Ethical problems encountered by mental health practitioners working with deaf clients are often complex and involve issues not fully addressed in professional codes of ethics. A principles-based ethical reasoning process can assist in resolving many of these ethical concerns. Principles such as beneficence, nonmaleficence, autonomy, fairness, integrity, and respect are found in the ethical codes of many disciplines; these can also create a common language or reference point when professionals from different fields attempt to deal with shared problems. This article discusses some applications of these principles in working with deaf individuals and proposes an ethical decision-making process that can provide a framework for ethical reasoning in thinking through complex problems.

Mental health professionals are usually introduced to a code of ethics early in their professional training. Examples include the American Association for Marriage and Family Therapy (AAMFT, 2001) Code of Ethics; the American Counseling Association (ACA, n.d.) Code of Ethics and Standards of Practice; the Code of Ethics of the American Psychological Association (APA, 2002); the International Association of Marriage and Family Counselors (IAMFC, n.d.) Ethical Standards; the Code of Ethics of the National Association of Social Workers (NASW, 1999); and the Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry (American Psychiatric Association, 2003). In addition to the professional codes of ethics, professionals in training must also learn fundamental legal requirements for professional practice found in state practice regulations, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), tort law, the Americans with Disabilities Act of 1990 (ADA), and case law on a wide variety of topics related to mental health practice. Although these professional and legal foundations can be so broad and detailed as sometimes to seem overwhelming, in practice they do not cover all situations. For example, the codes are usually silent or vague about topics such as working with interpreters, language and communication issues, accommodations, access to services, discrimination faced by deaf professionals, and myriad other problems commonly faced by mental health professionals working with deaf people and the Deaf community. Even topics that are explicitly covered in codes of ethics or law, such as confidentiality or overlapping relationships within the community, may have different implications for practitioners working with deaf people. For these reasons, code-based problem solving may not always suffice in addressing practical problems encountered in mental health practice.

Developing a systematic way of thinking through ethical problems can assist practitioners in solving problems that seem to be beyond the codes. The discussion here offers some methods and tools that can enhance the quality of ethical decisions in complex and confusing situations and can also provide a way of supporting, justifying, and documenting decisions if questions later arise.

Ethical Principles

It is possible to see all ethical codes as reflecting underlying ethical principles that are more general,
fundamental, and lasting than the specific behaviors endorsed or prohibited by the codes. The various mental health professions state the principles underlying their codes of ethics in various terms. For example, the NASW (1999) code lists “core values” of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. The ACA (n.d.) code is based on the principles of autonomy, nonmaleficence, beneficence, justice, and fidelity (Herlihy & Corey, 1996). The APA's Ethical Principles (APA, 2002) lists the following: “beneficence and nonmaleficence, fidelity and responsibility; integrity; justice; respect for people's rights and dignity” (p. 1). The American Psychiatric Association's discussion mentions competence, respect for human dignity, compassion, professionalism, and honesty, among other principles (American Psychiatric Association, 2003). The Canadian Psychological Association (CPA, 2000) cites respect for individual dignity, “responsible caring,” social responsibility, and integrity. Beauchamp and Childress (2001) attempt to summarize the most important underlying principles in the many versions of biomedical ethics using five categories: (a) respect for individuals’ autonomy; (b) nonmaleficence; (c) beneficence; (d) justice; and (e) maintaining a professional relationship, which includes honesty, privacy, fidelity, and confidentiality. Self-care is sometimes listed as an additional ethical principle. Principles-based ethical reasoning can allow for easier communication among different disciplines. Their codes of ethics may differ, but the underlying principles are likely to be similar. Implications of several principles in working with deaf clients are described in this article. After the principles are described, some special applications in work with deaf people are explored in more detail.

Nonmaleficence (“do not harm”) refers to all the things a clinician may do to avoid injuring, distressing, hurting, harming, or causing a negative outcome. The opposite, beneficence (“doing good”) implies an obligation to provide services that are in the client’s best interest and that are most likely to be helpful and to lead to a good outcome. When deaf clients are improperly diagnosed, inappropriately treated, or refused needed treatment, these principles are violated. Many treatments and services have the potential both to harm and to help. A familiar example in the field of deafness is the decision about cochlear implantation. Clinicians must know a great deal about the probability of benefit or harm in order to make ethical choices when working with a client considering such a procedure (Christiansen & Leigh, 2002).

Clinicians also encounter issues of weighing potential harm against potential benefit when asked to provide services outside their areas of training. This may happen frequently for clinicians in deafness, who may be asked to help clients with an enormous range of specialized problems. The potential for harm increases when a clinician provides services in areas outside of his or her training and experience; however, leaving the client untreated has potential for harm as well.

Autonomy or self-determination is an extremely important consideration for clinicians and clients, incorporating informed consent and lack of coercion. Respecting a client’s autonomy can be unexpectedly complicated. For example, a client cannot make a truly autonomous choice without clear and accurate information. This means that the clinician must provide honest information in a way that the client understands, give the client an opportunity to express a preference, and honor that preference. Autonomy issues can be difficult if a client is very impulsive, has poor judgment, or is easily intimidated. Furthermore, if a client has limited language skills or lacks essential background knowledge, it may be difficult even to explain clearly and fully what the choices are (Glickman, 2003). Autonomous choice may be compromised even when a clinician tries to give the client a choice. Some clients may be unaccustomed to expressing their wishes. In the case of children or cognitively impaired adults, parents or guardians may have the legal right to consent to treatment. However, this does not erase the clinician’s ethical responsibility to respect the client’s autonomy (see the section on autonomy and informed consent). Further complicating ethical decision making, ethical conflicts between autonomy and beneficence can arise if a clinician’s perception of what is best for the client conflicts with the client’s wishes.

“Justice” implies that professionals treat clients fairly and do not engage in or support discriminatory practices. We may encounter unjust practices when
agencies refuse to treat deaf patients, refuse to hire interpreters or provide other needed accommodations, or engage in stereotyping of deaf clients or professionals. Issues of justice are also involved when managed care organizations offer deaf clients a more limited range of providers than hearing clients.

As an ethical principle, **integrity** requires clinicians to be honest, providing accurate and unbiased information about any treatment options or professional issues. Integrity also requires providing accurate information about the clinician’s training, fees, and policies. Although no one likes to be deceived, deaf clients may particularly loathe hypocrisy and value forthrightness. Within the Deaf community, the principle of integrity may be doubly important for both its ethical and cultural implications.

**Fidelity** (faithfulness and concern) is a hallmark of the professional relationship. Clients place their trust in mental health professionals with the expectation that the clinician will conscientiously and carefully attend to their well-being. This principle subsumes many important ethical issues. Any exploitation of the client violates this principle. Multiple relationships that cause the clinician to lose focus on the client’s best interest also indicate lack of fidelity. The professional’s obligation to respect the client’s confidentiality and privacy are also related to the duties of fidelity and care. These issues are discussed further in the section on application of ethical concerns with deaf clients.

Making **self-care** an ethical principle reflects the insight that clinicians cannot provide good services if they are overstressed, exhausted, ill, addicted, or dealing with serious personal problems. Clinicians have an ethical obligation to monitor their fitness to practice, including judgment, decision making, problem solving, and self-control. Clinicians with the skills to work with deaf people are few and far between, and they may find it difficult to slow down or say no when so many clients are in need of their services. Considering self-care to be an ethical principle may help clinicians feel more justified in looking after their own well-being. Mental health professionals sometimes have difficulty finding methods of self-care that do not interfere with their commitment to caring for their clients. Professionally appropriate options include getting consultation or supervision, limiting high-stress work activities (with appropriate notice to clients and coverage of professional responsibilities), personal therapy, training and professional development, personal wellness-supporting activities (such as exercise, play, and creative activities), and setting appropriate boundaries to protect one’s personal life and privacy. However, self-care activities can be difficult to initiate and maintain for clinicians whose work and lives are in the Deaf community and who may simultaneously feel swamped and isolated.

**Personal Characteristics and Skills**

In addition to reflecting underlying principles, professional ethics can also be thought of in terms of the qualities, skills, and character of individual professionals. Beauchamp and Childress (2001) suggest that certain “virtues” make ethical practice more likely. Although there are many virtues that we hope our caregivers have, Beauchamp and Childress especially highlight compassion, judgment, insight, trustworthiness, competence, conscientiousness, and integrity. Without such traits, the mental health practitioner has no moral compass for making ethical choices. Kitchener (2000) additionally cites prudence, wisdom, and respectfulness as important aspects of professionals’ character that facilitate ethical behavior.

Such qualities are difficult to teach (although important for professional gatekeepers to consider) and are thus often not directly addressed in professional training. Professional competencies and skills, however, are receiving increasing emphasis. The Workgroup on Ethics of the APA’s 2002 Competencies Conference (Fuentes et al., 2002) identifies a number of ethical/legal competencies that supplement knowledge of codes, standards, guidelines, rules, and laws. These include (a) the ability to recognize ethical issues in varied contexts, (b) the ability to deal with conflict or ambiguity in the codes, (c) the ability to apply ethical knowledge in real-world situations, (d) the ability to consult with others when necessary, (e) the ability to confront and raise ethical issues in an appropriate manner with other professionals, (f) the ability to adapt one’s decision making when needed, (g) the ability to participate in a peer network, and (h) self-awareness and accurate self-assessment in ethical realms.
Ethical Reasoning

Ethical reasoning starts with knowledge of a formal code of ethics, then incorporates other aspects of ethics to help clinicians solve ethical problems. Systematic ethical reasoning procedures endeavor to help professionals (a) understand their own value systems, (b) recognize when an ethical problem exists, (c) analyze the problem carefully, (d) appropriately seek and use others’ advice and input, (e) identify the range of actions that might be taken, (f) weigh and choose among the possible actions, and (g) evaluate the outcome. A principles-based or ethical reasoning approach asks the clinician to think ethically, rather than simply following instructions (Ford, 2001; Lavin, 2003). Many issues that arise in working with deaf clients require both in-depth understanding of one’s professional code of ethics and excellent ethical thinking. Ethical problems can take many forms (Gutman, 2002). The following are a few:

- Different ethical principles may conflict.
- The requirements of law, policy, or contracts may conflict with ethical guidelines (McCrone, 2002).
- A clinician may want to comply with an ethical requirement but may find it impractical or difficult.
- A particular problem may not be addressed in the code of ethics at all.
- Two professionals may differ in their understanding of ethically appropriate behavior.

In general, mental health work with deaf people involves the same ethical principles as work with hearing clientele. However, ethical problems and potential solutions may affect deaf clients differently than hearing clients. Several ethical concerns that can have special meaning or impact in treatment of deaf clients will be discussed here.

Application of Ethical Concerns with Deaf Clients

Mental health service agencies not familiar with deaf individuals are at risk of making ethical as well as clinical errors when confronted with a deaf client or clinician. This can lead to substandard services, limited choices, and lack of communication access (DeVinney, 2003; McCrone, 2002; Raifman & Vernon, 1996). However, even clinicians who specialize in working with deaf clients face many ethical challenges. The Deaf community is closely knit, so clinicians may find that maintaining confidentiality and avoiding multiple relationships requires great delicacy and tact. Furthermore, due to being “the only game in town,” clinicians may be asked to practice outside their area of competence or to assist agencies that do not provide equal access to services for deaf clients.

Additionally, all clinicians, whether their clients are deaf or hearing, must be guided both by professional ethics and by law (including statutes, case law, and requirements of regulatory bodies). Sometimes these are in harmony but on some occasions, different sources may provide conflicting guidance (McCrone, 2002). Several ethically complicated problem areas are discussed next.

Competence

Because so few mental health professionals are trained to work with deaf people, questions related to a clinician’s competence are frequently encountered. These arise whenever clinicians must decide whether to accept a deaf individual as a client or to whom to refer a client needing more specialized services. In the case of a deaf client, a clinician’s competence has many aspects (Leigh, Corbett, Gutman, & Morere, 1996), including:

- possessing appropriate clinical skills for working with the client’s presenting problem;
- understanding enough about the developmental, cultural, educational, social, emotional, cognitive, linguistic, vocational, medical, and economic implications of deafness to place the client’s history and concerns in appropriate context;
- being able to evaluate and adapt to the client’s communication needs;
- knowing how to select and adapt treatment or assessment techniques to match the client’s communication abilities and preferred language; and
- understanding enough about the client’s cultural background and expectations to make sure that treatment approaches are culturally appropriate.
Clinicians lacking in any of these skills might judge their competencies to be inadequate for working with a deaf client. They might risk actually harming the client through inept service provision. Yet the ethical codes of the mental health professions mandate that clinicians should achieve competence in working with diverse clients, including those with disabilities, and should not make clinical decisions in a discriminatory way. Additionally, the ADA requires that services be accessible. Furthermore, it is sometimes the case that no other clinician or agency is able to provide better service to the client.

Thinking about the principles involved can help identify possible solutions. The principles of beneficence, nonmaleficence, and faithfulness require that clinicians provide only services that they are competent to provide. If clinicians provide services outside their areas of competence, they risk both failing to help the client and actually harming the client. However, if the clinician rejects the client for treatment without providing a better option, the client could be doubly harmed: demoralized and discouraged at the rejection, and still left with the original problem untreated. Consideration of these principles suggests approaches that might include the following:

- to accept the case but to “play catch-up” to get the information, training, consultation or supervision that is lacking (addressing concerns about helping and not harming the client—the clinician becomes competent to provide a helpful service);
- to assist the client in advocating with another, better qualified service or agency to provide appropriate treatment to the client (again, helping and not harming—the client receives a helpful service);
- to work within one’s own agency in obtaining resources to hire qualified clinicians and/or interpreters to serve the client (helping and justice—advocating to provide fair treatment for the client so that beneficial services can be provided to this client and perhaps to others with similar needs);
- to advocate with third-party payers to allow clients to be seen by the most qualified service provider, even if this is outside the provider’s usual network or panel (again, this addresses the principles of helping and justice); and
- to collaborate with another clinician or agency to provide service as a team (beneficence and nonmaleficence are enhanced—collaboration maximizes potential benefit and reduces the chance of harm).

The principles of autonomy and integrity further suggest that professionals must accurately disclose the limits of their competence to clients and allow the client to determine whether to engage in mental health treatment or assessment (unless the treatment or evaluation is court-ordered). Thus, whatever option the clinician pursues, an ethical clinician must make sure the client is informed about treatment possibilities and choices, and is involved in all treatment decisions. A meaningful informed consent procedure must take into account the client’s language, vulnerability, sophistication, and understanding of mental health services (Glickman, 2003).

Communication Access

Communication is such an important aspect of competence in working with deaf clients that it deserves special focus. Deaf clients typically view clear communication (and a concomitant positive attitude toward deaf people) as key characteristics of a competent service provider. However, communication competence requires investments of time and money. Agencies and individual clinicians sometimes try to avoid costs such as interpreters’ fees by either declining to serve deaf clients or by providing services that are substandard because of lack of communication. In some instances, programs do not understand either the mechanics or the ethics of working with an interpreter and refuse to serve deaf clients based on this misunderstanding.

However, the ethical principle of justice and legislation such as the ADA require that services offered to the general population be accessible to deaf individuals as well. Several cases have clarified the ADA requirements. Courts have required mental health service agencies to provide qualified interpreters (DeVinney, 2003), to hire clinicians who are fluent in sign language (Raifman & Vernon, 1996; Tugg v Towey, 1994), and to provide appropriate technology for clients to communicate with service providers. The ADA does not require agencies to provide
accommodations that are an “undue burden.” However, in assessing burden, courts consider all the resources available to the larger system of which a service, clinic, or agency is a part.

Mental health services cannot be provided without communication. Not all clients with hearing loss have the same communication needs, skills, or preferences. Some require a sign language interpreter for adequate communication. Others may want a deaf clinician or a Certified Deaf Interpreter. Some clients prefer oral communication or writing back and forth (either on paper or on a computer). Thus, the first issue in providing communication access is assessing the client’s needs and preferences. The ethical principles of fairness and respect for the individual’s wishes and choices are key in determining whether communication is adequate.

Confidentiality
Confidentiality is of major importance in mental health services and can be especially meaningful for deaf clients. The Deaf community shares some characteristics of rural communities, ethnic communities, and other small, tightly knit groups that can make privacy difficult to maintain (Gutman, 2002). First, people know each other within the community—there is little anonymity. Second, people notice and are interested in what others do. Third, individuals and families know one another over long periods of time, keeping contact from childhood through old age, so events of childhood or youth are remembered within the community throughout one’s life. Fourth, information and news about community members is shared rapidly. Even before the advent of instant messaging, deaf people in California often knew within hours of a problem experienced by a deaf family in New York. This can lead to quick community support in times of need, but it also makes it difficult to keep problems private. In fact, the norms of the Deaf community may favor sharing information and providing support, and withholding information can be interpreted as snobbery or lack of trust in the community.

In addition to the community issues mentioned above, many deaf people have had the experience of hearing people sharing information with each other but refusing to tell the deaf individual what is going on. This happens at the family dinner table as well as in professional contexts. Furthermore, many deaf people can remember a professional—perhaps a counselor, teacher, or supervisor—who told their parents or co-workers information that was meant to be confidential. All this can lead to a lowered expectation of privacy and difficulty trusting a clinician to keep information confidential.

Every ethical principle points to the importance of maintaining confidentiality. Violations of confidentiality may harm a client’s reputation or self-respect. Integrity requires the clinician to follow through on the implicit and explicit promises of confidentiality made to clients. Yet there are times when confidentiality cannot be preserved, such as when the client is a danger to self or others (the limits to confidentiality are spelled out in state and federal law). Respect for the client’s autonomy requires that clients know from the outset the limits of confidentiality. All ethical and legal standards require the clinician to be knowledgeable about when confidentiality will be upheld and when it will not, and to make sure that the client has accurate information. Among the confidentiality issues that could be discussed between clinician and client are (a) how to reduce the chances that the client will be seen by acquaintances when arriving for or leaving from appointments, (b) how the client or the clinician will avoid or respond to prying questions, and (c) how to behave if the client and clinician run into each other in a public setting (Leigh, 2002; Leigh & Lewis, 1999).

Clinicians also need to consider how they will handle information about clients that may be offered by third parties. Concerned friends of the client may approach the clinician at a social event to describe “what’s really going on.” Other professionals, such as teachers or vocational trainers, may feel some responsibility for the client and want to share information. Clinicians must decide how they will respond to such overtures, remembering that participating in a conversation about a client may be perceived as a violation of confidentiality, even if the clinician does not provide any information or acknowledge that the therapeutic relationship exists.

Similarly, two hearing clinicians seen talking at any length in a public place, such as an agency hallway, may
be assumed by onlookers to be discussing a client, even if that is not the topic of their conversation. Obviously, confidential information should not be discussed in public, even if the clinician believes bystanders will not hear the conversation. Beyond this, many clinicians who work with deaf clients believe that it is ethically appropriate to sign during all conversations that take place in public view, so as to avoid any misunderstanding. This promotes ethical principles of fidelity and trustworthiness in professional relationships.

Multiple Relationships

Overlapping relationships present constant ethical challenges to mental health professionals working with deaf people, especially those providing services within the Deaf community (Corbett, 2002; Guthmann & Sandberg, 2002; Gutman, 2002; Leigh, 2002). It is common for individuals within the community to have several social and professional relationships. A teacher may also be an interpreter; a clinician may also be a consultant to a vocational training program; a client’s parents might be close friends with a clinician’s office mate; a clinician’s daughter and a client’s son may attend the same school. Because multiple overlapping relationships are ubiquitous, their risks for clients and therapists can easily be overlooked or dismissed. It is true that some types of multiple relationships are considered to be benign and would not be expected to compromise a client’s services (Faulkner & Faulkner, 1997; Gutheil & Gabbard, 1993; Guthmann & Sandberg, 2002). However, there are ethical risks involved, specifically, the risk of the overlapping relationships causing harm to the client by reducing the clinician’s objectivity, exploiting the client, compromising confidentiality, creating a conflict of interest, or decreasing the effectiveness of treatment (Kitchener, 2000; Schank, Slater, Banerjee-Stevens, & Skovholt, 2003).

One way of looking at multiple relationships is in terms of personal and professional boundaries. A range of approaches to boundary issues in treating deaf clients has been suggested (Peoples, 2002; Guthmann & Sandberg, 2002). Several issues can make boundary management difficult. First, members of the community may be used to overlapping relationships in other spheres of personal and business life, and may even expect them. A satisfied client—deaf or hearing—may naturally want to refer friends and family members to the therapist. However, treating clients who are closely related or involved with other clients has a high risk of compromising a counselor’s objectivity. A similar issue arises when a client turns out to have ties to people in the therapist’s personal or professional life. This may threaten confidentiality, compromise services, and create conflicts of interest for the therapist. Deaf therapists may often be faced with the expectation that they will engage in multiple overlapping relationships, especially if they participate as active and respected community members (Leigh, 2002; Leigh & Lewis, 1999; Lytle & Lewis, 1996). Because overlapping relationships can blur the boundary between personal and professional lives, they can be difficult to analyze dispassionately. Consultation with a supervisor or trusted colleague is especially helpful in assessing potential risks. Questions to address include: (a) Does the multiple relationship create a role conflict for clinician or client? (b) Does the multiple relationship threaten confidentiality? and (c) Which relationship will be primary?

Autonomy and Informed Consent

A number of issues may compromise the autonomy of deaf individuals receiving mental health services. In the past, mental health providers have sometimes made treatment or assessment decisions “behind the back” of the deaf consumer. Further, information has been shared with hearing friends or relatives without the deaf individual giving appropriate permission (Glickman, 2003; Lane, 1992; Sussman & Brauer, 1999). The standard of care in health care today demands that clients be given the opportunity to choose whether to participate in treatment. Even if the client is a minor or not competent, assent is usually required. Several issues can interfere with a deaf client’s making a truly informed and autonomous choice about treatment. First, some professionals may lack the communication competence necessary to explain clearly the nature of treatment and the options available. In such a case, involvement of interpreters or communication specialists may be necessary to make the information provided clear and meaningful. Some deaf clients, however, may
be unsophisticated about treatment options and may not understand treatment options even when they are explained by an expert skilled in communicating with individuals who do not use standard sign systems. The client may not even understand that he or she has a choice, or may be so used to others making decisions that refusal would seem impossible. In such situations, the client’s consent or assent to treatment would lack real autonomy. One way to promote more autonomous decision making about treatment is to provide a pretreatment phase to educate the client about these matters so that true choice becomes possible (Glickman, 2003).

A second impediment to client autonomy occurs when a clinician intentionally or unintentionally slants the information given to the client so as to support the clinician’s own beliefs and opinions. Clients can make informed, autonomous decisions only if they have appropriate unbiased information. Mental health professionals who work with deaf people are likely to have personal and professional opinions about issues such as educational approaches, cultural identity, and cochlear implantation. Staying up to date on the best professional literature on all sides of such issues should be regarded as an ethical obligation (Pollard, 2002).

**Work with Children and Families**

Practitioners may be asked to work with families, often including both deaf and hearing members. Ethical principles become more complicated when working with a family because the potential benefits and harm to several people at once must be considered (Thor & Fruzzetti, 2003). Competence issues are enlarged because the clinician must understand family dynamics and child development as well as the professional and deafness-related skills mentioned earlier (Brice, 2002). Confidentiality becomes more complicated because parents may have the right to know what transpires in their child’s therapy, yet the child’s privacy is also important (Richards, 2003). Autonomy issues are more complicated if different family members have different preferences about communication or treatment. In addition, family treatment may often involve the “hot-button” issues mentioned above, such as cochlear implantation, language interventions, or educational choices (Pollard, 2002). One of the clinician’s obligations is to help parents get accurate and unbiased information, even though the clinician may have strong personal beliefs about particular interventions and approaches (Christiansen & Leigh, 2002).

Communication difficulties or conflicts within families can produce special ethical challenges (Harvey, 2002). For example, communication between deaf and hearing family members may be limited, yet some family members may resist using interpreters for family sessions. The principles of justice and helpfulness dictate that all family members should have equal access to treatment in a family therapy session. At the same time, the principle of autonomy endorses respecting clients’ wishes. What if the communication method requested by one family member conflicts with the wishes or needs of another member of the family? In family therapy, the therapist has an ethical obligation to each member of the family and to the family system as a whole (Huber, 2001; IAMFC, n.d.). Obtaining individual informed consent from each family member, including assent from the children (AAMFT, 2001; Ford, 2001), is one way to give each individual an opportunity to shape how the therapy will be conducted, including the type of communication to be used.

**Ethical Problem Solving**

With complex issues such as those discussed above, clinicians may not be able to get clear guidance from their profession’s code of ethics. All professional codes of ethics have limitations (Ford, 2001; McCrone, 2002). They always represent compromise consensus statements and are of necessity vague and general. They may be difficult to apply to specific situations and can produce dilemmas in which two or more principles or standards appear to conflict. Some problems may not be addressed in the code at all. Sometimes, more than one code of ethics may be involved and require different behaviors (for example, if the clinician unexpectedly finds him- or herself in more than one role, such as interpreter and therapist). In some situations, legal requirements may conflict with a code of ethics.

At such times, the clinician needs not only a thorough familiarity with the code of ethics and
its underlying principles but also a decision-making process to follow. An ethical decision-making model can provide a framework for ethical practice in situations where the code does not provide enough specific guidance. Several decision-making models or procedures have been suggested (e.g., CPA, 2000; Ford, 2001; Gutman, 2002; Haas & Maloof, 2002; Hill, Glaser & Hardin, 1995; Joseph & Conrad, 1995; Kitchener, 2000; Koocher & Keith-Spiegel, 1998; Welfel & Kitchener, 1992; Zitter, 1996). The model suggested in this section gives the service provider a method for considering ethical dilemmas or conflicts in a consistent, systematic, and thorough way; taking specific steps to resolve the problem; and documenting careful decision making in case of a later complaint. Suggested steps in ethical problem solving are delineated next, followed by an example of how they might be used to assist in resolving an ethical problem.

**Step 1.** Recognize that an ethical issue exists. This recognition may arise from knowledge of the ethical codes, conversations and feedback from colleagues and supervisors, client reactions, or a hard-to-define sense that “something’s not right.”

**Step 2.** Define the ethical issue. What does the code of ethics say? Do two contradictory actions both seem to be required? Is the clinician being asked to do something that is contrary to an ethical standard? Does the clinician have obligations to several parties whose rights or needs may conflict? Do legal or administrative requirements seem to contradict ethical mandates? Does the course of action that seems ethically appropriate appear to be impractical, undesirable, or unfeasible?

**Step 3.** Consider the ethical principles that are involved. Is the client at risk of harm? Is the client likely to benefit? Is the clinician acting honestly? Is the clinician being trustworthy and conscientious? Is the client being treated fairly? Are the client’s wishes and decisions respected?

**Step 4.** Consult with colleagues. Get feedback on what ethical issues are involved. Make notes of the consultations, including dates and the advice received.

**Step 5.** Generate possible solutions. Sometimes a dilemma can be resolved by forcing oneself to create three or more possibilities. This helps to make the problem-solving process more creative and open. Even if some of these seem far-fetched or impractical, they may contain the germ of a good idea. Continued consultation with colleagues can lead to additional ideas.

**Step 6.** Analyze each of the possible courses of action envisioned in Step 5. What outcomes would be expected of each? What benefits or harms might occur? Is there a way to combine several of the possibilities so as to maximize the benefits and minimize the risks?

**Step 7.** Based on the analysis of expected outcomes, choose a course of action. Additional consultation may be helpful in planning how to carry out the selected plan. Make notes about what was considered and why each possibility was selected or rejected.

**Step 8.** Implement the plan and observe the results.

**Step 9.** Evaluate the success of the action taken. Did it benefit the client? Did it cause anyone harm? Was it honest? Did it enhance the client’s autonomy? Did it seem fair to all concerned? Does it satisfy the clinician’s values? Get feedback about the result from colleagues or supervisors.

**Step 10.** Revise the plan, if necessary, based on this evaluation.

**Step 11.** Make sure that every step of the decision-making process is adequately documented and placed in the client’s chart or record. The dates of all contacts, consultations, and decisions should be included, as well as identification of all consultants or supervisors.

**Sample Case**

A graduate student, whom we will call Evelyn, attended a state school for the Deaf with about 85 students and had an excellent relationship with her high school English teacher, Mrs. Smith, who was also her homeroom teacher and class advisor. Mrs. Smith encouraged the students to write about their lives and experiences, and Evelyn shared much of herself in her writing. She started a journal in which she wrote about her own fears and dreams, conflicts with her mother, and relationships with friends and boyfriend. She often let Mrs. Smith read what she had written because she trusted her. Mrs. Smith committed a lot of time and energy to encouraging her best students, including Evelyn, to work to their potential and to go to college, and Evelyn continues to be grateful for her help. Currently, they exchange occasional e-mail and holiday
greetings, even though they haven’t seen each other for about 5 years. Evelyn still has several close friends from high school, and they get together several times a year and love to reminisce about their time together in high school.

Evelyn graduated from high school and college, then entered graduate school in one of the mental health professions. She is currently doing an internship back in her home state, in which she helps to run a group with deaf children who have been abused. One day Evelyn’s supervisor introduced her to a new child in the group, and Evelyn was stunned to learn that this 4-year-old is Mrs. Smith’s adopted daughter. The little girl had been abused by her birth parents, and at the age of two was taken away from her birth mother and placed in foster care, then later adopted by the Smiths.

Evelyn is unsure what to do. Is it okay for her to work with Mrs. Smith’s daughter? Should she say something to Mrs. Smith about it? Should she tell her supervisor she has a conflict of interest? What if her supervisor asks her to do a family interview? What if her friends start talking about Mrs. Smith the next time they get together? Here is how she might walk through a decision-making process for this ethical problem.

Step 1. Does an ethical issue exist? Evelyn knows that her discipline’s code of ethics warns that multiple relationships can be risky. She feels uncomfortable at the idea of changing her relationship with Mrs. Smith. How could she possibly presume to give parenting advice to Mrs. Smith? At the same time, she feels she owes Mrs. Smith and would like to help her family. Evelyn has lost sleep over this situation. Her discomfort tells her an ethical issue may exist.

Step 2. Define the ethical issue. Evelyn is concerned about having a prior personal relationship with a client. She is not sure whether she can be objective, and if she were required to give negative feedback to Mrs. Smith, she is not sure she could do it. In addition, Mrs. Smith has always been the one to advise and encourage Evelyn. It would be hard for Evelyn to switch roles and give advice or counsel to Mrs. Smith.

Step 3. Consider the ethical principles that are involved. If Evelyn cannot be objective about this family, the family may not get the best care. In addition, Evelyn may learn information about the family that she cannot share with her close friends, who are also close to Mrs. Smith. On the other hand, Mrs. Smith’s family needs services, and Evelyn does not want to be the reason that their child is not getting help. Evelyn is not sure that Mrs. Smith realizes that Evelyn now works at this agency and does not know whether Mrs. Smith realized when she requested services that Evelyn, a former student, might have access to personal information about her. There are multiple ethical principles involved, including beneficence, fidelity (confidentiality, multiple relationships), and justice.

Step 4. Consult with colleagues. Luckily for Evelyn, she has several supervisors in the agency. She hesitantly brings the issue up with the supervisor with whom she feels most comfortable. They discuss Evelyn’s past and current relationship with the Smith family. Evelyn makes a note about this discussion and includes it in the Smith family’s file. The note says that Evelyn and Dr. Jones discussed issues related to a prior relationship between Evelyn and the Smith family, and gives the date it was discussed. Both Evelyn and the supervisor sign the note.

Step 5. Generate possible solutions. After they have identified the issues and possible problems, Evelyn and Dr. Jones brainstorm possible actions. One possibility is for Evelyn to switch to a different rotation so that she will not need to work with the Smith family. Another is for the Smiths to be referred to another agency. Still another is for Evelyn to work with the Smith family as she does with the others who are referred to her unit. It might also be possible for another intern to work with the Smiths while Evelyn works with other children and families. They also talk about the possibility of discussing the situation with the Smiths to see what they prefer.

Step 6. Analyze each of the possible courses of action envisioned in Step 5. Dr. Jones and Evelyn want to think about the possibilities. They schedule a second meeting to think about what would have the least risks to the Smiths and the most potential benefit. Both Dr. Jones and Evelyn agree that Evelyn working with the Smiths has a risk of causing some serious problems in their treatment. It also risks damaging Evelyn’s relationship with Mrs. Smith, which she very much values. Furthermore, it might make Evelyn’s interactions
with her friends difficult, because they are likely to bring up Mrs. Smith in their casual conversation. They discuss how to get treatment for the Smiths without involving Evelyn. They discuss how to respect the Smith’s autonomy and privacy.

Step 7. Based on the analysis of expected outcomes, they choose a course of action. Evelyn and Dr. Jones decide that three possibilities are feasible, ethically appropriate, and would afford the Smiths access to services. They decide that Dr. Jones will meet with the Smiths and explain these three treatment options. Their first option is to place their daughter in the group. If they do that, Evelyn will not work directly with their daughter, but they may see her in the room working with other children. The Smith’s family situation will not be discussed at any meeting where Evelyn is present. However, Evelyn might have casual interaction with the Smith’s daughter, such as helping the children to line up for a fire drill or monitoring a group activity. A second option is for the Smith family to receive individual and family therapy from senior staff of the agency but not to have their daughter in the group. A third option is to refer them to another agency.

Evelyn’s agency provides the most deaf-culturally sensitive services in the area. If the Smiths receive services at another agency, they will have less deaf-friendly services but more privacy. Dr. Jones and Evelyn agree that they want the Smiths to have the opportunity to decide which of these values are more important to them. Evelyn writes a note for the file, summarizing the options that they considered and why they selected this approach. She and Dr. Jones both sign the note.

Step 8. Implement the plan and observe the results. Dr. Jones met with the Smiths. They chose to have individual and family therapy but not to have their daughter in the group. Mr. and Mrs. Smith gave Dr. Jones permission to explain this to Evelyn.

Step 9. Evaluate the success of the action taken. Dr. Jones and Evelyn met to review the decision and to let Evelyn know what the Smiths decided. At their first family therapy session, the family therapist checked with the family to see whether they still felt comfortable with their decision.

Step 10. Revise the plan, if necessary, based on this evaluation. The family therapist will take the responsibility of continuing to monitor how this is working out. Having taken over the case, he or she will be responsible for further treatment recommendations.

Step 11. Make sure that every step of the decision-making process is adequately documented and placed in the client’s chart or record. Dr. Jones and Evelyn carefully reviewed the file before they turned the case over to the family therapist to make sure that all their discussions were accurately noted, dated, and signed.

This decision-making process allowed Evelyn to resolve a difficult and sensitive issue and to do so in a collaborative way so that she did not feel alone or “out on a limb.” It allowed her to come to a decision that respected her needs as well as the needs of the client and to make sure that she had the support of her agency in doing so.

Conclusion

A principles-based ethical decision-making process can help mental health professionals deal with ethical problems or issues that are not adequately dealt with in the codes. Clinical work with deaf individuals requires creativity and flexible thinking, and may pose some special ethical challenges for clinicians. Because the principles underlying the various codes of ethics in the mental health professionals are similar, use of principles-based ethics can facilitate communication in multidisciplinary teams. A principles-based approach to ethics can also assist with creative problem solving when faced with ethical dilemmas.

Familiarity with a professional code of ethics, ethical principles, and relevant state and federal laws (such as the ADA) provides an important foundation for all ethical decisions. In situations where the codes and laws do not provide clear guidance, use of a systematic ethical decision-making process such as the one described here can lead to good and defensible solutions to ethical problems.

For clinicians at any level of experience, consultation with colleagues and supervisors knowledgeable about work with deaf clients is essential to provide high-quality services and to deal with ethical challenges as they arise.
Notes

1. The terms clinician, professional, or mental health professional are used to refer to practitioners in any mental health discipline, such as counseling, psychology, psychiatry, social work, or marriage and family therapy.

2. In this article, the convention of capitalizing the word deaf to indicate affiliation with the Deaf culture and community is followed. Use of the lowercase simply indicates an audiological condition of hearing loss.

3. This discussion does not provide legal guidance or consultation on specific cases. If such assistance is needed, an attorney experienced in mental health law or the ethics committee of the relevant professional association could be consulted.

4. This case, including all names and situations, is fictitious.

References


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