Informed Consent, Confidentiality, and Diagnosing: Ethical Guidelines for Counselor Practice

Informed consent and confidentiality are discussed in the context of counselors' use of the DSM diagnostic system. Considerations that can facilitate counselor diagnostic decision-making related to informed consent and confidentiality are identified in a case application. Suggestions that can enhance ethical diagnostic practices are provided.

The Council for the Accreditation of Counseling and Related Educational Programs (CACREP, 2009) requires that all trainees be instructed in ethical principles (CACREP, Section II.G.1.j). The CACREP standards also require that clinical mental health counselors and addictions counselors be trained in the use of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*, hereafter *DSM*; American Psychiatric Association [APA], 2000; CACREP Standards for Clinical Mental Health Counseling Section K.1 and Standards for Addiction Counseling Section K.1). With regard to the intersection of ethics and diagnosis and in relation to informed consent, the American Counseling Association (ACA) *Code of Ethics* (2005) states "Counselors take steps to ensure that clients understand the implications of diagnosis" (A.2.b.). The American Mental Health Counselors Association (AMHCA) *Code of Ethics* (2010) asserts that "Informed consent is ongoing and needs to be reassessed throughout the counseling relationship" (B.2.d.).

The *DSM* contains 297 diagnoses (APA, 2000), which will be explored with generally equal breadth and depth in the next *DSM* iteration (APA, 2011). It may therefore be difficult for counselors to fully understand the myriad ethical considerations that need to be addressed when applying *DSM* diagnoses (Eriksen & Kress, 2005). Calley (2009) stated that because they are elusive aspects of counselors' personal and professional behavior, ethics must be explicitly addressed if they are to be fully integrated into professional practices. Explicit discussions of *DSM* ethics-related issues are thus important if counselors are to be deliberate and ethical in their practice (Calley, 2009).

There is a need for context-specific applications of ethics related to informed consent, confidentiality, and the *DSM* (Eriksen & Kress, 2005; Kress, Hoffman, & Eriksen, 2010). A lack of professional exchange about this topic could give the impression that it is not of importance. Conversely, more detailed discussions should facilitate ethical practices related to the *DSM*, confidentiality, and informed consent (Calley, 2009). Although professional codes of ethics focus on appropriate use of the *DSM* (ACA, E.5.a.-E.5.d.; AMHCA, D.1.-D.3.) and CACREP requires counselor training in its use, the literature offers minimal guidance on how to use the *DSM* ethically. Only a few articles have touched specifically on the topic of client-informed consent and confidentiality as related to the *DSM* (e.g., Bassman, 2005; Kress et al., 2010; Walker, Logan, Clark, & Leukefeld, 2005).

Client diagnosis has risks, and clients are often not fully apprised of them. This lack of transparency compromises the counseling values of beneficence and nonmaleficence (because client well-being may be jeopardized), and autonomy (because the client is not given all the information needed for an informed decision). Calley (2009) suggested that counselors consider complex ethics issues comprehensively, explicitly identifying problems and relating them to the
principles of beneficence, nonmaleficence, justice, and fidelity. Calley suggested there is value in examining all ethical codes that apply to a particular dilemma and identifying how the standards are being executed.

According to Calley (2009), if upon consideration a counselor is unable to conclude that ethical codes are being upheld, it is necessary to explore the issue in greater depth. Calley suggested consulting resources to help identify desirable ethical standards and how they can be applied to a given ethical dilemma. This article disseminates a new way of demonstrating that ethical codes are upheld when diagnosing clients.

Because the literature provides no guidance, it is important to explore the multiple ethical dimensions of diagnosing, informed consent and confidentiality (Calley, 2009). Thus we discuss confidentiality and informed consent as related to counselors’ use of the DSM, offer specific suggestions for optimizing ethically-sensitive diagnosis, and describe a case study application.

**Informed Consent Considerations and Diagnosis**

Diagnosis is often not discussed as part of the informed consent process (Campbell, 2000; Eriksen & Kress, 2005; Fisher, 2002; Kress et al., 2010). At a minimum, clients should be informed that they may receive a diagnosis and, once given a diagnosis, they should be told what it is (Kress et al., 2010).

A diagnosis allows for reimbursement by third-party payers (i.e., health insurance companies or agency grant funders; Braun & Cox, 2005). Insurance companies require a medical diagnosis for reimbursements. Further, in organizations that obtain government or other funding to treat specific diagnoses (e.g., addictions), only clients diagnosed with those problems may receive services. Thus, DSM diagnoses give clients opportunities to attain needed services, which is particularly important given the high costs of treatment. From a psychological perspective, another potential strength is that some clients find relief and validation in having a label to describe their difficult experiences (Goodwin, 2009; Marzanski, Jainer, & Avery, 2002; Mitchell, 2007). Moreover, diagnosis can be used to guide counselor interventions and treatment plans. Ideally, counselors use diagnoses to select treatments that have proved to be successful.

The well-documented risks of diagnosis (e.g., Eriksen & Kress, 2005, 2006; Ivey & Ivey, 1998, 1999; Zalaquett, Fuerth, Stein, Ivey, & Ivey, 2008) should also be conveyed to clients. Clients with mental health diagnoses may be stigmatized at school or work and viewed and treated negatively (Eriksen & Kress, 2006). They may come to think of themselves as "less than" or perhaps as permanently "ill" with little possibility of becoming or seeing themselves as "well." Those diagnosed may take on the identity of a "sick" person and find it difficult to separate themselves from the label (Eriksen & Kress, 2005).

Clients who are not aware that not all DSM diagnoses are reimbursable may agree to incur the risks of receiving a diagnosis but not receive the financial benefit (Braun & Cox, 2005). Although the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the Federal Mental Health Parity Act; U.S. Department of Health and Human Services, 2008) prohibits providing discrepant benefits for mental health and substance abuse treatment, third-party payers are not required to reimburse for mental disorders that are not biologically based (U.S. Department of Health and Human Services, 2008). In other words, treatment for those mental illnesses (i.e., many illnesses other than schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder) is considered supplemental, and insurance companies have discretion about whether to reimburse (U.S. Department of Health and Human Services,
Also, under the Parity Act, employers can choose which non-biologically-based mental health and substance use diagnoses they will reimburse -- there is no coverage mandate. Clients should be informed that though a diagnosis may be required for third-party reimbursement for services, some diagnoses may not be eligible.

The counselor’s challenge is to find a balance between adequately explaining the potential harms associated with diagnosis and the benefits (see Hinkle, 1999, for a broader discussion of these issues; Kress et al., 2010). Because even trained counselors may struggle to do this, it is especially important to gain an objective view to help clients get an impartial picture of DSM advantages and disadvantages.

Veracity is also highly valued in the health professions (Hill, 2003). Veracity is the commitment of a professional to be open and honest with a client, despite the discomfort that might occur. Because the well-being of the client is at the heart of the relationship, it is imperative that the counselor be truthful and realistic. In the short term, it might seem more beneficent to give clients information that will encourage them to receive the services they seem to need, but for some clients the long-term consequences of diagnosis may outweigh the treatment benefits. Thus, fully informing clients of the potential risks as well as benefits of diagnosis allows counselors to uphold the traditional counseling values of beneficence, nonmaleficence, and autonomy (Calley, 2009).

Some counselors, feeling uncomfortable discussing diagnostic information with clients, may avoid full disclosure (Hill, 2003), and when counselors fully explain the risks of diagnosis, clients might choose not to receive services. The value of veracity suggests that counselors should nevertheless discuss uncomfortable topics like diagnosis because that will promote long-term benefits for counselors and clients (Hill, 2003).

Martin, Garske, and Davis (2000) found that an open and honest exchange is a key predictor of therapeutic success regardless of many other factors, such as the difficulties associated with diagnosis. Clients should have the opportunity to freely determine whether they will agree to receive a diagnosis. Counselors might provide the following information to present an objective view of the diagnostic process: (a) whether the client’s third-party payer or a prospective and desired program will require a diagnosis; (b) the most common problems associated with a diagnosis; (c) the benefits of a diagnosis; and (d) what the options are should the client choose not to receive a diagnosis or not to have a third-party payer involved. As most counseling employers require a diagnosis by the end of the first session, discussions related to diagnosis need to be part of informed consent discussions early in that meeting.

Confidentiality Considerations

Ethical practice requires that counseling professionals provide information about diagnosis and confidentiality as part of the informed consent process. Confidentiality-related information helps to ensure that client agreement to participate in counseling is adequately informed (ACA, 2005; AMHCA, 2010; Kaplan et al., 2009; Ponton, 2009). Thoughtfully and thoroughly conveying that information to clients assures clients that counselors will keep them apprised of important information while keeping the counseling experience confidential. Clients have a right to discuss and understand the risks and benefits of counseling before agreeing to participate.

The ACA (2005) and AMHCA (2010) Codes of Ethics state that clients have the right to confidentiality and to have its limitations explained. There are risks involved with the unanticipated - sometimes inadvertent - release of diagnostic information, and clients have a right to know of them.
Grover (2005) commented that "consent may not be truly informed in that the full implications of having the diagnosis and of having it communicated to others may not be adequately understood by the client at the time he or she proffers consent" (p. 78). For example, a client who signs a release on a job application that allows an employer to check into counseling history may be harmed, and the employer may not employ people with certain diagnoses (e.g., the military; Couture & Penn, 2003). Parents of young clients may sign releases for mental health professionals to communicate with schools (U.S. Department of Health and Human Services, 2010), perhaps making a diagnosis part of the child's permanent school record, which can result in stigmatization as long as the client is a student.

Mental health records and diagnoses may also be used against clients during legal battles and in court hearings (Denton, 1989; Kress et al., 2010; Scott, 2000; Woody, 2000); the result can range from stigmatization and embarrassment to a loss in a legal battle. Diagnoses become a permanent part of client mental health records, which often must be released in civil or criminal cases (Luepker, 2003; Scott, 2000; Woody, 2000). Although privileged communication is a responsibility of counseling professionals, the law does not always support such ethical considerations (Fisher, 2003). Counseling information - including diagnoses - may have to be disclosed in court and might lead to a client not being awarded custody of a child (Glosoff, Herlihy, & Spence, 2000). Although it is routinely mentioned during the initial informed consent conversation that a judge's written order can overrule confidentiality, clients may not foresee the impact this could have on them.

Confidentiality is further complicated in group or family counseling, where diagnostic information may be shared; the legal system often does not acknowledge privileged communication in such situations (Woody, 2000).

There are also risks in releasing diagnostic codes to insurance companies (Ackley, 1997; Campbell, 2000) that clients need to be made aware of (Braun & Cox, 2005). A client's diagnosis becomes a permanent part of the insurance record after one reimbursed service using the ascribed diagnosis is billed (Privacy Rights Clearinghouse, 2011). This information can then be classified as a preexisting condition that can be accessed by future employers and insurers. Depending on state laws and how long ago the client was diagnosed (U.S. Department of Labor, 2009), clients may lose job or insurance opportunities based upon past mental health diagnoses.

Employers may also determine that some clients are not suitable employees because their mental health needs are severe or from fear that they will raise employer insurance premiums. What complicates the issue is that such clients may have difficulty obtaining their own health insurance due to documented preexisting conditions (Ackley, 1997; Campbell, 2000). If they are able to secure insurance, services for preexisting conditions may not be reimbursed immediately, if at all. Therefore, clients who lose their health insurance may have to pay for their own counseling or suffer with untreated difficulties.

Clients may also consent to diagnoses being released without fully understanding what they are consenting to. In other words, clients may not grasp the long-term implications of sharing diagnoses (e.g., the client wants information shared with disability services, yet the information may be defamatory, such as a diagnosis of malingering). Clients may not understand that when diagnoses are released to other professionals, they may become a permanent part of those files, too. Finally, clients should understand that some diagnoses are retained indefinitely. For example, a person diagnosed with alcohol dependence will always - according to the DSM - be
diagnosed with alcohol dependence, even though the disorder may be qualified as "in remission" (APA, 2000).

Further complicating this issue of confidentiality and informed consent is the fact that clients may only be made aware of their diagnosis when, or even after, the information has been shared (Grover, 2005). Clients are often given a diagnosis at the initial session, and if that session is reimbursed, it automatically becomes part of the client's permanent mental health record (Privacy Rights Clearinghouse, 2011). Therefore, clients typically only have the length of one session to determine if they want a diagnosis. Even if the informed consent discussion is thorough, clients may not have enough time to process the information and make an informed decision before their health records are affected and the associated risks are incurred.

**Case Application**

The following composite case based on the authors' experiences illustrates some of the ethical problems that may arise in relation to diagnosis, confidentiality, and informed consent.

**Case Study**

Madison, 28, is a mother of three who recently separated from her husband of five years. She has reported feeling sad and lonely since, and she also reported a history of "significant periods of sadness and depression." She stated that the separation has already become contentious and was fearful that her husband would make the divorce proceedings difficult.

Madison has also been using alcohol to cope; she estimated that she drinks three to four times a week. Although she said that she has not experienced any negative effects of her alcohol use, she was aware that using alcohol was not a good way of coping with her sadness. On the advice of a friend, Madison decided to seek counseling to get help with her alcohol use and sadness at a local agency that offers services on a sliding fee scale. As part of the informed consent process, the counselor, Rita, explains to Madison that she may receive a mental health diagnosis and informs her that the purpose of the diagnosis is to help determine the best treatment for her problems.

Rita incorporated information from Madison’s intake assessment and initial interviews to formulate a diagnosis. The client's primary complaint was her feelings of sadness and depression, and Rita considered a primary diagnosis of adjustment disorder with depressed mood. However, Madison reported having had depressive symptoms before the separation. This information supported the primary Axis I diagnosis of Depressive Disorder N.O.S. The additional concern about alcohol use did not warrant a secondary Axis I diagnosis of alcohol dependence, but the full criteria for alcohol abuse were met.

Madison was forthcoming about her impending divorce, her struggles with alcohol use, and her feelings that she was not an effective parent. She completed about 20 sessions of counseling before choosing to discontinue treatment because she "felt better." Rita felt that Madison had made good progress and was supportive of her decision to discontinue treatment. About two months later, Rita received a subpoena from family court. Madison and her husband were involved in a custody dispute and the Family Court Judge had appointed a guardian ad litem to help determine the best living circumstances for the children. Rita was subpoenaed to testify about Madison's functioning, her diagnosis, and her progress in treatment. Rita is concerned that Madison's diagnosis (depressive disorder NOS and alcohol abuse) may be taken out of context in the custody determination; she believes that Madison may be unnecessarily penalized for her decision to seek treatment.
Case Discussion

Although Madison was aware that she would be assigned a mental health diagnosis as part of the counseling process, she was not explicitly informed that this information might be subpoenaed in the divorce proceedings. Rita obtained consent from Madison for her diagnosis and treatment but did not explain that Madison's diagnosis might be used as an indication that she was unable to be an effective parent. This is particularly noteworthy because Rita was aware that the divorce would be acrimonious.

Rita might have taken the initiative to expand upon the limits of confidentiality, exploring with Madison situations that often result in mental health records being subpoenaed. Informing Madison that her diagnoses might be revealed in court would have given her enough information to decide if she was comfortable with the risk of receiving a diagnosis. It would also have been helpful for Rita to explore with Madison how the diagnosis might be used adversely in the court case. Exploring with Madison how mental health disorders may be (incorrectly) perceived by others as negative could have helped prepare her for possible disclosure of potentially damaging information.

Preparing Madison for possible disclosure might also have altered how forthcoming she was with personal information. Rita might have discussed the possibility of Madison electing to be treated without a formal diagnosis, which would probably have resulted in her, rather than a third party, paying for the services. Although not legally required, these discussions might have helped Madison make a more thoughtful informed consent decision.

Practice Suggestions

Even when counselors are aware of and willing to discuss informed consent issues related to diagnosis, finding a therapeutic balance in describing the risks and benefits takes skill (Martin et al., 2000). The realities of deciding how and when to provide this information and how much information needs to be revealed to facilitate, rather than harm, counseling efforts are complicated. For example, even when clients are informed, many may decide that they have no choice but to accept these risks, because without reimbursement they would be unable to pursue counseling (Wittig, 2000).

The ethical principle of beneficence requires that counselors strive to improve the quality of their clients' lives (Remley & Herlihy, 2007). A comprehensive understanding of the benefits and risks of giving diagnoses could potentially conflict with the counselor's ascription to beneficence. In fact, Mead, Hohenshil, and Singh (1997) found that over 60% of clinicians were aware of instances of intentional over- or under-diagnosis. That is, some clinicians reported giving a less serious diagnosis than was warranted or putting only the least serious diagnosis on the client's permanent record to avoid labeling or stigmatizing the client (Mead et al., 1997). Clinicians also reported giving or continuing to use an unwarranted Axis I diagnosis so that the client could receive third-party reimbursement for mental health services.

Although altering diagnoses might seem to allow counselors to uphold the values of beneficence and nonmalfeasance, it is not only ethically unsound, it is illegal (Mezzich, 1999; Welfel, 2002). Not only can under- or over-diagnosing clients prevent them from receiving the care that they need, it also interferes with their right to autonomy (Remley & Herlihy, 2007). The value of veracity also compels counselors to be honest with clients (Hill, 2003). The authors cited suggest completely describing the benefits and risks of accurate diagnosis and allowing
clients to make the final decision on diagnosis-and emphasizing that diagnoses will not be inappropriately ascribed.

A best practice approach to informed consent and diagnosis may be to openly discuss the facts that are likely to impact clients and offer assistance and information as they weigh their choices (Kaplan et al, 2009). Eriksen and Kress (2006) suggested that the medical model for making mental health diagnoses can coexist with a multifaceted counseling approach. Counselors should take care to understand symptoms and cures in terms of the client's worldview, social stressors, and interpersonal history (Eriksen & Kress, 2006).

Once sure that a diagnosis is accurate, the counselor can explain the probable counseling duration, process, and outcome to the client, and process with the client the benefits and any possible unhelpful consequences (Eriksen & Kress, 2006; Hill, 2003). Using basic counseling techniques that promote introspection and problem-solving skills, clients can be empowered to assess their ability to overcome the potential risks of diagnosis.

Clearly, not all situations carry significant diagnosis-related risks, and a counselor should determine when risks are more likely. When working with clients at particularly high risk of a negative effect of receiving a diagnosis (e.g., those involved in custody hearings), counselors should provide more thorough and detailed education about the risks and benefits during the intake session and may discuss how clients might manage these risks (Fisher, 2002; Jepson & Robertson, 2003; Luepker, 2003; McGivern & Marquart, 2000).

When they are educated about the risks, clients are better able to decide whether they want to receive a diagnosis. In helping clients establish what they will do to manage possible risks, it may be useful to encourage them to gather additional information to inform their decision. Depending on the situation, a client might benefit from a better understanding of the implications of receiving a diagnosis. For example, if involved in a custody dispute, clients might choose to speak to their attorneys before continuing counseling. They might also ask their attorneys about what counseling records can and cannot be shared with third parties, and what disclosure might mean for them.

In terms of managing risks, clients might also be invited to consider what information they disclose to the counselor. Clients may elect to share some but not other information. For example, a client who is seeking counseling for depression issues might elect to withhold a past substance abuse history. For a client seeking, say, to enter the military, that might be a prudent decision.

Electing to not receive a diagnosis may place the financial burden of treatment on clients who may not be able to afford counseling, but it also provides clients who do have greater financial means with more opportunities to avoid being diagnosed. However, most counseling agencies have policies that require that clients complete a DSM multi-axial assessment, so clients wishing to avoid formal diagnosis may have no choice but to seek counseling in private practice settings. Conversely, clients who do not have the means to seek private practice counseling may be forced to receive diagnoses and thus be subjected -- arguably unfairly -- to the risks of diagnostic labeling (Erikson & Kress, 2005).

There [may] also be intervention and treatment issues when counselors diagnose some, but not other, clients. Theoretically, counselors working from a traditional model may rely on a diagnosis to guide treatment interventions; these counselors may not feel comfortable withholding a diagnosis. Counselors electing to not provide a diagnosis might instead select interventions and treatment approaches that are rooted in the client's stated presenting concern.
instead of diagnosing a client with depression and applying a Cognitive Behavioral Therapy (CBT) approach, a counselor might instead identify the treatment goals clients want specifically to address (e.g., finding more joy in life) and use CBT approaches to help them do so.

Complicating informed consent discussions is the fact that informed consent is generally acquired before counseling services are provided; thus, it is often difficult to determine how much detail to cover in the discussion. Rather than conceiving of informed consent as an agreement to be reached before counseling (i.e., a one-time event), such discussions should be part of the full assessment and counseling process. As the counseling process unfolds, counselors need to exercise discretion in deciding when and how to fully inform clients (Fisher, 2002; Jepson & Robertson, 2003).

Counselors also need to guard against informing clients too late in counseling of the potential limitations of diagnosis; if clients have agreed to the counseling relationship on the basis of incomplete information, information provided too late may damage a therapeutic alliance (Fisher, 2003). Moreover, counselors may want to inform clients about the possibility that an initial DSM diagnosis may change, given new information gathered over the course of several sessions. In other words, clients should be informed that DSM diagnoses are dynamic rather than static; they may change with a client’s symptom presentation. If the diagnosis does change during counseling, the client should be informed about the rationale for the change. Related to this issue, client improvements or changes (e.g., remission, severity indicators) should also be documented in client records, including discharge/termination summaries.

Counselors’ theoretical models generally shape their relationships with clients and may also influence the degree to which they discuss with clients the risks and benefits of diagnosis. Some schools of thought (e.g., Feminist Counseling Theory) place counselors in more egalitarian roles with clients; others encourage counselors to promote a more authoritarian relationship (Corey, Corey, & Callahan, 2007; Marzanski et al., 2002). However, whether they embrace or shun the power associated with their therapeutic role, counselors should be aware of the power they have related to use of the DSM within the counseling relationship. Thoughtful reflection on how power influences the diagnosis or informing clients about diagnoses may be helpful in making decisions related to informed consent and the diagnostic process.

In summary, counselors are responsible for evaluating the consequences of issuing diagnoses, following jurisdictional laws, and upholding ethical standards. At minimum, we recommend that clients be fully informed, both in writing and orally, of potential benefits and risks of a DSM diagnosis. Although there is no one-size-fits-all approach, here is an example of a statement that a counselor might use orally or in informed consent documents:

A formal assessment will be conducted in order to help me gain an understanding of your current situation; it is possible that you will receive a diagnosis. The purpose of the diagnosis is to help us and other mental health professionals identify the problems you are experiencing and the counseling procedures that may be most helpful in treating those problems. In some cases, a diagnosis may also be required in order to receive third-party reimbursement for services counselors provide. Certain diagnoses (e.g., partner or parent-child relational problems, academic problems, personality disorders) may not be covered by your insurance plan.

It is important that we review several possible limitations of mental health diagnosis. First, if you use a third-party payer to pay for your services, your diagnosis, or diagnoses, will be revealed to the insurance company as part of the reimbursement request. It is your responsibility to contact your insurance company to identify the
organization's specific method for storing and sharing confidential information. If you are concerned about this, we can discuss alternative options, including out-of-pocket pay, pro bono services, or referral to other service providers. Also, if you are involved in any type of litigation, such as a child custody situation, your counseling records, including your mental health diagnosis, may be subpoenaed by the courts and released during court proceedings.

Lastly, please be aware that your mental health diagnosis - and any accompanying records - may be revealed if you sign a release of information for disclosure of your medical records to any other agency or individual (e.g., school, probation office, family physician).

This discussion should occur before any assessment, and follow-up conversations may be required. Specifically, informed consent should be seen as a continuing process that occurs before any major event in the counseling relationship (e.g., giving or changing a diagnosis, releasing records, bringing a significant other into a session).

The authors have found that using this statement with clients invites healthy dialogue. Clients who have been to numerous other mental health providers have expressed surprise that they had previously received a diagnosis. Some clients express gratitude for making them more aware of the benefits and risks associated with sharing certain information. Clients appear to most value specific examples of how confidential information could cause harm.

**Discussion**

A thorough discussion of informed consent and confidentiality issues as related to the *DSM* should occur early in the counseling process. Before counselors ascribe a diagnosis, clients should be informed that they may receive one and, once a diagnosis is made, they should be informed of it. After reviewing this information, a thorough discussion of the possible repercussions of a formal diagnosis should be addressed, and unique client life circumstances (e.g., getting a divorce, renegotiating child custody, planning to enlist in the military) that could be impacted by a diagnosis should be explored.

Clients need to be informed about the diagnostic process, including (a) what *DSM* diagnoses are in general and their own specific diagnosis; (b) how diagnoses are made and when they are changed; (c) that clients may receive one or more diagnoses; (d) the role the client will play in formulation of the diagnosis; and (e) the risks and benefits of receiving a diagnosis.

The extent to which a client is given information about informed consent issues needs to be based on the treatment setting, the presenting client concerns and needs, and the personal ramifications to the client receiving the diagnosis. Decisions related to the depth to which informed consent issues and diagnosis are discussed will ultimately be based upon clinical judgment. However, counselors are ethically bound to ensure that this judgment is informed.

Counselors need to be aware of the potential power differential inherent in the diagnostic process. Although *DSM* diagnoses are currently a necessity, counselors must intentionally balance the process of diagnosing with the foundational values (e.g., strength-based, wellness-oriented) of the counseling profession. However, by providing information about *DSM* diagnosis and being transparent about the diagnostic process, counselors can help establish a positive foundation for counseling.

**References**


Ethics Codes, Laws, and Regulations

Athealth.com Editor's Note:

Practitioners are governed by state laws and regulations and by codes of ethics. All major organizations in the mental health professions have adopted a code of ethics. Readers are encouraged to examine their state laws and regulations as well as provisions of the ethics codes related to the topics in this program. Below is information about some of the ethical issues and state laws and regulations in California and Florida related to topics discussed in this program.

Ethics Codes

APA: Ethical Principles of Psychologists and Code of Conduct
California Law and Ethical Standards

Accepted Ethical Standard for Psychologists

Pursuant to Section 2936 of the California Business and Professions Code, the American Psychological Association's, *Ethical Principles of Psychologists and Code of Conduct*, is the accepted ethical standard applicable to the practice of psychology in California.

Section 2936 states as follows:

2936. The board shall adopt a program of consumer and professional education in matters relevant to the ethical practice of psychology. The board shall establish as its standards of ethical conduct relating to the practice of psychology, the "Ethical Principles and Code of Conduct" published by the American Psychological Association (APA). Those standards shall be applied by the board as the accepted standard of care in all licensing examination development and in all board enforcement policies and disciplinary case evaluations.

To facilitate consumers in receiving appropriate psychological services, all licensees and registrants shall be required to post, in a conspicuous location in their principal psychological business office, a notice which reads as follows:

"NOTICE TO CONSUMERS: The Department of Consumer Affair's Board of Psychology receives and responds to questions and complaints regarding the practice of psychology. If you have questions or complaints, you may contact the board on the Internet at www.psychboard.ca.gov, by calling 1-866-503-3221, or by writing to the following address:

Board of Psychology
1422 Howe Avenue, Suite 22
Sacramento, California 95825-3236"
The APA *Ethical Principles of Psychologists and Code of Conduct* provides, in part, as follows:

**Principle A: Beneficence and Nonmaleficence**
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 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.

*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.

*3.10 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. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

(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. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

*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.

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. (See also Standard 2.05, Delegation of Work to Others.)

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. (See also Standard 3.10, Informed Consent.)

(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.

Florida Clinical, Counseling, and Psychotherapy Services

Accepted Ethical Standard for Psychologists
The American Psychological Association's, *Ethical Principles of Psychologists and Code of Conduct*, is also the accepted ethical standard for Florida psychologists. It is recommended that Florida psychologists review the APA ethics code provisions referenced above.

Grounds for Disciplinary Action
Pursuant to Chapter 490, Florida Statutes: Psychology, s. 490.009, and Chapter 491, Florida Statutes: Clinical, Counseling, and Psychotherapy Services, s. 491.009, grounds for disciplinary action against a licensed psychologist, clinical social worker, marriage and family therapist, and/or mental health counselor include, but are not limited to, the following:

- Failing to perform any statutory or legal obligation placed upon a person licensed under this chapter.
- Making misleading, deceptive, untrue, or fraudulent representations in the practice of any profession licensed under this chapter.
- Failing to maintain in confidence a communication made by a patient or client in the context of such services, except as provided in s. 490.0147.

Confidentiality
Florida addresses confidentiality and privileged communications in s. 490.0147 and s. 491.0147.

490.0147. Confidentiality and privileged communications.--Any communication between any person licensed under this chapter and her or his patient or client shall be confidential. This privilege may be waived under the following conditions:
(1) When the person licensed under this chapter is a party defendant to a civil, criminal, or disciplinary action arising from a complaint filed by the patient or client, in which case the waiver shall be limited to that action.

(2) When the patient or client agrees to the waiver, in writing, or when more than one person in a family is receiving therapy, when each family member agrees to the waiver, in writing.

(3) When there is a clear and immediate probability of physical harm to the patient or client, to other individuals, or to society and the person licensed under this chapter communicates the information only to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.