

6.01 Documentation of Professional and Scientific Work and Maintenance of Records

Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law.

6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work

(a) Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium.

(b) If confidential information concerning recipients of psychological services is entered into databases or systems of records available to persons whose access has not been consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers.

(c) Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice.

6.03 Withholding Records for Nonpayment

Psychologists may not withhold records under their control that are requested and needed for a client's/patient's emergency treatment solely because payment has not been received.

6.04 Fees and Financial Arrangements

(a) As early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements.

(b) Psychologists' fee practices are consistent with law.

(c) Psychologists do not misrepresent their fees.

(d) If limitations to services can be anticipated because of limitations in financing, this is discussed with the recipient of services as early as is feasible.

(e) If the recipient of services does not pay for services as agreed, and if psychologists intend to use collection agencies or legal measures to collect the fees, psychologists first inform the person that such measures will be taken and provide that person an opportunity to make prompt payment.

6.05 Barter With Clients/Patients

Barter is the acceptance of goods, services, or other non-monetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative.

6.06 Accuracy in Reports to Payors and Funding Sources

In their reports to payors for services or sources of research funding, psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided or research conducted, the fees, charges, or payments, and where applicable, the identity of the provider, the findings, and the diagnosis.

6.07 Referrals and Fees

When psychologists pay, receive payment from, or divide fees with another professional, other than in an employer-employee relationship, the payment to each is based on the services provided (clinical, consultative, administrative, or other) and is not based on the referral itself.

7. Education and Training

7.01 Design of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that the programs are designed to provide the appropriate knowledge and proper experiences, and to meet the requirements for licensure, certification, or other goals for which claims are made by the program.

7.02 Descriptions of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that there is a current and accurate description of the program content (including participation in required course- or program-related counseling, psychotherapy, experiential groups, consulting projects, or community service), training goals and objectives, stipends and benefits, and requirements that must be met for satisfactory completion of the program. This information must be made readily available to all interested parties.

7.03 Accuracy in Teaching

(a) Psychologists take reasonable steps to ensure that course syllabi are

accurate regarding the subject matter to be covered, bases for evaluating progress, and the nature of course experiences. This standard does not preclude an instructor from modifying course content or requirements when the instructor considers it pedagogically necessary or desirable, so long as students are made aware of these modifications in a manner that enables them to fulfill course requirements.

(b) When engaged in teaching or training, psychologists present psychological information accurately.

7.04 Student Disclosure of Personal Information

Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.

7.05 Mandatory Individual or Group Therapy

(a) When individual or group therapy is a program or course requirement, psychologists responsible for that program allow students in undergraduate and graduate programs the option of selecting such therapy from practitioners unaffiliated with the program.

Psychologists responsible for education and training programs take reasonable steps to ensure that there is a current and accurate description of the program content (including participation in required course- or program-related counseling, psychotherapy, experiential groups, consulting projects, or community service), training goals and objectives, stipends and benefits, and requirements that must be met for satisfactory completion of the program. This information must be made readily available to all interested parties.

7.03 Accuracy in Teaching

(a) Psychologists take reasonable steps to ensure that course syllabi are accurate regarding the subject matter to be covered, bases for evaluating progress, and the nature of course experiences. This standard does not preclude an instructor from modifying course content or requirements when the instructor considers it pedagogically necessary or desirable, so long as students are made aware of these modifications in a manner that enables them to fulfill course requirements.

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Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate

or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.

7.05 Mandatory Individual or Group Therapy

(a) When individual or group therapy is a program or course requirement, psychologists responsible for that program allow students in undergraduate and graduate programs the option of selecting such therapy from practitioners unaffiliated with the program.

(b) Faculty who are or are likely to be responsible for evaluating students' academic performance do not themselves provide that therapy.

7.06 Assessing Student and Supervisee Performance

(a) In academic and supervisory relationships, psychologists establish a timely and specific process for providing feedback to students and supervisees. Information regarding the process is provided to the student at the beginning of supervision.

(b) Psychologists evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.

7.07 Sexual Relationships With Students and Supervisees

Psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority.

8. Research and Publication

8.01 Institutional Approval

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

8.02 Informed Consent to Research

(a) When obtaining informed consent as required in Standard 3.10, Informed Consent, psychologists inform participants about (1) the purpose of the research, expected duration, and procedures; (2) their right to decline to participate and to withdraw from the research once participation has begun; (3) the foreseeable consequences of declining or withdrawing; (4) reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort, or adverse effects; (5) any prospective research benefits; (6) limits of confidentiality; (7) incentives for participation; and (8) whom to contact for questions about the research and research participants' rights. They provide opportunity for the prospective participants to ask questions and receive answers.

(b) Psychologists conducting intervention research involving the use of experimental treatments clarify to participants at the outset of the research (1) the experimental nature of the treatment; (2) the services that will or will not be available to the control group(s) if appropriate; (3) the means

by which assignment to treatment and control groups will be made; (4) available treatment alternatives if an individual does not wish to participate in the research or wishes to withdraw once a study has begun; and (5) compensation for or monetary costs of participating including, if appropriate, whether reimbursement from the participant or a third-party payor will be sought.

8.03 Informed Consent for Recording Voices and Images in Research

Psychologists obtain informed consent from research participants prior to recording their voices or images for data collection unless (1) the research consists solely of naturalistic observations in public places, and it is not anticipated that the recording will be used in a manner that could cause personal identification or harm, or (2) the research design includes deception, and consent for the use of the recording is obtained during debriefing.

8.04 Client/Patient, Student, and Subordinate Research Participants

(a) When psychologists conduct research with clients/patients, students, or subordinates as participants, psychologists take steps to protect the prospective participants from adverse consequences of declining or withdrawing from participation.

(b) When research participation is a course requirement or an opportunity for extra credit, the prospective participant is given the choice of equitable alternative activities.

8.05 Dispensing With Informed Consent for Research

Psychologists may dispense with informed consent only (1) where research would not reasonably be assumed to create distress or harm and involves (a) the study of normal educational practices, curricula, or classroom management methods conducted in educational settings; (b) only anonymous questionnaires, naturalistic observations, or archival research for which disclosure of responses would not place participants at risk of criminal or civil liability or damage their financial standing, employability, or reputation, and confidentiality is protected; or (c) the study of factors related to job or organization effectiveness conducted in organizational settings for which there is no risk to participants' employability, and confidentiality is protected or (2) where otherwise permitted by law or federal or institutional regulations.

8.06 Offering Inducements for Research Participation

(a) Psychologists make reasonable efforts to avoid offering excessive or inappropriate financial or other inducements for research participation when such inducements are likely to coerce participation.

(b) When offering professional services as an inducement for research participation, psychologists clarify the nature of the services, as well as the risks, obligations, and limitations.

8.07 Deception in Research

(a) Psychologists do not conduct a study involving deception unless they have determined that the use of deceptive techniques is justified by the study's significant prospective scientific, educational, or applied value and that

effective non-deceptive alternative procedures are not feasible.

(b) Psychologists do not deceive prospective participants about research that is reasonably expected to cause physical pain or severe emotional distress.

(c) Psychologists explain any deception that is an integral feature of the design and conduct of an experiment to participants as early as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the data collection, and permit participants to withdraw their data.

8.08 Debriefing

(a) Psychologists provide a prompt opportunity for participants to obtain appropriate information about the nature, results, and conclusions of the research, and they take reasonable steps to correct any misconceptions that participants may have of which the psychologists are aware.

(b) If scientific or humane values justify delaying or withholding this information, psychologists take reasonable measures to reduce the risk of harm.

(c) When psychologists become aware that research procedures have harmed a participant, they take reasonable steps to minimize the harm.

8.09 Humane Care and Use of Animals in Research

(a) Psychologists acquire, care for, use, and dispose of animals in compliance with current federal, state, and local laws and regulations, and with professional standards.

(b) Psychologists trained in research methods and experienced in the care of laboratory animals supervise all procedures involving animals and are responsible for ensuring appropriate consideration of their comfort, health, and humane treatment.

(c) Psychologists ensure that all individuals under their supervision who are using animals have received instruction in research methods and in the care, maintenance, and handling of the species being used, to the extent appropriate to their role.

(d) Psychologists make reasonable efforts to minimize the discomfort, infection, illness, and pain of animal subjects.

(e) Psychologists use a procedure subjecting animals to pain, stress, or privation only when an alternative procedure is unavailable and the goal is justified by its prospective scientific, educational, or applied value.

(f) Psychologists perform surgical procedures under appropriate anesthesia and follow techniques to avoid infection and minimize pain during and after surgery.

(g) When it is appropriate that an animal's life be terminated, psychologists proceed rapidly, with an effort to minimize pain and in accordance with accepted procedures.

8.10 Reporting Research Results

(a) Psychologists do not fabricate data.

(b) If psychologists discover significant errors in their published data, they take reasonable steps to correct such errors in a correction, retraction, erratum, or other appropriate publication means.

8.11 Plagiarism

Psychologists do not present portions of another's work or data as their own, even if the other work or data source is cited occasionally.

8.12 Publication Credit

(a) Psychologists take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have substantially contributed.

(b) Principal authorship and other publication credits accurately reflect the relative scientific or professional contributions of the individuals involved, regardless of their relative status. Mere possession of an institutional position, such as department chair, does not justify authorship credit. Minor contributions to the research or to the writing for publications are acknowledged appropriately, such as in footnotes or in an introductory statement.

(c) Except under exceptional circumstances, a student is listed as principal author on any multiple-authored article that is substantially based on the student's doctoral dissertation. Faculty advisors discuss publication credit with students as early as feasible and throughout the research and publication process as appropriate.

8.13 Duplicate Publication of Data

Psychologists do not publish, as original data, data that have been previously published. This does not preclude republishing data when they are accompanied by proper acknowledgment.

8.14 Sharing Research Data for Verification

(a) After research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release. This does not preclude psychologists from requiring that such individuals or groups be responsible for costs associated with the provision of such information.

b) Psychologists who request data from other psychologists to verify the substantive claims through reanalysis may use shared data only for the declared purpose. Requesting psychologists obtain prior written agreement for all other uses of the data.

8.15 Reviewers

Psychologists who review material submitted for presentation, publication, grant, or research proposal review respect the confidentiality of and the proprietary rights in such information of those who submitted it.

9. Assessment

9.01 Bases for Assessments

(a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings.

b) Except as noted in 9.01c, psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations.

(c) When psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations.

9.02 Use of Assessments

(a) Psychologists administer, adapt, score, interpret, or use assessment techniques, interviews, tests, or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.

(b) Psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation.

(c) Psychologists use assessment methods that are appropriate to an individual's language preference and competence, unless the use of an alternative language is relevant to the assessment issues.

9.03 Informed Consent in Assessments

(a) Psychologists obtain informed consent for assessments, evaluations, or diagnostic services, as described in Standard 3.10, Informed Consent, except when (1) testing is mandated by law or governmental regulations; (2) informed consent is implied because testing is conducted as a routine educational, institutional, or organizational activity (e.g., when participants voluntarily agree to assessment when applying for a job); or (3) one purpose of the testing is to evaluate decisional capacity. Informed consent includes an explanation of the nature and purpose of the assessment, fees, involvement of third parties, and limits of confidentiality and sufficient opportunity for the client/patient to ask questions and receive answers.

(b) Psychologists inform persons with questionable capacity to consent or for whom testing is mandated by law or governmental regulations about the nature and purpose of the proposed assessment services, using language that is reasonably understandable to the person being assessed.

(c) Psychologists using the services of an interpreter obtain informed consent from the client/patient to use that interpreter, ensure that confidentiality of

test results and test security are maintained, and include in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, discussion of any limitations on the data obtained.

9.04 Release of Test Data

(a) The term *test data* refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of *test data*. Pursuant to a client/patient release, psychologists provide test data to the client/patient or other persons identified in the release. Psychologists may refrain from releasing test data to protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law.

(b) In the absence of a client/patient release, psychologists provide test data only as required by law or court order.

9.05 Test Construction

Psychologists who develop tests and other assessment techniques use appropriate psychometric procedures and current scientific or professional knowledge for test design, standardization, validation, reduction or elimination of bias, and recommendations for use.

9.06 Interpreting Assessment Results

When interpreting assessment results, including automated interpretations, psychologists take into account the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences, that might affect psychologists' judgments or reduce the accuracy of their interpretations. They indicate any significant limitations of their interpretations.

9.07 Assessment by Unqualified Persons

Psychologists do not promote the use of psychological assessment techniques by unqualified persons, except when such use is conducted for training purposes with appropriate supervision.

9.08 Obsolete Tests and Outdated Test Results

(a) Psychologists do not base their assessment or intervention decisions or recommendations on data or test results that are outdated for the current purpose.

(b) Psychologists do not base such decisions or recommendations on tests and measures that are obsolete and not useful for the current purpose.

9.09 Test Scoring and Interpretation Services

(a) Psychologists who offer assessment or scoring services to other professionals accurately describe the purpose, norms, validity, reliability,

and applications of the procedures and any special qualifications applicable to their use.

(b) Psychologists select scoring and interpretation services (including automated services) on the basis of evidence of the validity of the program and procedures as well as on other appropriate considerations.

(c) Psychologists retain responsibility for the appropriate application, interpretation, and use of assessment instruments, whether they score and interpret such tests themselves or use automated or other services.

9.10 Explaining Assessment Results

Regardless of whether the scoring and interpretation are done by psychologists, by employees or assistants, or by automated or other outside services, psychologists take reasonable steps to ensure that explanations of results are given to the individual or designated representative unless the nature of the relationship precludes provision of an explanation of results (such as in some organizational consulting, preemployment or security screenings, and forensic evaluations), and this fact has been clearly explained to the person being assessed in advance.

9.11. Maintaining Test Security

The term *test materials* refers to manuals, instruments, protocols, and test questions or stimuli and does not include *test data* as defined in Standard 9.04, Release of Test Data. Psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligations, and in a manner that permits adherence to this Ethics Code.

10. Therapy

10.01 Informed Consent to Therapy

(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality, and 6.04, Fees and Financial Arrangements.)

(b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation.

(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.

10.02 Therapy Involving Couples or Families

(a) When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the

individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained.

(b) If it becomes apparent that psychologists may be called on to perform potentially conflicting roles (such as family therapist and then witness for one party in divorce proceedings), psychologists take reasonable steps to clarify and modify, or withdraw from, roles appropriately.

10.03 Group Therapy

When psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality

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10.04 Providing Therapy to Those Served by Others

In deciding whether to offer or provide services to those already receiving mental health services elsewhere, psychologists carefully consider the treatment issues and the potential client's/patient's welfare. Psychologists discuss these issues with the client/patient or another legally authorized person on behalf of the client/patient in order to minimize the risk of confusion and conflict, consult with the other service providers when appropriate, and proceed with caution and sensitivity to the therapeutic issues.

10.05 Sexual Intimacies With Current Therapy Clients/Patients

Psychologists do not engage in sexual intimacies with current therapy clients/patients.

10.06 Sexual Intimacies With Relatives or Significant Others of Current Therapy Clients/Patients

Psychologists do not engage in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of current clients/patients. Psychologists do not terminate therapy to circumvent this standard.

10.07 Therapy With Former Sexual Partners

Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies.

10.08 Sexual Intimacies With Former Therapy Clients/Patients

(a) Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy.

(b) Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient bear the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated; (2) the nature, duration, and intensity of the therapy; (3) the circumstances of termination; (4) the client's/patient's personal history; (5)

the client's/patient's current mental status; (6) the likelihood of adverse impact on the client/patient; and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a posttermination sexual or romantic relationship with the client/patient

10.09 Interruption of Therapy

When entering into employment or contractual relationships, psychologists make reasonable efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the client/patient.

10.10 Terminating Therapy

(a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.

(b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.

(c) Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate

ACA Code of Ethics and Standards of Practice

Code of Ethics

PREAMBLE

The American Counseling Association is an educational, scientific, and professional organization whose members are dedicated to the enhancement of human development throughout the life-span. Association members recognize diversity in our society and embrace a cross- cultural approach in support of the worth, dignity, potential, and uniqueness of each individual.

The specification of a code of ethics enables the association to clarify to current and future members, and to those served by members, the nature of the ethical responsibilities held in common by its members. As the code of ethics of the association, this document establishes principles that define the ethical behavior of association members. All members of the American Counseling Association are required to adhere to the Code of Ethics and the Standards of Practice. The Code of Ethics will serve as the basis for processing ethical complaints initiated against members of the association.

A: The Counseling Relationship

A.1. **Client Welfare**

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

b. Positive Growth and Development. Counselors encourage client growth and development in ways that foster the clients+ interest and welfare; counselors avoid fostering dependent counseling relationships.

c. Counseling Plans. Counselors and their clients work jointly in devising integrated, individual counseling plans that offer reasonable promise of success and are consistent with abilities and circumstances of clients. Counselors and clients regularly review counseling plans to ensure their continued viability and effectiveness, respecting clients+ freedom of choice. (See A.3.b.)

d. Family Involvement. Counselors recognize that families are usually important in clients+ lives and strive to enlist family understanding and involvement as a positive resource, when appropriate.

e. Career and Employment Needs. Counselors work with their clients in considering employment in jobs and circumstances that are consistent with the clients+ overall abilities, vocational limitations, physical restrictions, general temperament, interest and aptitude patterns, social skills, education, general qualifications, and other relevant characteristics and needs. Counselors neither place nor participate in placing clients in positions that will result in damaging the interest and the welfare of clients, employers, or the public.

A.2. Respecting Diversity

a. Nondiscrimination. Counselors do not condone or engage in discrimination based on age, color, culture, disability, ethnic group, gender, race, religion, sexual orientation, marital status, or socioeconomic status. (See C.5.a., C.5.b., and D.1.i.)

b. Respecting Differences. Counselors will actively attempt to understand the diverse cultural backgrounds of the clients with whom they work. This includes, but is not limited to, learning how the counselor+s own cultural/ethnic/racial identity impacts her or his values and beliefs about the counseling process. (See E.8. and F.2.i.)

A.3. Client Rights

a. Disclosure to Clients. When counseling is initiated, and throughout the counseling process as

necessary, counselors inform clients of the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services to be performed, and other pertinent information. Counselors take steps to ensure that clients understand the implications of diagnosis, the intended use of tests and reports, fees, and billing arrangements. Clients have the right to expect confidentiality and to be provided with an explanation of its limitations, including supervision and/or treatment team professionals; to obtain clear information about their case records; to participate in the ongoing counseling plans; and to refuse any recommended services and be advised of the consequences of such refusal. (See E.5.a. and G.2.)

b. Freedom of Choice. Counselors offer clients the freedom to choose whether to enter into a counseling relationship and to determine which professional(s) will provide counseling. Restrictions that limit choices of clients are fully explained. (See A.1.c.)

c. Inability to Give Consent. When counseling minors or persons unable to give voluntary informed consent, counselors act in these clients+ best interests. (See B.3.)

A.4. Clients Served by Others

If a client is receiving services from another mental health professional, counselors, with client consent, inform the professional persons already involved and develop clear agreements to avoid confusion and conflict for the client. (See C.6.c.)

A.5. Personal Needs and Values

a. Personal Needs. In the counseling relationship, counselors are aware of the intimacy and responsibilities inherent in the counseling relationship, maintain respect for clients, and avoid actions that seek to meet their personal needs at the expense of clients.

b. Personal Values. Counselors are aware of their own values, attitudes, beliefs, and behaviors and how these apply in a diverse society, and avoid imposing their values on clients. (See C.5.a.)

A.6. Dual Relationships

a. Avoid When Possible. Counselors are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of clients. Counselors make every effort to avoid dual relationships with clients that could impair professional judgment or increase the risk of harm to clients. (Examples of such relationships include, but are not limited to, familial, social, financial, business, or close personal relationships with clients.) When a dual relationship cannot be avoided, counselors take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no exploitation occurs. (See F.1.b.)

b. Superior/Subordinate Relationships. Counselors do not accept as clients superiors or subordinates with whom they have administrative, supervisory, or evaluative relationships.

A.7. Sexual Intimacies With Clients

a. Current Clients. Counselors do not have any type of sexual intimacies with clients and do not counsel persons with whom they have had a sexual relationship.

b. Former Clients. Counselors do not engage in sexual intimacies with former clients within a minimum of 2 years after terminating the counseling relationship. Counselors who engage in such relationship after 2 years following termination have the responsibility to examine and document thoroughly that such relations did not have an exploitative nature, based on factors such as duration of counseling, amount of time since counseling, termination circumstances, client+s personal history and mental status, adverse impact on the client, and actions by the counselor suggesting a plan to initiate a sexual relationship with the client after termination.

A.8. Multiple Clients

When counselors agree to provide counseling services to two or more persons who have a relationship

(such as husband and wife, or parents and children), counselors clarify at the outset which person or persons are clients and the nature of the relationships they will have with each involved person. If it becomes apparent that counselors may be called upon to perform potentially conflicting roles, they clarify, adjust, or withdraw from roles appropriately. (See B.2. and B.4.d.)

A.9. Group Work

a. Screening. Counselors screen prospective group counseling/therapy participants. To the extent possible, counselors select members whose needs and goals are compatible with goals of the group, who will not impede the group process, and whose well-being will not be jeopardized by the group experience.

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

A.10. Fees and Bartering (See D.3.a. and D.3.b.)

a. Advance Understanding. Counselors clearly explain to clients, prior to entering the counseling relationship, all financial arrangements related to professional services including the use of collection agencies or legal measures for nonpayment. (A.11.c.)

b. Establishing Fees. In establishing fees for professional counseling services, counselors consider the financial status of clients and locality. In the event that the established fee structure is inappropriate for a client, assistance is provided in attempting to find comparable services of acceptable cost. (See A.10.d., D.3.a., and D.3.b.)

c. Bartering Discouraged. Counselors ordinarily refrain from accepting goods or services from clients in return for counseling services because such arrangements create inherent potential for conflicts, exploitation, and distortion of the professional relationship. Counselors may participate in bartering only if the relationship is not exploitative, if the client requests it, if a clear written contract is established, and if such arrangements are an accepted practice among professionals in the community. (See A.6.a.)

d. Pro Bono Service. Counselors contribute to society by devoting a portion of their professional activity to services for which there is little or no financial return (pro bono).

A.11. Termination and Referral

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

b. Inability to Assist Clients. If counselors determine an inability to be of professional assistance to clients, they avoid entering or immediately terminate a counseling relationship. Counselors are knowledgeable about referral resources and suggest appropriate alternatives. If clients decline the suggested referral, counselors should discontinue the relationship.

c. Appropriate Termination. Counselors terminate a counseling relationship, securing client agreement when possible, when it is reasonably clear that the client is no longer benefiting, when services are no longer required, when counseling no longer serves the client+s needs or interests, when clients do not pay fees charged, or when agency or institution limits do not allow provision of further counseling services. (See A.10.b. and C.2.g.)

A.12. Computer Technology

a. Use of Computers. When computer applications are used in counseling services, counselors ensure that (1) the client is intellectually, emotionally, and physically capable of using the computer application; (2) the computer application is appropriate for the needs of the client; (3) the client understands the purpose and operation of the computer applications; and (4) a follow-up of client use of a computer application is provided to correct possible misconceptions, discover inappropriate use, and assess subsequent needs.

b. Explanation of Limitations. Counselors ensure that clients are provided information as a part

of the counseling relationship that adequately explains the limitations of computer technology.

c. Access to Computer Applications. Counselors provide for equal access to computer applications in counseling services. (See A.2.a.)

Section B: Confidentiality

B.1. Right to Privacy

a. Respect for Privacy. Counselors respect their clients right to privacy and avoid illegal and unwarranted disclosures of confidential information. (See A.3.a. and B.6.a.)

b. Client Waiver. The right to privacy may be waived by the client or his or her legally recognized representative.

c. Exceptions. The general requirement that counselors keep information confidential does not apply when disclosure is required to prevent clear and imminent danger to the client or others or when legal requirements demand that confidential information be revealed. Counselors consult with other professionals when in doubt as to the validity of an exception.

d. Contagious, Fatal Diseases. A counselor who receives information confirming that a client has a disease commonly known to be both communicable and fatal is justified in disclosing information to an identifiable third party, who by his or her relationship with the client is at a high risk of contracting the disease. Prior to making a disclosure the counselor should ascertain that the client has not already informed the third party about his or her disease and that the client is not intending to inform the third party in the immediate future. (See B.1.c and B.1.f.)

e. Court-Ordered Disclosure. When court ordered to release confidential information without a client+s permission, counselors request to the court that the disclosure not be required due to potential harm to the client or counseling relationship. (See B.1.c.)

f. Minimal Disclosure. When circumstances require the disclosure of confidential information, only essential information is revealed. To the extent possible, clients are informed before confidential information is disclosed.

g. Explanation of Limitations. When counseling is initiated and throughout the counseling process as necessary, counselors inform clients of the limitations of confidentiality and identify foreseeable situations in which confidentiality must be breached. (See G.2.a.)

h. Subordinates. Counselors make every effort to ensure that privacy and confidentiality of clients are maintained by subordinates including employees, supervisees, clerical assistants, and volunteers. (See B.1.a.)

i. Treatment Teams. If client treatment will involve a continued review by a treatment team, the client will be informed of the team+s existence and composition.

B.2. Groups and Families

a. Group Work. In group work, counselors clearly define confidentiality and the parameters for the specific group being entered, explain its importance, and discuss the difficulties related to confidentiality involved in group work. The fact that confidentiality cannot be guaranteed is clearly communicated to group members.

b. Family Counseling. In family counseling, information about one family member cannot be disclosed to another member without permission. Counselors protect the privacy rights of each family member. (See A.8., B.3., and B.4.d.) B.3. Minor or Incompetent Clients When counseling clients who are minors or individuals who are unable to give voluntary, informed consent, parents or guardians may be included in the counseling process as appropriate. Counselors act in the best interests of clients and take measures to safeguard confidentiality. (See A.3.c.)

B.4. Records

a. Requirement of Records. Counselors maintain records necessary for rendering professional services to their clients and as required by laws, regulations, or agency or institution procedures.

b. Confidentiality of Records. Counselors are responsible for securing the safety and confidentiality of any counseling records they create, maintain, transfer, or destroy whether the records are written, taped, computerized, or stored in any other medium. (See B.1.a.)

c. Permission to Record or Observe. Counselors obtain permission from clients prior to electronically recording or observing sessions. (See A.3.a.)

d. Client Access. Counselors recognize that counseling records are kept for the benefit of clients, and therefore provide access to records and copies of records when requested by competent clients, unless the records contain information that may be misleading and detrimental to the client. In situations involving multiple clients, access to records is limited to those parts of records that do not include confidential information related to another client. (See A.8., B.1.a., and B.2.b.)

e. Disclosure or Transfer. Counselors obtain written permission from clients to disclose or transfer records to legitimate third parties unless exceptions to confidentiality exist as listed in Section B.1. Steps are taken to ensure that receivers of counseling records are sensitive to their confidential nature.

B.5. Research and Training

a. Data Disguise Required. Use of data derived from counseling relationships for purposes of training, research, or publication is confined to content that is disguised to ensure the anonymity of the individuals involved. (See G.3.d.)

b. Agreement for Identification. Identification of a client in a presentation or publication is permissible only when the client has reviewed the material and has agreed to its presentation or publication. (See G.3.d.)

B.6. Consultation

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

b. Cooperating Agencies. Before sharing information, counselors make efforts to ensure that there are defined policies in other agencies serving the counselor+s clients that effectively protect the confidentiality of information.

Section C: Professional Responsibility

C.1. Standards Knowledge

Counselors have a responsibility to read, understand, and follow the Code of Ethics and the Standards of Practice.

C.2. Professional Competence

a. Boundaries of Competence. Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Counselors will demonstrate a commitment to gain knowledge, personal awareness, sensitivity, and skills pertinent to working with a diverse client population.

b. New Specialty Areas of Practice. Counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience. While developing skills

in new specialty areas, counselors take steps to ensure the competence of their work and to protect others from possible harm.

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

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

e. Ethical Issues Consultation. Counselors take reasonable steps to consult with other counselors or related professionals when they have questions regarding their ethical obligations or professional practice. (See H.1.)

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

g. Impairment. Counselors refrain from offering or accepting professional services when their physical, mental, or emotional problems are likely to harm a client or others. They are alert to the signs of impairment, seek assistance for problems, and, if necessary, limit, suspend, or terminate their professional responsibilities. (See A.11.c.)

C.3. Advertising and Soliciting Clients

a. Accurate Advertising. There are no restrictions on advertising by counselors except those that can be specifically justified to protect the public from deceptive practices. Counselors advertise or represent their services to the public by identifying their credentials in an accurate manner that is not false, misleading, deceptive, or fraudulent. Counselors may only advertise the highest degree earned which is in counseling or a closely related field from a college or university that was accredited when the degree was awarded by one of the regional accrediting bodies recognized by the Council on Postsecondary Accreditation.

b. Testimonials. Counselors who use testimonials do not solicit them from clients or other persons who, because of their particular circumstances, may be vulnerable to undue influence.

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

d. Recruiting Through Employment. Counselors do not use their places of employment or institutional affiliation to recruit or gain clients, supervisees, or consultees for their private practices. (See C.5.e.)

e. Products and Training Advertisements. Counselors who develop products related to their profession or conduct workshops or training events ensure that the advertisements concerning these products or events are accurate and disclose adequate information for consumers to make informed choices.

f. Promoting to Those Served. Counselors do not use counseling, teaching, training, or supervisory relationships to promote their products or training events in a manner that is deceptive or would exert undue influence on individuals who may be vulnerable. Counselors may adopt textbooks they have authored for instruction purposes.

g. Professional Association Involvement. Counselors actively participate in local, state, and national associations that foster the development and improvement of counseling.

C.4. Credentials

a. Credentials Claimed. Counselors claim or imply only professional credentials possessed and

are responsible for correcting any known misrepresentations of their credentials by others. Professional credentials include graduate degrees in counseling or closely related mental health fields, accreditation of graduate programs, national voluntary certifications, government-issued certifications or licenses, ACA professional membership, or any other credential that might indicate to the public specialized knowledge or expertise in counseling.

b. ACA Professional Membership. ACA professional members may announce to the public their membership status. Regular members may not announce their ACA membership in a manner that might imply they are credentialed counselors.

c. Credential Guidelines. Counselors follow the guidelines for use of credentials that have been established by the entities that issue the credentials.

d. Misrepresentation of Credentials. Counselors do not attribute more to their credentials than the credentials represent, and do not imply that other counselors are not qualified because they do not possess certain credentials.

e. Doctoral Degrees From Other Fields. Counselors who hold a master's degree in counseling or a closely related mental health field, but hold a doctoral degree from other than counseling or a closely related field, do not use the title "Dr." in their practices and do not announce to the public in relation to their practice or status as a counselor that they hold a doctorate.

C.5. Public Responsibility

a. Nondiscrimination. Counselors do not discriminate against clients, students, or supervisees in a manner that has a negative impact based on their age, color, culture, disability, ethnic group, gender, race, religion, sexual orientation, or socioeconomic status, or for any other reason. (See A.2.a.)

b. Sexual Harassment. Counselors do not engage in sexual harassment. Sexual harassment is defined as sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with professional activities or roles, and that either (1) is unwelcome, is offensive, or creates a hostile workplace environment, and counselors know or are told this; or (2) is sufficiently severe or intense to be perceived as harassment to a reasonable person in the context. Sexual harassment can consist of a single intense or severe act or multiple persistent or pervasive acts.

c. Reports to Third Parties. Counselors are accurate, honest, and unbiased in reporting their professional activities and judgments to appropriate third parties including courts, health insurance companies, those who are the recipients of evaluation reports, and others. (See B.1.g.)

d. Media Presentations. When counselors provide advice or comment by means of public lectures, demonstrations, radio or television programs, prerecorded tapes, printed articles, mailed material, or other media, they take reasonable precautions to ensure that (1) the statements are based on appropriate professional counseling literature and practice; (2) the statements are otherwise consistent with the Code of Ethics and the Standards of Practice; and (3) the recipients of the information are not encouraged to infer that a professional counseling relationship has been established. (See C.6.b.)

e. Unjustified Gains. Counselors do not use their professional positions to seek or receive unjustified personal gains, sexual favors, unfair advantage, or unearned goods or services. (See C.3.d.)

C.6. Responsibility to Other Professionals

a. Different Approaches. Counselors are respectful of approaches to professional counseling that differ from their own. Counselors know and take into account the traditions and practices of other professional groups with which they work.

b. Personal Public Statements. When making personal statements in a public context, counselors clarify that they are speaking from their personal perspectives and that they are not speaking

on behalf of all counselors or the profession. (See C.5.d.)

c. Clients Served by Others.When counselors learn that their clients are in a professional relationship with another mental health professional, they request release from clients to inform the other professionals and strive to establish positive and collaborative professional relationships. (See A.4.)

Section D: Relationships With Other Professionals

D.1. Relationships With Employers and Employees

a. Role Definition. Counselors define and describe for their employers and employees the parameters and levels of their professional roles.

b. Agreements. Counselors establish working agreements with supervisors, colleagues, and subordinates regarding counseling or clinical relationships, confidentiality, adherence to professional standards, distinction between public and private material, maintenance and dissemination of recorded information, work load, and accountability. Working agreements in each instance are specified and made known to those concerned.

c. Negative Conditions. Counselors alert their employers to conditions that may be potentially disruptive or damaging to the counselor's professional responsibilities or that may limit their effectiveness.

d. Evaluation. Counselors submit regularly to professional review and evaluation by their supervisor or the appropriate representative of the employer.

e. In-Service. Counselors are responsible for in-service development of self and staff.

f. Goals .Counselors inform their staff of goals and programs.

g. Practices. Counselors provide personnel and agency practices that respect and enhance the rights and welfare of each employee and recipient of agency services. Counselors strive to maintain the highest levels of professional services.

h. Personnel Selection and Assignment. Counselors select competent staff and assign responsibilities compatible with their skills and experiences.

i. Discrimination. Counselors, as either employers or employees, do not engage in or condone practices that are inhumane, illegal, or unjustifiable (such as considerations based on age, color, culture, disability, ethnic group, gender, race, religion, sexual orientation, or socioeconomic status) in hiring, promotion, or training. (See A.2.a. and C.5.b.)

j. Professional Conduct. Counselors have a responsibility both to clients and to the agency or institution within which services are performed to maintain high standards of professional conduct.

k. Exploitative Relationships. Counselors do not engage in exploitative relationships with individuals over whom they have supervisory, evaluative, or instructional control or authority.
l. Employer Policies. The acceptance of employment in an agency or institution implies that counselors are in agreement with its general policies and principles. Counselors strive to reach agreement with employers as to acceptable standards of conduct that allow for changes in institutional policy conducive to the growth and development of clients.

D.2. Consultation (See B.6.)

a. Consultation as an Option. Counselors may choose to consult with any other professionally competent persons about their clients. In choosing consultants, counselors avoid placing the consultant in a conflict of interest situation that would preclude the consultant being a proper party to the counselor's efforts to help the client. Should counselors be engaged in a work setting that compromises this consultation standard, they consult with other professionals whenever possible to consider justifiable alternatives.

b. Consultant Competency. Counselors are reasonably certain that they have or the organization represented has the necessary competencies and resources for giving the kind of consulting services needed and that appropriate referral resources are available.

c. Understanding With Clients. When providing consultation, counselors attempt to develop with their clients a clear understanding of problem definition, goals for change, and predicted consequences of interventions selected. d. Consultant Goals. The consulting relationship is one in which client adaptability and growth toward self-direction are consistently encouraged and cultivated. (See A.1.b.)

D.3. Fees for Referral

a. Accepting Fees From Agency Clients. Counselors refuse a private fee or other remuneration for rendering services to persons who are entitled to such services through the counselor's employing agency or institution. The policies of a particular agency may make explicit provisions for agency clients to receive counseling services from members of its staff in private practice. In such instances, the clients must be informed of other options open to them should they seek private counseling services. (See A.10.a., A.11.b., and C.3.d.)

b. Referral Fees. Counselors do not accept a referral fee from other professionals.

D.4. Subcontractor Arrangements

When counselors work as subcontractors for counseling services for a third party, they have a duty to inform clients of the limitations of confidentiality that the organization may place on counselors in providing counseling services to clients. The limits of such confidentiality ordinarily are discussed as part of the intake session. (See B.1.e. and B.1.f.)

Section E: Evaluation, Assessment, and Interpretation

E.1. General

a. Appraisal Techniques. The primary purpose of educational and psychological assessment is to provide measures that are objective and interpretable in either comparative or absolute terms. Counselors recognize the need to interpret the statements in this section as applying tothe whole range of appraisal techniques, including test and nontest data.

b. Client Welfare. Counselors promote the welfare and best interests of the client in the development, publication, and utilization of educational and psychological assessment techniques. They do not misuse assessment results and interpretations and take reasonable steps to prevent others from misusing the information these techniques provide. They respect the client's right to know the results, the interpretations made, and the bases for their conclusions and recommendations.

E.2. Competence to Use and Interpret Tests

a. Limits of Competence. Counselors recognize the limits of their competence and perform only those testing and assessment services for which they have been trained. They are familiar with reliability, validity, related standardization, error of measurement, and proper application of any technique utilized. Counselors using computer-based test interpretations are trained in the construct being measured and the specific instrument being used prior to using this type of computer application. Counselors take reasonable measures to ensure the proper use of psychological assessment techniques by persons under their supervision.

b. Appropriate Use. Counselors are responsible for the appropriate application, scoring, interpretation, and use of assessment instruments, whether they score and interpret such tests themselves or use computerized or other services.

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

d. Accurate Information. Counselors provide accurate information and avoid false claims or misconceptions when making statements about assessment instruments or techniques. Special efforts are made to avoid unwarranted connotations of such terms as IQ and grade equivalent scores. (See C.5.c.)

E.3. Informed Consent

a. Explanation to Clients. Prior to assessment, counselors explain the nature and purposes of assessment and the specific use of results in language the client (or other legally authorized person on behalf of the client) can understand, unless an explicit exception to this right has been agreed upon in advance. Regardless of whether scoring and interpretation are completed by counselors, by assistants, or by computer or other outside services, counselors take reasonable steps to ensure that appropriate explanations are given to the client.

b. Recipients of Results. The examinee's welfare, explicit understanding, and prior agreement determine the recipients of test results. Counselors include accurate and appropriate interpretations with any release of individual or group test results. (See B.1.a. and C.5.c.)

E.4. Release of Information to Competent Professionals

a. Misuse of Results. Counselors do not misuse assessment results, including test results, and interpretations, and take reasonable steps to prevent the misuse of such by others. (See C.5.c.)

b. Release of Raw Data. Counselors ordinarily release data (e.g., protocols, counseling or interview notes, or questionnaires) in which the client is identified only with the consent of the client or the client+s legal representative. Such data are usually released only to persons recognized by counselors as competent to interpret the data. (See B.1.a.)

E.5. Proper Diagnosis of Mental Disorders

a. Proper Diagnosis. Counselors take special care to provide proper diagnosis of mental disorders. Assessment techniques (including personal interview) used to determine client care (e.g., locus of treatment, type of treatment, or recommended follow-up) are carefully selected and appropriately used. (See A.3.a. and C.5.c.)

b. Cultural Sensitivity. Counselors recognize that culture affects the manner in which clients' problems are defined. Clients' socioeconomic and cultural experience is considered when diagnosing mental disorders.

E.6. Test Selection

a. Appropriateness of Instruments. Counselors carefully consider the validity, reliability, psychometric limitations, and appropriateness of instruments when selecting tests for use in a given situation or with a particular client.

b. Culturally Diverse Populations. Counselors are cautious when selecting tests for culturally diverse populations to avoid inappropriateness of testing that may be outside of socialized behavioral or cognitive patterns.

E.7. Conditions of Test Administration

a. Administration Conditions. Counselors administer tests under the same conditions that were established in their standardization. When tests are not administered under standard conditions or when unusual behavior or irregularities occur during the testing session, those conditions are noted in interpretation, and the results may be designated as invalid or of questionable validity.

b. Computer Administration. Counselors are responsible for ensuring that administration programs function properly to provide clients with accurate results when a computer or other electronic methods are used for test administration. (See A.12.b.)

c. Unsupervised Test Taking. Counselors do not permit unsupervised or inadequately supervised use of tests or assessments unless the tests or assessments are designed, intended, and

validated for self-administration and/or scoring.

d. Disclosure of Favorable Conditions. Prior to test administration, conditions that produce most favorable test results are made known to the examinee.

E.8. Diversity in Testing

Counselors are cautious in using assessment techniques, making evaluations, and interpreting the performance of populations not represented in the norm group on which an instrument was standardized. They recognize the effects of age, color, culture, disability, ethnic group, gender, race, religion, sexual orientation, and socioeconomic status on test administration and interpretation and place test results in proper perspective with other relevant factors. (See A.2.a.)

E.9. Test Scoring and Interpretation

a. Reporting Reservations. In reporting assessment results, counselors indicate any reservations that exist regarding validity or reliability because of the circumstances of the assessment or the inappropriateness of the norms for the person tested.

b. Research Instruments. Counselors exercise caution when interpreting the results of research instruments possessing insufficient technical data to support respondent results. The specific purposes for the use of such instruments are stated explicitly to the examinee.

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

E.10. Test Security

Counselors maintain the integrity and security of tests and other assessment techniques consistent with legal and contractual obligations. Counselors do not appropriate, reproduce, or modify published tests or parts thereof without acknowledgment and permission from the publisher.

E.11. Obsolete Tests and Outdated Test Results

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

E.12. Test Construction

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

Section F: Teaching, Training, and Supervision

F.1. Counselor Educators and Trainers

a. Educators as Teachers and Practitioners. Counselors who are responsible for developing, implementing, and supervising educational programs are skilled as teachers and practitioners. They are knowledgeable regarding the ethical, legal, and regulatory aspects of the profession, are skilled in applying that knowledge, and make students and supervisees aware of their responsibilities. Counselors conduct counselor education and training programs in an ethical manner and serve as role models for professional behavior. Counselor educators should make an effort to infuse material related to human diversity into all courses and/or workshops that are designed to promote the development of professional counselors.

b. Relationship Boundaries With Students and Supervisees. Counselors clearly define and maintain ethical, professional, and social relationship boundaries with their students and supervisees. They are aware of the differential in power that exists and the student's or supervisee's possible incomprehension of that power differential. Counselors explain to students and supervisees the potential for the relationship to become exploitive.

c. Sexual Relationships. Counselors do not engage in sexual relationships with students or supervisees and do not subject them to sexual harassment. (See A.6. and C.5.b)

d. Contributions to Research. Counselors give credit to students or supervisees for their contributions to research and scholarly projects. Credit is given through coauthorship, acknowledgment, footnote statement, or other appropriate means, in accordance with such contributions. (See G.4.b. and G.4.c.)

e. Close Relatives. Counselors do not accept close relatives as students or supervisees.

f. Supervision Preparation. Counselors who offer clinical supervision services are adequately prepared in supervision methods and techniques. Counselors who are doctoral students serving as practicum or internship supervisors to master's level students are adequately prepared and supervised by the training program.

g. Responsibility for Services to Clients. Counselors who supervise the counseling services of others take reasonable measures to ensure that counseling services provided to clients are professional.

h. Endorsement. Counselors do not endorse students or supervisees for certification, licensure, employment, or completion of an academic or training program if they believe students or supervisees are not qualified for the endorsement. Counselors take reasonable steps to assist students or supervisees who are not qualified for endorsement to become qualified.

F.2. Counselor Education and Training Programs

a. Orientation. Prior to admission, counselors orient prospective students to the counselor education or training program+s expectations, including but not limited to the following: (1) the type and level of skill acquisition required for successful completion of the training, (2) subject matter to be covered, (3) basis for evaluation, (4) training components that encourage self-growth or self-disclosure as part of the training process, (5) the type of supervision settings and requirements of the sites for required clinical field experiences, (6) student and supervisee evaluation and dismissal policies and procedures, and (7) up-to-date employment prospects for graduates.

b. Integration of Study and Practice. Counselors establish counselor education and training programs that integrate academic study and supervised practice.

c. Evaluation. Counselors clearly state to students and supervisees, in advance of training, the levels of competency expected, appraisal methods, and timing of evaluations for both didactic and experiential components. Counselors provide students and supervisees with periodic performance appraisal and evaluation feedback throughout the training program.

d. Teaching Ethics. Counselors make students and supervisees aware of the ethical responsibilities and standards of the profession and the students+ and supervisees' ethical responsibilities to the profession. (See C.1. and F.3.e.)

e. Peer Relationships. When students or supervisees are assigned to lead counseling groups or provide clinical supervision for their peers, counselors take steps to ensure that students and supervisees placed in these roles do not have personal or adverse relationships with peers and that they understand they have the same ethical obligations as counselor educators, trainers, and supervisors. Counselors make every effort to ensure that the rights of peers are not compromised when students or supervisees are assigned to lead counseling groups or provide clinical supervision.

f. Varied Theoretical Positions. Counselors present varied theoretical positions so that students and supervisees may make comparisons and have opportunities to develop their own positions. Counselors provide information concerning the scientific bases of professional practice. (See C.6.a.)

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

h. Dual Relationships as Supervisors. Counselors avoid dual relationships such as performing the role of site supervisor and training program supervisor in the student's or supervisee's training program. Counselors do not accept any form of professional services, fees, commissions, reimbursement, or remuneration from a site for student or supervisee placement.

i. Diversity in Programs. Counselors are responsive to their institution's and program's recruitment and retention needs for training program administrators, faculty, and students with diverse backgrounds and special needs. (See A.2.a.)

F.3. Students and Supervisees

a. Limitations. Counselors, through ongoing evaluation and appraisal, are aware of the academic and personal limitations of students and supervisees that might impede performance. Counselors assist students and supervisees in securing remedial assistance when needed, and dismiss from the training program supervisees who are unable to provide competent service due to academic or personal limitations. Counselors seek professional consultation and document their decision to dismiss or refer students or supervisees for assistance. Counselors ensure that students and supervisees have recourse to address decisions made to require them to seek assistance or to dismiss them.

b. Self-Growth Experiences. Counselors use professional judgment when designing training experiences conducted by the counselors themselves that require student and supervisee self-growth or self-disclosure. Safeguards are provided so that students and supervisees are aware of the ramifications their self-disclosure may have on counselors whose primary role as teacher, trainer, or supervisor requires acting on ethical obligations to the profession. Evaluative components of experiential training experiences explicitly delineate predetermined academic standards that are separate and do not depend on the student's level of self-disclosure. (See A.6.)

c. Counseling for Students and Supervisees. If students or supervisees request counseling, supervisors or counselor educators provide them with acceptable referrals. Supervisors or counselor educators do not serve as counselor to students or supervisees over whom they hold administrative, teaching, or evaluative roles unless this is a brief role associated with a training experience. (See A.6.b.)

d. Clients of Students and Supervisees. Counselors make every effort to ensure that the clients at field placements are aware of the services rendered and the qualifications of the students and supervisees rendering those services. Clients receive professional disclosure information and are informed of the limits of confidentiality. Client permission is obtained in order for the students and supervisees to use any information

concerning the counseling relationship in the training process. (See B.1.e.)

e. Standards for Students and Supervisees. Students and supervisees preparing to become counselors adhere to the Code of Ethics and the Standards of Practice. Students and supervisees have the same obligations to clients as those required of counselors. (See H.1.)

Section G: Research and Publication

G.1. Research Responsibilities

a. Use of Human Subjects. Counselors plan, design, conduct, and report research in a manner consistent with pertinent ethical principles, federal and state laws, host institutional regulations, and scientific standards governing research with human subjects. Counselors design and conduct research that reflects cultural sensitivity appropriateness.

b. Deviation From Standard Practices. Counselors seek consultation and observe stringent safeguards to protect the rights of research participants when a research problem suggests a deviation from standard acceptable practices. (See B.6.)

c. Precautions to Avoid Injury. Counselors who conduct research with human subjects are

responsible for the subjects' welfare throughout the experiment and take reasonable precautions to avoid causing injurious psychological, physical, or social effects to their subjects.
d. Principal Researcher Responsibility. The ultimate responsibility for ethical research practice lies with the principal researcher. All others involved in the research activities share ethical obligations and full responsibility for their own actions.
e. Minimal Interference. Counselors take reasonable precautions to avoid causing disruptions in subjects' lives due to participation in research. f. Diversity. Counselors are sensitive to diversity and research issues with special populations. They seek consultation when appropriate. (See A.2.a. and B.6.)

G.2. Informed Consent

a. Topics Disclosed. In obtaining informed consent for research, counselors use language that is understandable to research participants and that (1) accurately explains the purpose and procedures to be followed; (2) identifies any procedures that are experimental or relatively untried; (3) describes the attendant discomforts and risks; (4) describes the benefits or changes in individuals or organizations that might be reasonably expected; (5) discloses appropriate alternative procedures that would be advantageous for subjects; (6) offers to answer any inquiries concerning the procedures; (7) describes any limitations on confidentiality; and (8) instructs that subjects are free to withdraw their consent and to discontinue participation in the project at any time. (See B.1.f.)

b. Deception. Counselors do not conduct research involving deception unless alternative procedures are not feasible and the prospective value of the research justifies the deception. When the methodological requirements of a study necessitate concealment or deception, the investigator is required to explain clearly the reasons for this action as soon as possible.

c. Voluntary Participation. Participation in research is typically voluntary and without any penalty for refusal to participate. Involuntary participation is appropriate only when it can be demonstrated that participation will have no harmful effects on subjects and is essential to the investigation.

d. Confidentiality of Information. Information obtained about research participants during the course of an investigation is confidential. When the possibility exists that others may obtain access to such information, ethical research practice requires that the possibility, together with the plans for protecting confidentiality, be explained to participants as a part of the procedure for obtaining informed consent. (See B.1.e.)

e. Persons Incapable of Giving Informed Consent. When a person is incapable of giving informed consent, counselors provide an appropriate explanation, obtain agreement for participation, and obtain appropriate consent from a legally authorized person.

f. Commitments to Participants. Counselors take reasonable measures to honor all commitments to research participants.

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

h. Agreements to Cooperate. Counselors who agree to cooperate with another individual in research or publication incur an obligation to cooperate as promised in terms of punctuality of performance and with regard to the completeness and accuracy of the information required.

i. Informed Consent for Sponsors. In the pursuit of research, counselors give sponsors, institutions, and publication channels the same respect and opportunity for giving informed consent that they accord to individual research participants. Counselors are aware of their obligation to future research workers and ensure that host institutions are given feedback information and proper acknowledgment.

G.3. Reporting Results

a. Information Affecting Outcome. When reporting research results, counselors explicitly mention all variables and conditions known to the investigator that may have affected the outcome of a study or the interpretation of data.

b. Accurate Results. Counselors plan, conduct, and report research accurately and in a manner that minimizes the possibility that results will be misleading. They provide thorough discussions of the limitations of their data and alternative hypotheses. Counselors do not engage in fraudulent research, distort data, misrepresent data, or deliberately bias their results.

c. Obligation to Report Unfavorable Results. Counselors communicate to other counselors the results of any research judged to be of professional value. Results that reflect unfavorably on institutions, programs, services, prevailing opinions, or vested interests are not withheld.

d. Identity of Subjects. Counselors who supply data, aid in the research of another person, report research results, or make original data available take due care to disguise the identity of respective subjects in the absence of specific authorization from the subjects to do otherwise. (See B.1.g. and B.5.a.)

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

G.4. Publication

a. Recognition of Others. When conducting and reporting research, counselors are familiar with and give recognition to previous work on the topic, observe copyright laws, and give full credit to those to whom credit is due. (See F.1.d. and G.4.c.)

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

c. Student Research. For an article that is substantially based on a student+s dissertation or thesis, the student is listed as the principal author. (See F.1.d. and G.4.a.)
d. Duplicate Submission. Counselors submit manuscripts for consideration to only one journal at a time. Manuscripts that are published in whole or in substantial part in another journal or published work are not submitted for publication without acknowledgment and permission from the previous publication.

e. Professional Review. Counselors who review material submitted for publication, research, or other scholarly purposes respect the confidentiality and proprietary rights of those who submitted it.

Section H: Resolving Ethical Issues

H.1. Knowledge of Standards

Counselors are familiar with the Code of Ethics and the Standards of Practice and other applicable ethics codes from other professional organizations of which they are member, or from certification and licensure bodies. Lack of knowledge or misunderstanding of an ethical responsibility is not a defense against a charge of unethical conduct. (See F.3.e.)

H.2. Suspected Violations

a. Ethical Behavior Expected. Counselors expect professional associates to adhere to the Code of Ethics. When counselors possess reasonable cause that raises doubts as to whether a counselor is acting in an ethical manner, they take appropriate action. (See H.2.d. and H.2.e.)

b. Consultation. When uncertain as to whether a particular situation or course of action may be in violation of the Code of Ethics, counselors consult with other counselors who are

knowledgeable about ethics, with colleagues, or with appropriate authorities.

c. Organization Conflicts. If the demands of an organization with which counselors are affiliated pose a conflict with the Code of Ethics, counselors specify the nature of such conflicts and express to their supervisors or other responsible officials their commitment to the Code of Ethics. When possible, counselors work toward change within the organization to allow full adherence to the Code of Ethics.

d. Informal Resolution. When counselors have reasonable cause to believe that another counselor is violating an ethical standard, they attempt to first resolve the issue informally with the other counselor if feasible, providing that such action does not violate confidentiality rights that may be involved.

e. Reporting Suspected Violations. When an informal resolution is not appropriate or feasible, counselors, upon reasonable cause, take action such as reporting the suspected ethical violation to state or national ethics committees, unless this action conflicts with confidentiality rights that cannot be resolved.

f. Unwarranted Complaints. Counselors do not initiate, participate in, or encourage the filing of ethics complaints that are unwarranted or intend to harm a counselor rather than to protect clients or the public.

H.3. Cooperation With Ethics Committees

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

Standards of Practice

All members of the American Counseling Association (ACA) are required to adhere to the Standards of Practice and the Code of Ethics. The Standards of Practice represent minimal behavioral statements of the Code of Ethics. Members should refer to the applicable section of the Code of Ethics for further interpretation and amplification of the applicable Standard of Practice.

Section A: The Counseling Relationship

- Standard of Practice One (SP-1): Nondiscrimination. Counselors respect diversity and must not discriminate against clients because of age, color, culture, disability, ethnic group, gender, race, religion, sexual orientation, marital status, or socioeconomic status. (See A.2.a.)

- Standard of Practice Two (SP-2): Disclosure to Clients. Counselors must adequately inform clients, preferably in writing, regarding the counseling process and counseling relationship at or before the time it begins and throughout the relationship. (See A.3.a.)

- Standard of Practice Three (SP-3): Dual Relationships. Counselors must make every effort to avoid dual relationships with clients that could impair their professional judgment or increase the risk of harm to clients. When a dual relationship cannot be avoided, counselors must take appropriate steps to ensure that judgment is not impaired and that no exploitation occurs. (See A.6.a. and A.6.b.)

- Standard of Practice Four (SP-4): Sexual Intimacies With Clients. Counselors must not engage in any type of sexual intimacies with current clients and must not engage in sexual intimacies with former clients within a minimum of 2 years after terminating the counseling relationship. Counselors who engage in such relationship after 2 years following termination have the responsibility to examine and document thoroughly that such relations did not have an exploitative nature.

- Standard of Practice Five (SP-5): Protecting Clients During Group Work. Counselors must take steps to protect

clients from physical or psychological trauma resulting from interactions during group work. (See A.9.b.)

- Standard of Practice Six (SP-6): Advance Understanding of Fees. Counselors must explain to clients, prior to their entering the counseling relationship, financial arrangements related to professional services. (See A.10. a.-d. and A.11.c.)

- Standard of Practice Seven (SP-7): Termination. Counselors must assist in making appropriate arrangements for the continuation of treatment of clients, when necessary, following termination of counseling relationships. (See A.11.a.)

- Standard of Practice Eight (SP-8): Inability to Assist Clients. Counselors must avoid entering or immediately terminate a counseling relationship if it is determined that they are unable to be of professional assistance to a client. The counselor may assist in making an appropriate referral for the client. (See A.11.b.)

Section B: Confidentiality

- Standard of Practice Nine (SP-9): Confidentiality Requirement. Counselors must keep information related to counseling services confidential unless disclosure is in the best interest of clients, is required for the welfare of others, or is required by law. When disclosure is required, only information that is essential is revealed and the client is informed of such disclosure. (See B.1. a.+f.)

- Standard of Practice Ten (SP-10): Confidentiality Requirements for Subordinates. Counselors must take measures to ensure that privacy and confidentiality of clients are maintained by subordinates. (See B.1.h.)

- Standard of Practice Eleven (SP-11): Confidentiality in Group Work. Counselors must clearly communicate to group members that confidentiality cannot be guaranteed in group work. (See B.2.a.)

- Standard of Practice Twelve (SP-12): Confidentiality in Family Counseling. Counselors must not disclose information about one family member in counseling to another family member without prior consent. (See B.2.b.)

- Standard of Practice Thirteen (SP-13): Confidentiality of Records. Counselors must maintain appropriate confidentiality in creating, storing, accessing, transferring, and disposing of counseling records. (See B.4.b.)

- Standard of Practice Fourteen (SP-14): Permission to Record or Observe. Counselors must obtain prior consent from clients in order to record electronically or observe sessions. (See B.4.c.)

- Standard of Practice Fifteen (SP-15): Disclosure or Transfer of Records. Counselors must obtain client consent to disclose or transfer records to third parties, unless exceptions listed in SP-9 exist. (See B.4.e.)

- Standard of Practice Sixteen (SP-16): Data Disguise Required. Counselors must disguise the identity of the client when using data for training, research, or publication. (See B.5.a.) Section C: Professional Responsibility

- Standard of Practice Seventeen (SP-17): Boundaries of Competence. Counselors must practice only within the boundaries of their competence. (See C.2.a.)

- Standard of Practice Eighteen (SP-18): Continuing Education. Counselors must engage in continuing education to maintain their professional competence. (See C.2.f.)

- Standard of Practice Nineteen (SP-19): Impairment of Professionals. Counselors must refrain from offering professional services when their personal problems or conflicts may cause harm to a client or others. (See C.2.g.)

- Standard of Practice Twenty (SP-20): Accurate Advertising. Counselors must accurately represent their

credentials and services when advertising. (See C.3.a.)

- Standard of Practice Twenty-One (SP-21): Recruiting Through Employment. Counselors must not use their place of employment or institutional affiliation to recruit clients for their private practices. (See C.3.d.)

- Standard of Practice Twenty-Two (SP-22): Credentials Claimed. Counselors must claim or imply only professional credentials possessed and must correct any known misrepresentations of their credentials by others. (See C.4.a.)
- Standard of Practice Twenty-Three (SP-23): Sexual Harassment. Counselors must not engage in sexual harassment. (See C.5.b.)

- Standard of Practice Twenty-Four (SP-24): Unjustified Gains. Counselors must not use their professional positions to seek or receive unjustified personal gains, sexual favors, unfair advantage, or unearned goods or services. (See C.5.e.)

- Standard of Practice Twenty-Five (SP-25): Clients Served by Others. With the consent of the client, counselors must inform other mental health professionals serving the same client that a counseling relationship between the counselor and client exists. (See C.6.c.)

- Standard of Practice Twenty-Six (SP-26): Negative Employment Conditions. Counselors must alert their employers to institutional policy or conditions that may be potentially disruptive or damaging to the counselor+s professional responsibilities, or that may limit their effectiveness or deny clients' rights. (See D.1.c.)

- Standard of Practice Twenty-Seven (SP-27): Personnel Selection and Assignment. Counselors must select competent staff and must assign responsibilities compatible with staff skills and experiences. (See D.1.h.)

- Standard of Practice Twenty-Eight (SP-28): Exploitative Relationships With Subordinates. Counselors must not engage in exploitative relationships with individuals over whom they have supervisory, evaluative, or instructional control or authority. (See D.1.k.) S

Section D: Relationship With Other Professionals

- Standard of Practice Twenty-Nine (SP-29): Accepting Fees From Agency Clients. Counselors must not accept fees or other remuneration for consultation with persons entitled to such services through the counselor+s employing agency or institution. (See D.3.a.)

- Standard of Practice Thirty (SP-30): Referral Fees. Counselors must not accept referral fees. (See D.3.b.)

Section E: Evaluation, Assessment and Interpretation

- Standard of Practice Thirty-One (SP-31): Limits of Competence. Counselors must perform only testing and assessment services for which they are competent. Counselors must not allow the use of psychological assessment techniques by unqualified persons under their supervision. (See E.2.a.)

- Standard of Practice Thirty-Two (SP-32): Appropriate Use of Assessment Instruments. Counselors must use assessment instruments in the manner for which they were intended. (See E.2.b.)

- Standard of Practice Thirty-Three (SP-33): Assessment Explanations to Clients. Counselors must provide explanations to clients prior to assessment about the nature and purposes of assessment and the specific uses of results. (See E.3.a.)

- Standard of Practice Thirty-Four (SP-34): Recipients of Test Results. Counselors must ensure that accurate and appropriate interpretations accompany any release of testing and assessment information. (See E.3.b.)

- Standard of Practice Thirty-Five (SP-35): Obsolete Tests and Outdated Test Results. Counselors must not base their assessment or intervention decisions or recommendations on data or test results that are obsolete or outdated for the current purpose. (See E.11.)

Section F: Teaching, Training, and Supervision

- Standard of Practice Thirty-Six (SP-36): Sexual Relationships With Students or Supervisees. Counselors must not engage in sexual relationships with their students and supervisees. (See F.1.c.)
- Standard of Practice Thirty-Seven (SP-37): Credit for Contributions to Research. Counselors must give credit to students or supervisees for their contributions to research and scholarly projects. (See F.1.d.)
- Standard of Practice Thirty-Eight (SP-38): Supervision Preparation. Counselors who offer clinical supervision services must be trained and prepared in supervision methods and techniques. (See F.1.f.)
- Standard of Practice Thirty-Nine (SP-39): Evaluation Information. Counselors must clearly state to students and supervisees in advance of training the levels of competency expected, appraisal methods, and timing of evaluations. Counselors must provide students and supervisees with periodic performance appraisal and evaluation feedback throughout the training program. (See F.2.c.)
- Standard of Practice Forty (SP-40): Peer Relationships in Training. Counselors must make every effort to ensure that the rights of peers are not violated when students and supervisees are assigned to lead counseling groups or provide clinical supervision. (See F.2.e.)
- Standard of Practice Forty-One (SP-41): Limitations of Students and Supervisees. Counselors must assist students and supervisees in securing remedial assistance, when needed, and must dismiss from the training program students and supervisees who are unable to provide competent service due to academic or personal limitations. (See F.3.a.)
- Standard of Practice Forty-Two (SP-42): Self-Growth Experiences. Counselors who conduct experiences for students or supervisees that include self-growth or self-disclosure must inform participants of counselors+ ethical obligations to the profession and must not grade participants based on their nonacademic performance. (See F.3.b.)
- Standard of Practice Forty-Three (SP-43): Standards for Students and Supervisees. Students and supervisees preparing to become counselors must adhere to the Code of Ethics and the Standards of Practice of counselors. (See F.3.e.)

Section G: Research and Publication

- Standard of Practice Forty-Four (SP-44): Precautions to Avoid Injury in Research. Counselors must avoid causing physical, social, or psychological harm or injury to subjects in research. (See G.1.c.)
- Standard of Practice Forty-Five (SP-45): Confidentiality of Research Information. Counselors must keep confidential information obtained about research participants. (See G.2.d.)
- Standard of Practice Forty-Six (SP-46): Information Affecting Research Outcome. Counselors must report all variables and conditions known to the investigator that may have affected research data or outcomes. (See G.3.a.)
- Standard of Practice Forty-Seven (SP-47): Accurate Research Results. Counselors must not distort or misrepresent research data, nor fabricate or intentionally bias research results. (See G.3.b.)
- Standard of Practice Forty-Eight (SP-48): Publication Contributors. Counselors must give appropriate credit to those who have contributed to research. (See G.4.a. and G.4.b.)

Section H: Resolving Ethical Issues

- Standard of Practice Forty-Nine (SP-49): Ethical Behavior Expected. Counselors must take appropriate action when they possess reasonable cause that raises doubts as to whether counselors or other mental health professionals are acting in an ethical manner. (See H.2.a.)
- Standard of Practice Fifty (SP-50): Unwarranted Complaints. Counselors must not initiate, participate in, or encourage the filing of ethics complaints that are unwarranted or intended to harm a mental health professional rather than to protect clients or the public. (See H.2.f.)
- Standard of Practice Fifty-One (SP-51): Cooperation With Ethics Committees. Counselors must cooperate with investigations, proceedings, and requirements of the ACA Ethics Committee or ethics committees of other duly constituted associations or boards having jurisdiction over those charged with a violation. (See H.3.)

References

The following documents are available to counselors as resources to guide them in their practices. These resources are not a part of the Code of Ethics and the Standards of Practice.

- American Association for Counseling and Development/Association for Measurement and Evaluation in Counseling and Development. (1989). The responsibilities of users of standardized tests (rev.). Washington, DC: Author.
- American Counseling Association. (1988). Ethical standards. Alexandria, VA: Author.
- American Psychological Association. (1985). Standards for educational and psychological testing (rev.). Washington, DC: Author.
- American Rehabilitation Counseling Association, Commission on Rehabilitation Counselor Certification, and National Rehabilitation Counseling Association. (1995). Code of professional ethics for rehabilitation counselors. Chicago, IL: Author.
- American School Counselor Association. (1992). Ethical standards for school counselors. Alexandria, VA: Author.
- Joint Committee on Testing Practices. (1988). Code of fair testing practices in education. Washington, DC: Author.
- National Board for Certified Counselors. (1989). National Board for Certified Counselors code of ethics. Alexandria, VA: Author.
- Prediger, D. J. (Ed.). (1993, March). Multicultural assessment standards. Alexandria, VA: Association for Assessment in Counseling.

Procedures For Handling Complaints

RESOLVING ETHICAL ISSUES

Familiarity With Ethics Code.

Psychologists have an obligation to be familiar with this Ethics Code, other applicable ethics codes, and their application to psychologists' work. Lack of awareness or misunderstanding of an ethical standard is not itself a defense to a charge of unethical conduct.

Confronting Ethical Issues.

When a psychologist is uncertain whether a particular situation or course of action would violate this Ethics Code, the psychologist ordinarily consults with other psychologists knowledgeable about ethical issues, with state or national psychology ethics committees, or with other appropriate authorities in order to choose a proper response.

Conflicts Between Ethics and Organizational Demands.

If the demands of an organization with which psychologists are affiliated conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and to the extent feasible, seek to resolve the conflict in a way that permits the fullest adherence to the Ethics Code.

Informal Resolution of Ethical Violations.

When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual if an in- formal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved.

Reporting Ethical Violations.

If an apparent ethical violation is not appropriate for informal resolution under Standard 8.04 or is not resolved properly in that fashion, psychologists take further action appropriate to the situation, unless such action conflicts with confidentiality rights in ways that cannot be resolved. Such action might

include referral to state or national committees on professional ethics or to state licensing boards.

Cooperating With Ethics Committees.

Psychologists cooperate in ethics investigations, proceedings, and resulting requirements of the APA or any affiliated state psychological association to which they belong. In doing so, they make reasonable efforts to resolve any issues as to confidentiality. Failure to cooperate is itself an ethics violation.

Improper Complaints.

Psychologists do not file or encourage the filing of ethics complaints that are frivolous and are intended to harm the respondent rather than to protect the public.

COUNSELING LABORATORY

Frequently Used Referral Resources

ALCOHOLICS ANONYMOUS

CAREER DEVELOPMENT CENTER

COUNSELING CENTER, JSU

HINDS COUNTY YOUTH COURT

HINDS COUNTY PUBLIC SCHOOL

JPS PUPIL PERSONNEL SERVICES

PSYCHOLOGICAL SERVICES:

HEALTH SERVICES:

SPEECH AND HEARING SERVICES:

ADULT EDUCATION SERVICES:

MISSISSIPPI STATE EMPLOYMENT SERVICE

PSYCHOLOGY CLINIC

READING CENTER-DEPARTMENT OF CURRICULUM AND INSTRUCTION

SPEECH AND HEARING CLINIC

VOCATIONAL REHABILITATION

Child Abuse/Neglect Reporting
MISSISSIPPI CODE OF 1972

As Amended

SEC. 43-21-353. Duty to inform state agencies and officials.

(1) Any attorney, physician, dentist, intern, resident, nurse, psychologist, social worker, child care giver, minister, law enforcement officer, public or private school employee or any other person having reasonable cause to suspect that a child is a neglected child or an abused child, shall cause an oral report to be made immediately by telephone or otherwise and followed as soon thereafter as possible by a report in writing to the Department of Human Services, and immediately a referral shall be made by the Department of Human Services to the intake unit and where appropriate to the youth court prosecutor. Upon receiving a report that a child has been abused and that the abusive act would be a felony under state law, the Department of Human Services shall promptly notify the law enforcement agency in whose jurisdiction the abuse occurred and shall notify the district attorney's office within seventy-two (72) hours. The law enforcement agency shall investigate the reported abuse immediately and shall file a preliminary report with the district attorney's office within twenty-four (24) hours and shall file a final report with the district attorney's office within seventy-two (72) hours.

(2) Any report to the Department of Human Services shall contain the names and addresses of the child and his parents or other persons responsible for his care, if known, the child's age, the nature and extent of the child's injuries, including any evidence of previous injuries and any other information that might be helpful in establishing the cause of the injury and the identity of the perpetrator.

(3) The Department of Human Services shall maintain a statewide incoming wide area telephone service or similar service for the purpose of receiving reports of suspected cases of child abuse; provided that any attorney, physician, dentist, intern, resident, nurse, psychologist, social worker, child care giver, minister, law enforcement officer or public or private school employee who is required to report under subsection (1) of this section shall report in the manner required in subsection (1).

(4) Reports of abuse and neglect made under this chapter and the identity of the reporter are confidential except when the court in which the investigation report is filed, in its discretion, determines the testimony of the person reporting to be material to a judicial proceeding.

(5) Reports made under subsection (1) of this section by the Department of Human Services to the law enforcement agency and to the district attorney's office shall include the following, if known to the department:

(a) The name and address of the child;

(b) The names and addresses of the parents;

(c) The name and address of the suspected perpetrator;

(d) The names and addresses of all witnesses, including the reporting party if a material witness to the abuse;

(e) A brief statement of the facts indicating that the child has been abused and any other information from the agency files or known to the social worker making the investigation, including medical records or other records, which may assist law enforcement or the district attorney in investigating and/or prosecuting the case; and

(f) What, if any, action is being taken by the Department of Human Services.

(6) In any investigation of a report made under this chapter of the abuse or neglect of a child as defined in Section 43-21-105 (m), the Department of Human Services may request the appropriate law enforcement officer with jurisdiction to accompany the department in its investigation, and in such cases the law enforcement officer shall comply with such request.

(7) Anyone who willfully violates any provision of this section shall be, upon being found guilty, punished by a fine not to exceed Five Thousand Dollars ($5,000.00), or by imprisonment in jail not to exceed one (1) year, or both.

(8) If a report is made directly to the Department of Human Services that a child has been abused or neglected in an out-of-home setting, a referral shall be made immediately to the law enforcement agency in whose jurisdiction the abuse occurred and the department shall notify the district attorney's office within seventy-two (72) hours. The law enforcement agency shall investigate the reported abuse immediately and shall file a preliminary report with the district attorney's office within twenty-four (24) hours and shall file a final report with the district attorney's office within seventy-two (72) hours. If the out-of-home setting is a licensed facility, an additional referral shall be made by the Department of Human Services to the licensing agency.

SOURCES:

Laws, 1979, ch. 506, Sec. 41; 1980, ch. 550, Sec. 17; 1984, ch. 342; 1985, ch. 360; 1993, ch. 522, Sec. 1, eff from and after July 1, 1993. Laws, 1994, ch. 387, Sec. 1; 1994, ch. 591, Sec. 3; 1995, ch. 335, Sec. 1; 1996, ch. 323, Sec. 2, eff from and after July 1, 1996.

1997 Amendment:

SECTION 10. Section 43-21-353, Mississippi Code of 1972, is amended as follows:

(1) Any attorney, physician, dentist, intern, resident, nurse, psychologist, social worker, child care giver, minister, law enforcement officer, public or private school employee or any other person having reasonable cause to suspect that a child is a neglected child or an

abused child, shall cause an oral report to be made immediately by telephone or otherwise and followed as soon thereafter as possible by a report in writing to the Department of Human Services, and immediately a referral shall be made by the Department of Human Services to the youth court intake unit, which unit shall promptly comply with Section 43-21-357. Where appropriate, the Department of Human Services shall additionally make a referral to the youth court prosecutor. Upon receiving a report that a child has been abused and that the abusive act would be a felony under state law, the Department of Human Services shall promptly notify the law enforcement agency in whose jurisdiction the abuse occurred and shall notify the district attorney's office within seventy-two (72) hours. The law enforcement agency shall investigate the reported abuse immediately and shall file a preliminary report with the district attorney's office within twenty-four (24) hours and shall file a final report with the district attorney's office within seventy-two (72) hours.

(2) Any report to the Department of Human Services shall contain the names and addresses of the child and his parents or other persons responsible for his care, if known, the child's age, the nature and extent of the child's injuries, including any evidence of previous injuries and any other information that might be helpful in establishing the cause of the injury and the identity of the perpetrator.

(3) The Department of Human Services shall maintain a statewide incoming wide-area telephone service or similar service for the purpose of receiving reports of suspected cases of child abuse; provided that any attorney, physician, dentist, intern, resident, nurse, psychologist, social worker, child care giver, minister, law enforcement officer or public or private school employee who is required to report under subsection (1) of this section shall report in the manner required in subsection (1).

(4) Reports of abuse and neglect made under this chapter and the identity of the reporter are confidential except when the court in which the investigation report is filed, in its discretion, determines the testimony of the person reporting to be material to a judicial proceeding.

(5) Reports made under subsection (1) of this section by the Department of Human Services to the law enforcement agency and to the district attorney's office shall include the following, if known to the department:

(a) The name and address of the child;

(b) The names and addresses of the parents;

(c) The name and address of the suspected perpetrator;

(d) The names and addresses of all witnesses, including the reporting party if a material witness to the abuse;

(e) A brief statement of the facts indicating that the child has been abused and any other information from the agency files or known to the social worker making the investigation, including medical records or other records, which may assist law

enforcement or the district attorney in investigating and/or prosecuting the case; and

(f) What, if any, action is being taken by the Department of Human Services.

(6) In any investigation of a report made under this chapter of the abuse or neglect of a child as defined in Section 43-21-105(m), the Department of Human Services may request the appropriate law enforcement officer with jurisdiction to accompany the department in its investigation, and in such cases the law enforcement officer shall comply with such request.

(7) Anyone who willfully violates any provision of this section shall be, upon being found guilty, punished by a fine not to exceed Five Thousand Dollars ($5,000.00), or by imprisonment in jail not to exceed one (1) year, or both.

(8) If a report is made directly to the Department of Human Services that a child has been abused or neglected in an out-of-home setting, a referral shall be made immediately to the law enforcement agency in whose jurisdiction the abuse occurred and the department shall notify the district attorney's office within seventy-two (72) hours. The law enforcement agency shall investigate the reported abuse immediately and shall file a preliminary report with the district attorney's office within twenty-four (24) hours and shall file a final report with the district attorney's office within seventy-two (72) hours. If the out-of-home setting is a licensed facility, an additional referral shall be made by the Department of Human Services to the licensing agency.

SOURCE:

1997 Laws, Chapter 440, Sec. 10, SB2510, Effective July 1, 1997.

REPORT OF SUSPECTED ABUSE/NEGLECTED

TO: ____

Name of Local Welfare Department

____

Name of County Youth Court Designee

FROM: ____

Name of Person or Institution Making Report

Case Number: ____

Name of Child: ____

Address *(where child may Be seen)*____

Birthday: ______________________________Age: ____________

Name of Person(s) Responsible for Child's Care: ____________________________

Address: ____

Relationship: ____

Name of Suspected Abuser: ____

Address: ____

Relation *(of suspected abuser)*: ____

The nature and extent of the current injuries or neglect to the child in question. (Please include any evidence of previous violations.

____

____

Comments: ____

____

____

____ ____________

Signature of Person Making Report *Date:*

NOTE: Complete one set. Please respond to each item even if reply is "unknown" or "none".

NOTE: Complete one set. Please respond to each item even if reply is "unknown" or "none".

NOTE: Complete one set. Please respond to each item even if reply is "unknown" or "none".