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2005 ACA Code of Ethics

Ethical Challenges in a Complex World: Highlights of the 2005 ACA Code of Ethics

Michael M. Kocet

Being an effective counselor includes having knowledge of and the ability to integrate a code of ethics into one's professional practice. This article addresses some of the highlights of the changes in the 2005 ACA [American Counseling Association] *Code of Ethics* such as end-of-life issues, boundaries and relationships, and multicultural and diversity considerations. It is critical for counselors to demonstrate cultural sensitivity during the ethical decision-making process throughout their counseling, supervision, teaching, and research practice.

A code of ethics for most professional organizations or associations is designed to articulate the standards of practice for a group of people. It is a way to express the collective values of a profession. A code of ethics "is a living document that can assist with individual ethical quandaries and be broad enough to encompass many divergent ethical situations" (Kocet, 2006, p. 7). There are two central components of a code of ethics for counselors: First, a code outlines the prescribed or mandatory professional behaviors by which counselors are expected to govern their conduct, and second, a code contains aspirational components, which encourage active ethical reflection that fosters clarification of the fundamental ethical beliefs of the profession (Hinman, 2003; Welfel, 2006). No code of ethics can encompass every potential ethical dilemma faced by a professional; however, a code of ethics can serve as a blueprint for laying the foundation necessary to promote the competency and efficacy of counselors.

Last year, the American Counseling Association (ACA) Governing Council approved the adoption of the 2005 ACA *Code of Ethics* (2005 Code). The Code is revised approximately every 7 to 10 years and provides an opportunity for the counseling profession to examine current practices and issues faced by professionals in the roles and settings in which counselors most frequently work (such as mental health agencies, schools, research, clinical practice, supervision, and counselor education). A central focus of the professional code of ethics is to help guide professional practice with clients, students, supervisees, colleagues, and research participants. A code of ethics is designed to protect the well-being of those served by counselors, as well as to advance the work of the profession (Eriksen & Kress, 2005; Kocet, 2005). The purpose of this article is to provide a brief over-

view of the revision process and to highlight some of the differences between the 1995 *Code of Ethics and Standards of Practice* (1995 Code) and the current 2005 Code.

The Revision Process

In early 2002, David Kaplan, then ACA president, created what was to be called the ACA Ethics Code Revision Task Force. The purpose of this task force was twofold: (a) to propose revisions to the 1995 *Code of Ethics and Standards of Practice* and (b) to make recommendations for changes within the 1995 *Code of Ethics* with special (but not exclusive) emphasis on multicultural, diversity, and social justice issues. The following individuals selected to serve on the task force were chosen because of their areas of professional expertise, their scholarship and research, and service to the association: John Bloom, Tammy Bringaze, Rocco Cottone, Harriet Glossoff, Barbara Herlihy, Michael M. Kocet (chair), Courtland Lee, Judy Miranti, E. Christine Moll, and Vilia Tarvydas. In addition, Anna Harpster and Michael Hartley, two doctoral students, served as note-takers and were responsible for taking meeting minutes and recording the main changes made to the document.

The process of revising the 1995 Code took place between 2002 and 2005. Task force members met primarily via monthly telephone conference calls and one face-to-face meeting a year held during the annual ACA convention. Technology (e-mail and an electronic mailing list) played a critical role in enabling the members to accomplish the business of the task force between formal meetings with the entire group. To make the work of the task force proceed efficiently, smaller "working groups" were responsible for reviewing and creating recommendations on one of the eight main sections of the 1995 Code. The

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entire task force would then review the recommendations of each working group and discuss new additions, changes, and deletions for each section and provide input on what the individual working groups created.

During the code revision process, there were various avenues allowing members of the association to provide comments and feedback to the Code Revision Task Force on the new document. A draft *Code of Ethics* was placed in the ACA publication *Counseling Today* as well as on the ACA Web (Kocet, 2004). An online mechanism enabled members to provide their comments in an electronic format that provided feedback to the task force that was organized and easy to review. Leaders in the ACA divisions, state leaders, national counseling experts, as well as legal counsel provided input on relevant sections of the draft. Counselor educators and faculty members used the draft *Code of Ethics* document as an academic assignment for students in ethics courses who reviewed the entire code and critiqued its strengths and limitations. Providing students with an opportunity to give suggestions on the new code of ethics was not only an excellent pedagogical activity, but it also helped students become more knowledgeable about the professional code of ethics and helped them become more invested in the profession by making a significant contribution to this historic document. As Hinman (2003) stated, ethics can be viewed “as an ongoing conversation” (p. 3), and it is incumbent upon counselor educators and those supervising counselors to engage counselors-in-training by helping them become ethically intentional when weighing the cultural complexities inherent in most ethical dilemmas (Frame & Williams, 2005; Kocet, 2005). Scholars in the area of feminist ethics encourage the forming of mutually respectful relationships in the counseling process and seek to recognize the power differential that can exist by handling power in an ethical manner that honors both individuals in the relationship and emphasizes care and concern as a central fixture in the therapeutic process (Eriksen & Kress, 2005; Stocker, 2005; Welfel, 2006). Many of the changes in the 2005 *Code* are designed to integrate this perspective throughout the document, which emphasizes the promotion of growth-fostering relationships.

In addition to receiving electronic feedback, two town hall meetings were held during the 2004 and 2005 ACA national conventions. These were open meetings where members of the association met with members of the Code Revision Task Force and viewed and discussed highlights of the draft document. The feedback provided by members during both town hall meetings was instrumental in making necessary changes to the document. Throughout the process of creating the 2005 *Code*, input was sought on all levels and in a variety of venues.

Various changes were made to the 2005 *Code*; however, it is beyond the scope of this article to present a comprehensive and detailed review. Counselors are encouraged to consult with additional resources that provide a more detailed analysis of the 2005 *Code* (Corey, Corey, & Callanan, 2007;

Herlihy & Corey, 2006; Welfel, 2006). In the following sections, I discuss highlights of some of the major differences in the document.

■ New Features

Numerous features were added to the 2005 *Code*. The first is a section stating the five main purposes of the *Code*: (a) to enable 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; (b) to support the mission of the association; (c) to establish principles that define ethical behavior and best practices; (d) to serve as an ethical guide designed to assist members in constructing a professional course of action that best serves those utilizing counseling services and best promotes the values of the counseling profession; and (e) to serve as the basis for processing of ethical complaints and inquiries initiated against members of the association.

Another new feature is the aspirational introductions that begin each of the main sections of the code. Each of these aspirational introductions helps “set the tone for that particular section and provides a starting point that invites reflection on the ethical mandates contained in each part of the *ACA Code of Ethics*” (ACA, 2005, p. 3). It is crucial to point out that although some ethical issues tend to be more gray and have a wider range of possible avenues to resolve them, others have a clearly prescriptive expectation in the way that the ethical dilemma should be handled. The new introductions acknowledge that reasonable differences of opinion can occur among counseling professionals regarding which values, ethical principles, and ethical standards should be applied when faced with certain situations (Glossoff & Kocet, 2006). The 2005 *Code* calls upon counselors to be “empowered to make decisions that help expand the capacity of people to grow and develop” (p. 3). Practitioners are encouraged to review the ethics literature and to select an ethical decision-making model that best fits their counseling approach and to seek consultation with supervisors and colleagues when faced with an ethical challenge (Frame & Williams, 2005; Glossoff & Kocet, 2006; Herlihy & Corey, 2006; Welfel, 2006). An ethical consult can include (but is not limited to) (a) arranging a face-to-face or telephone meeting with a supervisor or colleague; (b) participating in a workshop or seminar on ethical issues; (c) reading a book, journal, or online article on ethics; or (d) reviewing a case scenario presenting an ethical conundrum.

Two additional features to the new document are a glossary and an index. The glossary provides readers with definitions of basic terminology found within the 2005 *Code*. These definitions are not intended to be viewed as the only way of defining these terms, but the glossary was included to provide readers with a consistent framework for understanding how the terms were being used within the document. An index was also

added to the new *Code* to provide a quick and user-friendly guide for locating specific sections of the document that pertain to a particular ethical situation or academic discussion.

■ Highlights of the 2005 *Code*

The 2005 *Code* consists of the same eight main sections as the 1995 document with some minor changes in the titles: A. The Counseling Relationship; B. Confidentiality, Privileged Communication, and Privacy; C. Professional Responsibility; D. Relationships With Other Professionals; E. Evaluation, Assessment, and Interpretation; F. Supervision, Training, and Teaching; G. Research and Publication; and H. Resolving Ethical Issues.

The “Standards of Practice” found in the 1995 document were removed as a separate section and were instead integrated into the body of the main document. This decision was made to streamline the document and to eliminate the confusion over the role of how to use the Standards of Practice. Although the Standards’ original purpose was to outline the minimum expectations for ethical behavior, the purpose became unclear when it came to the actual implementation of the Standards to direct clinical practice, as well as challenges when trying to use the Standards in adjudications by the ACA Ethics Committee, as well as in personal study and use. Therefore, it was decided early in the current code revision process to incorporate the standards into the body of the *Code of Ethics* itself. Therefore, the 2005 document is simply titled the *ACA Code of Ethics*.

Some key areas new to the 2005 edition are Counseling Plans (A.1.c.), Potentially Beneficial Interactions (A.5.d.), Advocacy (A.6.a), End-of-Life Care for Terminally Ill Clients (A.9.), Technology Applications (A.12.), Deceased Clients (B.3.f.), Counselor Incapacitation or Termination of Practice (C.2.h.), Historical and Social Prejudices in the Diagnosis of Pathology (E.5.c.), Multicultural Issues/Diversity in Assessment (E.8.), Innovative Theories and Techniques (F.6.f.), change from use of the term research *subjects* to *participants* (Section G), Plagiarism (G.5.b.), and Conflicts Between Ethics and Laws (H.1.b.). The 2005 *Code* also infuses multicultural and diversity issues throughout the document.

As previously stated, one of the charges given to the Code Revision Task Force by the ACA Governing Council was that the 1995 *Code* be revised with special (but not exclusive) consideration of cultural and social justice issues faced by counselors in today’s complex world. The following is a brief review of some ways that multicultural and diversity issues are infused in the 2005 *Code*.

■ Multicultural and Diversity Issues

An ethical mandate for counselors is being a culturally competent practitioner, which means demonstrating awareness of diverse cultures (recognizing both our own and others’

cultural identities), acquiring and using knowledge about others’ cultures, and incorporating counseling skills in a culturally respectful manner (Eriksen & Kress, 2005; Frame & Williams, 2005; Welfel, 2006). Throughout the 2005 *Code*, particular attention was paid to ensure that multicultural and diversity issues were incorporated into key aspects of counseling practice. For example, Section A.2.c., Developmental and Cultural Sensitivity, addresses the significance of counselors communicating in a manner that can be understood by clients as developmentally and culturally appropriate (ACA, 2005, p. 4). Section C.5., Non-discrimination, has been expanded to include not only issues identified in the 1995 *Code* (age, culture, disability, ethnicity, race, religion, gender, sexual orientation, and socioeconomic status) but also the concern that discrimination not take place based on other key aspects of a person’s identity such as “spirituality, . . . gender identity, marital status/partnership, language preference, . . . or any basis proscribed by law” (ACA, 2005, p. 10). This section of the code illustrates the profession’s more inclusive way of defining multiculturalism.

Following are a few more examples of ways in which issues of culture, diversity, and social justice are addressed in the new 2005 *Code*. The title of Section A.1.d. was changed from “Family Involvement” to “Support Network Involvement” and revised wording in the section broadens the concept of family to include any person from the perspective of the client who plays a central role in that person’s life. This can include individuals such as a religious or spiritual leader, friends, or family. Another culturally relevant example contained in the 2005 *Code* is the new Standard A.10.e., Receiving Gifts, which states “Counselors understand the challenges of accepting gifts from clients and recognize that in some cultures, small gifts are a token of respect and showing gratitude” (p. 6). According to Glosoff and Kocet (2006), counselors must also be aware of and sensitive to cultural meanings of confidentiality and privacy and how these issues may be viewed differently depending on the cultural worldview of the client (see B.1.a., Multicultural/Diversity Considerations). Another central facet of counseling that is multicultural/diversity sensitive takes into account the cultural ramifications of labeling clients with an inappropriate diagnosis or as having pathology. Eriksen and Kress (2005) challenged traditional notions of what abnormal behavior is and who decides the criteria that determine whether or not a client has a mental disorder. They purport that inappropriately diagnosing a client can have a negative impact on client well-being and can lead women and people from marginalized communities to feel disempowered and actually feel harmed. The 2005 *Code* addresses this issue in the new Standard E.5.c., which directs counselors to “recognize historical and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups and the role of mental health professionals in perpetuating

these prejudices through diagnosis and treatment” (p. 12). There are also additional sections of the 2005 *Code* that address multicultural/diversity in the areas of supervision, research, and counselor education. I now briefly highlight some of the key changes in the remainder of the document.

■ Section A: The Counseling Relationship

ACA made several additions to this section. The standards related to boundary issues between counselors and clients and counselors and former clients are evolving. A paradigm shift is currently taking place within the counseling profession and within other mental health organizations when it comes to how professionals view dual or multiple relationships with clients. Traditionally, avoiding dual/multiple relationships whenever possible has been the standard practice. However, recent ethics scholars challenge this notion and say that dual/multiple relationships, sometimes known as “boundary crossings,” are normative and can actually be meaningful in the counseling relationship, particularly in rural or certain cultural communities (Glossoff, Corey, & Herlihy, 2006; Moleski & Kiselica, 2005). For example, in some smaller communities, a client may also be the only mechanic in town or a client who has been attending counseling to work on improving her relationship with her partner invites the counselor to attend her wedding. It is the counselors’ responsibility to monitor any multiple relationships, or boundary crossings, that exist between themselves and clients and to ensure that they are not exploitive or detrimental to clients in any manner. Counselors must maintain an ongoing dialogue with clients about any challenges or difficulties that either the counselor or the client is experiencing and to explore ways to remedy the situation.

The 2005 *Code* contains a new standard, A.5.d., that speaks to potentially beneficial interactions between counselors and clients that go beyond the traditional professional counseling relationship. Please consult A.5.d. to learn more about potentially beneficial relationships and factors that should be considered. Another change related to boundary issues is in Standard A.5.b., which changed the prohibition on having sexual or romantic relationships with former clients from 2 to 5 years following the last professional contact and expanded the language to include prohibiting such relationships with romantic partners or family members of former clients. Although many in the profession advocate that counselors should never engage in sexual or intimate relationships with former clients, the task force recognized the varying types of counseling relationships and the range of issues that bring people to counseling. For example, when applying Standard A.5.b. to their own relationship with a former client, counselors must consider the primary reason for which the client is seeking services. The situation of a client seeking career-related guidance for editing a résumé is significantly different from that of a counselor helping a client through a childhood trauma or abusive situation. The

counseling context significantly governs the ethical steps taken by a practitioner.

A significant addition to the 2005 *Code* is Section A.9., which provides guidance to counselors serving clients who request support when considering end-of-life issues. ACA is one of the few national mental health organizations to specifically address end-of-life care in its code of ethics. In doing so, ACA does not endorse one way of approaching this sensitive issue. Rather, it directs counselors to take measures that enable clients

1. to obtain high quality end-of-life care . . . ;
2. to exercise the highest degree of self-determination possible;
3. to be given every opportunity possible to engage in informed decision making regarding their end-of-life care; and
4. to receive complete and adequate assessment regarding their ability to make competent, rational decisions on their own behalf from a mental health professional who is experienced in end-of-life care practice. (ACA 2005, A.9.a., p. 5)

Counselors facing end-of-life issues are also ethically responsible for seeking supervision and consultation to help clients receive competent care from a wide range of professionals.

Section A.12. Technology Applications greatly expands on the same section in the 1995 *Code*. ACA integrated the Ethical Standards for Internet On-Line Counseling adopted by ACA in 1999 into the new Section A.12. and broadened the ethical use of technology in research, record keeping, and the provision of services to consumers.

■ Section B: Confidentiality, Privileged Communication, and Privacy

One major change in Section B is an increased discussion of privacy and confidentiality when working with clients who are minors or adults who cannot give informed consent. Standards B.5.a., B.5.b., and B.5.c. outline the need for counselors to protect the confidentiality of such clients and to collaborate with parents and legal guardians in determining the best possible services needed by the minor or client incapable of giving consent. To maintain an appropriate therapeutic relationship, counselors must actively involve minor clients and adults incapable of giving consent in understanding (on their developmental level) how information will be shared and used by others.

Two new standards in Section B are pertinent. First, Standard B.3.f. reminds counselors that even in the event of the death of a client, a counselor has the obligation to protect and maintain the confidentiality of deceased clients. Confidentiality does not end upon the death of a client. Second, there is a significant change related to family counseling. Standard B.4.b. of the 2005 *Code* is now called Couples and Family Counseling and addresses the need of counselors to

clearly define who is considered “the client” and discuss expectations and limitations of confidentiality. Counselors seek agreement and document in writing such agreement among all involved parties having capacity to give consent concerning each individual’s right to confidentiality and any obligation to preserve the confidentiality of information known. (p. 8)

Section C: Professional Responsibility

Counselors work with clients on a variety of significant and heart-wrenching issues such as sexual abuse, grief and loss, and natural disasters, just to name a few. Consistently dealing with such severe and complex issues without obtaining personal support can often lead to counselors’ professional impairment. Section C of the 2005 *Code* provides more detailed language on counselor impairment in Standard C.2.g. In addition to counselors being responsible for seeking assistance with problems that reach the level of their professional impairment, we, as counselors, are now also ethically obligated to “assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted” (pp. 9–10). In addition, counselors must recognize that situations, even unanticipated or unwelcome life events such as illnesses, accidents, or even death, can affect our work as counselors. Standard C.2.h. addresses the importance for all counseling professionals to create a plan for the transfer of clients and records to an appropriate colleague in the event of a counselor’s incapacitation, death, or termination of practice (Standard C.2.h.). Whether a professional works in a school setting, mental health agency, hospital, university, or other types of environments, counselors must have a specific plan in place in the event that they either choose to, or can no longer continue to, practice counseling.

Another addition to the 2005 *Code* is Standard C.6.e., Scientific Bases for Treatment Modalities. Although the 1995 *Code* directed counselors to monitor their effectiveness, it did not speak to the responsibility to base techniques and treatment plans on theory and/or empirical or scientific results. Standard C.6.e. further states that counselors who do not have such a basis “must define the techniques/procedures as ‘unproven’ or ‘developing’ and explain the potential risks and ethical considerations of using such techniques/procedures and take steps to protect clients from possible harm” (ACA, 2005, p. 11). Counselors must be careful not to engage in modalities that do not treat clients with dignity and respect their cultural identity.

Section D: Relationships With Other Professionals

Section D addresses the relationship between counselors and other colleagues and constituents. Typically, counselors find themselves part of an interdisciplinary team. There are several

new standards that address responsibilities to develop and strengthen relationships with colleagues from other disciplines to best serve clients (D.1.b.); to keep the focus on the well-being of clients by “drawing on the perspectives, values, and experiences of the counseling profession and those of colleagues from other disciplines” (D.1.c.; ACA, 2005, p. 11); and to clarify professional roles, parameters of confidentiality, and ethical obligations of the team and its members (D.1.d., D.1.e.).

Section E: Evaluation, Assessment, and Interpretation

Counselors ensure that they have the necessary training and competency to engage in a variety of assessment approaches. One noteworthy semantic change can be found throughout this section. The word *test* used in the 1995 *Code* has been replaced with the word *assessment*, which has a broader, more holistic meaning that can be applied in a variety of contexts. Another significant addition to the 2005 document is standards that address the ever-increasing counselor involvement in legal proceedings, including forensic evaluations. New Standards E.13.a. through E.13.d. were created to address the need for counselors to understand their primary obligations when conducting forensic evaluations, how these obligations differ from those involved in counseling, and their responsibility to explain this to clients, for example, what and how much testimony will be shared that is based on the client’s files and other clinical information. The new standards also prohibit counselors from conducting forensic evaluations with clients they are counseling or have counseled and advise them to “avoid potentially harmful professional or personal relationships with family members, romantic partners, and close friends of individuals they are evaluating or have evaluated in the past” (E.13.d.; ACA, 2005, p. 13).

Section F: Supervision, Training, and Teaching

Section F features a number of new additions that affect the way that new professionals are trained, including some of the key components that should be included in training programs. This section addresses the basic expectations for counselors-in-training and those professionals and educators who supervise their work. Section F focuses on two central components: first, the supervisory relationship between the counseling supervisor and the supervisee, and, second, the relationship between counselor educators and students. In the supervisory relationship, the following issues are addressed: client welfare across settings, informed consent in the supervisory relationship, competence of counseling supervisors, supervisor responsibilities, potentially harmful and beneficial relationships between supervisors and supervisees, and termination of the supervisory relationship

(F.4.d.). This section addresses the importance of the supervisor and supervisee attempting to work through any difficulties that are negatively affecting the relationship. If these difficulties cannot be resolved, the supervisor has an obligation to provide the supervisee with a referral to an appropriate alternative supervisor. Sections F.6. through F.10. specifically pertain to the role of counseling faculty and students. Areas discussed in these sections include student welfare and orientation, self-growth experiences, impairment of counseling students and supervisees, ethical evaluation of the performance of supervisees and students, and endorsement of supervisees and students. Because of the significant number of changes made to Section F, counselors, supervisors, counselor educators, and counseling students are encouraged to closely review this section of the 2005 Code. Multicultural and diversity issues are intertwined throughout Section F as these pertain to the role that culture plays within the supervisory relationship and within academic training programs.

Section G: Research and Publication

This section discusses the guidelines necessary to conduct research in an ethical manner and in a way that promotes the growth of knowledge within the field. Research contributes to knowledge that can be used by clinicians in the field, and work done by clinicians influences the type of research that is being conducted. It is a cyclical relationship, and counselors, even those who may not consider themselves researchers, are encouraged to review this section. Another semantic change in the Code can be found in the change from the term *research subjects* (in the 1995 Code) to the term *research participants* (in the 2005 Code), meant to be more inclusive and less clinically detached. This section provides guidance to counselors on the appropriate handling of records during the research process, informed consent with research participants, and confidentiality regarding people involved with research projects. Although research is often conducted by faculty members of counselor education programs, there are counselors practicing in a variety of settings who are engaged in research. According to the new Standard G.1.c., when these “independent” researchers do not have access to an institutional review board (IRB), they have an ethical obligation to consult with researchers who are knowledgeable with IRB procedures for providing appropriate safeguards for research participants. Section G also addresses issues related to publication. There is a new standard specifically stating that counselors do not plagiarize the work of others (G.5.b.).

Section H: Resolving Ethical Issues

The 2005 Code provides greater clarity and more specificity to counselors regarding ways to address potential conflicts

between ethical guidelines and legal requirements. Counselors are reminded that one of the first steps taken when attempting to resolve an ethical dilemma is to try to resolve the situation informally (H.2.b.). Counselors who are concerned about the unethical conduct of colleagues or supervisors and who circumvent the process and do not first address their concerns informally and directly with the party or parties involved may in fact be acting unethically themselves. If the conflict cannot be resolved by such means, counselors may then adhere to the requirements of law, regulations, or other governing legal authority. Another change in this section is expansion of the list of potential agencies/organizations to which information regarding suspected or documented ethical violations may be reported to include “state or national committees on professional ethics, voluntary national certification bodies, state licensing boards, or . . . the appropriate institutional authorities” (Standard H.2.c., p. 19). Finally, there is a new standard (H.2.g.) that protects the rights of ACA members who either have made or been the subject of an ethics complaint. Counselors who file a formal ethics complaint or who are formally accused of committing an ethical violation should not be denied employment or admission opportunities simply by being involved in an ethics inquiry. However, once a proceeding or official outcome has taken place, such action appropriate to the ethical violation may be warranted.

Conclusion

It is critical, in fact it is an ethical obligation, for counselors to thoroughly review the entire 2005 Code to understand how to apply the new Code to their day-to-day practice. No code of ethics can address any and all situations that counselors may face. Consulting with ethics experts in the field should be an ongoing part of one’s professional development. It is recommended that practitioners contact the ACA Ethics Committee for a formal interpretation of the 2005 Code by submitting a scenario and questions about specific standards to the ACA Ethics Committee staff liaison. This is one more step toward achieving ethical clarity.

As stated by Herlihy and Corey (2006), “Resolving the ethical dilemmas . . . requires a commitment to questioning your own behavior and motives. A sign of your good faith is the willingness to share your struggles openly with colleagues or with fellow students” (p. 257). As they maneuver through the multiple layers of information and complexities inherent in most ethical situations, counselors must continually evaluate, study, consult, and reflect on the response that seems to fit the “best practice” standard and takes into account the cultural and contextual information in the dilemma. It is important for all practitioners to know that they have trusted colleagues, supervisors, and the profession itself to provide guidance, empathy, and support through even the most difficult and emotionally challenging situation.

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