Counseling is defined in the *ACA Code of Ethics* (American Counseling Association [ACA], 2014) as “a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (Preamble). In exploring the role of values in counseling, key terms in this definition are *professional*, *empower*, and *goals*. Counseling is a *professional* relationship that differs from other close relationships, such as friendships. Friends provide each other with mutual support, whereas the counseling process is focused on providing support and help to one party in the relationship—the client. The purpose of counseling is to *empower* clients to determine and work to achieve their own *goals* (Dobmeier, Reiner, Casquarelli, & Fallon, 2013).

Counselors rarely question this definition when they are working with clients whose goals and values are aligned with values that the counselors also espouse. Sometimes, however, clients think, believe, and behave in ways that run counter to the personal values of their counselors. In these instances, counselors may struggle with how to manage the conflicts between their values and the client’s values. Counselors are not expected to agree with the values of their clients, but they must respect the right of clients to hold different values (G. Corey et al., 2015).

The *Code* states that “counselors are aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors” (ACA, 2014, Standard A.4.b.). Although this ethical standard may seem simple and straightforward, it can be difficult—if not impossible—to uphold in practice (Remley...
& Herlihy, 2014). Levitt and Moorhead (2013) contend that values inevitably enter the counseling relationship and can significantly affect many facets of the counseling process. Counselors are expected to be able to set aside their personal beliefs and values when working with a diverse range of clients. It takes effort and vigilance for counselors to remain aware of how their values and beliefs may be subtly entering into a counseling session. As Francis and Dugger (2014) point out, counselors can communicate their personal values in many indirect ways: through nonverbal responses, by focusing on and responding to some elements of a client’s story while ignoring others, and through the suggestions they make and the interventions they select. Because of the power differential that exists in the counseling relationship, clients are in a vulnerable position, and “even the most subtle communication of personal values has a likelihood of swaying a client to act in accordance with the counselor’s values rather than facilitating the client’s exploration of his or her own values” (p. 132). Some research has found that clients tend to change in ways that align with their counselors’ values and adopt the values of their counselors (Zinnbauer & Pargament, 2000).

Although the values of both the counselor and the client are inevitably present in the counseling session, counselors will be less likely to impose their values, even inadvertently, if they are keenly aware of their values, beliefs, biases, and assumptions. It is particularly important that counselors clarify how their own values and beliefs might affect their therapeutic work with clients who present with value-laden issues. When this happens, counselors must set their personal values aside during the counseling session, a process Kocet and Herlihy (2014) call “ethical bracketing.”

When conflicts arise between the strong, deeply held values and beliefs of some counselors and the values and beliefs of certain clients, counselors may object to working with these clients and may want to refer them to another counselor. However, referring a client because of a value conflict constitutes a discriminatory referral, which is unethical. Value conflicts have been at the heart of a series of court cases that have generated controversy in recent years.

The first court case that captured the attention of the counseling profession was Bruff v. North Mississippi Health Services (2001). A similar case, Walden v. Centers for Disease Control and Prevention (2010), occurred about a decade later. These cases are briefly summarized here (for a more detailed discussion, see Herlihy, Hermann, & Greden, 2014). The plaintiff in each case was an employment assistance counselor who referred a lesbian client who had asked for assistance with improving her relationship with her partner. Both Bruff and Walden considered homosexuality to be immoral based on their religious beliefs. Although Bruff’s and Walden’s employers tried to accommodate their religious beliefs, both counselors were eventually terminated from employment. Each sued, claiming religious discrimination against them. The courts in each case upheld the termination of employment but based their decisions on the finding that the counselors had been “inflexible” in responding to their employers’ attempts to accom-
modate their religious beliefs. These cases raised, but did not resolve, the question of whether counselors can use their religious beliefs as the basis for refusing to provide affirmative counseling to nonheterosexual clients.

Two other widely publicized court cases involved master’s-level school counseling students who were dismissed from their training programs (Keeton v. Anderson-Wiley, 2010; Ward v. Wilbanks, 2010, 2012). These cases presented challenges to the ACA Code of Ethics (ACA, 2014). In the first case, Jennifer Keeton, a counseling student at Augusta State University (ASU), stated that she “condemned homosexuality” based on her interpretation of the Bible’s teachings and that she approved of reparative or conversion therapy. The second case involved Julea Ward, who was a student enrolled in her counseling practicum at Eastern Michigan University (EMU) when she was assigned a client whose records indicated that she had previously sought counseling to discuss same-sex relationship issues. Ward informed her practicum supervisor that her religious beliefs prevented her from providing “gay-affirmative” counseling (Ward v. Wilbanks, 2010, p. 34), and the client was reassigned to another counselor. The counseling faculties at both ASU and EMU offered to assist the students in learning to set aside their own belief systems while counseling diverse clients, but neither student completed a remediation plan. Both Keeton and Ward eventually were dismissed from their degree programs, and they brought suit against the faculties and the universities appealing their dismissals. The legal process has been concluded in both cases: The Court in Keeton upheld the decision of the faculty at ASU, and the Ward case was settled to the mutual satisfaction of the parties prior to trial in 2012 (Dugger & Francis, 2014). (If you are interested in learning about these cases in more detail, see the special section of the Journal of Counseling & Development, April 2014). All of these cases have illuminated an important question: What is the ethically appropriate way to resolve conflicts between personal values and professional ethical standards?

As we discuss in the Introduction to the Casebook, the taskforce that created the ACA Code of Ethics (ACA, 2014) was aware of the questions that had arisen because of the court cases. As a result, revisions to the Code provide direction and clarification regarding values-related issues. The professional values statement in the Preamble spells out the professional values of enhancing human development, honoring diversity, promoting social justice, safeguarding the integrity of the counseling relationship, and practicing with competence and ethical diligence. These values are presented as a way to strengthen the foundation for other sections of the Code that deal with values and related issues of referrals, competence, and discrimination. To add more guidance to the standard that counselors must be “aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors” (Standard A.4.b.), a new standard was added that specifically prohibits making referrals “based solely on the counselor’s personally held values, attitudes, beliefs, and behaviors” (Standard A.11.b.). Counselors are advised to “seek training in areas in which they
are at risk of imposing their values onto clients, especially when the counselor’s values are inconsistent with the client’s goals or are discriminatory in nature” (Standard A.11.b).

In previous versions of the Code, it was not clear that referrals must be based on lack of competence rather than value conflicts. Not only must counselors practice within the boundaries of their competence (see Chapter 4), they must develop multicultural competency in working with a diverse client population (Standard C.2.a.). Multicultural competence is addressed in an additional standard that notes that “counselors do not condone or engage in discrimination . . . based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital/partnership status, language preference, socioeconomic status, immigration status, or any basis proscribed by law” (Standard C.5.). This last standard serves as a reminder that value conflicts can occur around many issues. Counselors may struggle with the behaviors of clients regarding abortion, the right to die and end-of-life decision making, child or elder abuse, genetic engineering, premarital and extramarital sex, and religion and spirituality (G. Corey et al., 2015; Remley & Herlihy, 2014). The four court cases described earlier revolved around clashes between the religious beliefs and values of counselors and counselors-in-training and the chosen goals of their clients that were related to the clients’ sexual orientation. In Case Study 10 (A Parental Dilemma: Hastening the Death of a Child), presented at the end of this chapter, the counselor must be aware of and bracket his personal values regarding end-of-life decision making so that he can be effective in assisting the parents of a terminally ill child.

Any consideration of values needs to include both the personal values of a counselor and the professional values of the counseling profession. The Preamble to the Code of Ethics (ACA, 2014) communicates the collective values of the counseling profession (Francis & Dugger, 2014) that “are an important way of living out an ethical commitment.” Ethical problems can occur when the personal values of a counselor are in conflict with the professional values of counseling and this conflict is not resolved. Individuals who aspire to become counselors need to be able to embrace the professional values that are articulated in the Code and to integrate professional ethics with personal values (Handelsman et al., 2005). Ametrano (2014) describes how students learn, throughout their enrollment in an ethics course, to become more aware of how their values influence ethical decision making and reconcile their values with the values of the profession. Sometimes, when counselors-in-training become aware of personal values that may interfere with their ability to work effectively with a client whose values, beliefs, or behaviors conflict with their own values, they struggle to learn how to work effectively with the client. If they are open to learning new cultural competencies and a process for setting aside their personal values, opportunities will be provided throughout their training program. In Case Study 9 (I’m Stuck), such a scenario is depicted when a student experiences a values conflict during a role-play counseling ses-
Managing Value Conflicts

Managing Value Conflicts

The case describes some of the learning opportunities provided to her as she works to resolve this conflict.

Working at the intersection of personal and professional values can be particularly difficult for counselors and counselors-in-training who hold strong personal beliefs or values, but the ethical mandates of the profession must be upheld regardless of the counselor’s personal values (Granello & Young, 2012). If you are a student and, during your training experiences, you find it difficult to work with clients whose behaviors conflict with your values, it is vital for you to learn to promote the welfare of your clients by assisting them in finding their own way (Remley & Herlihy, 2014). G. Corey et al. (2015) capture the essence of this learning when they state: “Counseling is about working with clients within the framework of their value system. If you experience difficulties over conflicting personal values, the ethical course of action is to seek supervision and learn ways to effectively manage these differences” (p. 73). They further add: “The counseling process is not about your personal values; it is about the values and needs of your clients. Your task is to help clients explore and clarify their beliefs and apply their values to solving their problems” (p. 73). It may be helpful to use the decision-making model offered by Kocet and Herlihy (2014) to learn how to work through personal and professional value conflicts.

Clearly, the issue of values in the counseling relationship is complex. Values are always present in the counseling relationship and arise visibly in a number of the case studies that appear in different chapters. In Case Study 1 (Keep Kendra’s Secret, or Not?), the counselor needs to reflect on the goals for counseling a teenager who is engaging in cutting behavior, to ensure that the goals are not based on her own personal reactions and values related to self-harm behavior. In Case Study 5 (The Slap—How to Best Help Hope), the counselor needs to be aware of his own values and beliefs related to child rearing and discipline so that he does not judge his client’s behavior according to his own values. The counselor in Case Study 12 (A Pregnant Teenager: A School Counselor’s Quandary) recognizes the necessity of reflecting on his own values regarding teen pregnancy and abortion. Two case studies present values issues related to religious beliefs. In Case Study 13 (Disputing Unhealthy Beliefs or Imposing Values?), a counselor must be aware of her views that a client’s religious beliefs may be an impediment to progress in counseling, so that she will be able to work within the client’s belief system. In Case Study 20 (An Imposition of Values?), a college counselor struggles with what to do when she perceives that a client’s religious beliefs are contributing to the client’s mental health problems. Values issues are pervasive in counseling, and they present some of the most troubling ethical dilemmas that counselors encounter.

As counseling students begin to work directly with clients, it is likely that the value conflicts we describe in this chapter will emerge in some fashion. When that happens, keep in mind that your counselor educators and supervisors will respect your values and will not ask you to “give
them up.” Rather, they will expect you to be aware of your personal values and to monitor how your values are influencing your counseling work. If you have difficulty in maintaining objectivity regarding a certain value, consider this as being your problem rather than the client’s. If you cannot bracket, or set aside, your values so that you can listen to the client’s agenda, then you might want to consider whether counseling is the right profession for you. Your ethical responsibility is to be open to further learning and supervision, and perhaps personal counseling, to understand how your personal values are intruding in your professional work.

Case Study 9
I’m Stuck
Anneliese A. Singh

Larissa, age 26, is enrolled in a master’s degree program in counseling with the goal of becoming a school counselor. She is a full-time student who is now in her second semester. One of the courses she is taking is Advanced Counseling Methods. In this course, students are assigned to counsel a “client” for six sessions. Each “client” is a doctoral student in the counselor education program who has been instructed to role-play the same client throughout the six counseling sessions. The course instructor, Dr. Charles, observes each session and provides feedback to the student.

Larissa’s “client” is Tamara, who is role-playing a 16-year-old African American high school student. As the first session begins, Tamara presents as distraught and tearful and states that she is seeking counseling because she is experiencing conflict in a romantic relationship. When Larissa asks her to say more about the relationship, Tamara describes a series of misunderstandings within the relationship that have left her with hurt feelings and wondering whether this is the “right” relationship for her. As she talks, she refers to the other person in the relationship as “this person,” “my significant other,” and “my so-called partner.” Larissa attempts to reflect back to Tamara her understanding of what Tamara has expressed by stating, “It sounds as though you are questioning whether it’s even worth it, to keep trying to work things out with him.” Tamara looks at her for a long moment, and then says, “It’s not a ‘him,’ it’s a ‘her.’ I’m a lesbian.” There is a lengthy silence, and then Larissa turns to Dr. Charles and says, “I’m stuck.”

Dr. Charles begins processing the aborted session by asking Larissa to reflect on what was happening with her when she got stuck and asks if Larissa had been assuming that her client’s romantic relationship had been a heterosexual one. Larissa acknowledges that she had been making that assumption and was taken by surprise, but she believes she will do a better job in the next session. She says she will work on checking her assumptions.

During the second role-play session, Tamara again expresses her distress over the conflict in her relationship with her girlfriend. Larissa inquires
about Tamara’s support system and asks whether she has “come out” to her parents and her friends. Tamara responds that she has kept the relationship a secret, but if it works out, she plans to be open about it with friends and family and would like some help with handling the process of coming out. Larissa then attempts to explore Tamara’s history of romantic relationships, asking if she has dated or been attracted to boys. The remainder of the session does not go well; Tamara withdraws and is minimally responsive.

When Dr. Charles processes this second session with Larissa, Larissa admits that she realizes the session was not productive. She thinks it would help her if she could be clear about the goals for counseling this client. She says that she believes it would be therapeutic for the client to explore her sexual orientation because “she’s young, and she could change.” She tells Dr. Charles that she has heard of “conversion therapy” and would like to learn more about it before the next session. Dr. Charles reminds her that the counseling goals must be set by the client, not the counselor, and that the client has expressed goals of resolving conflict in her current relationship and coming out as lesbian. At this point, Larissa says, “I just don’t know how to work with this client. I grew up in a very religious family, and it was ingrained in me that homosexuality is a sin.” She adds, “I know I need to learn how to work with sexual orientation issues if I am going to work effectively with teenagers.”

Questions for Thought and Discussion

1. If you were the course instructor, where would you start in helping Larissa learn to be a more effective counselor?
2. Do you think Larissa can learn to counsel clients with different sexual orientations, given her religious beliefs? If so, what would be the best ways to help her learn?

Analysis

This master’s student seems to be open to learning how to counsel lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQQ) clients. She is only in her second semester, and she will have many opportunities to develop her competencies. First, she will need to focus on increasing her self-awareness. Dr. Charles might ask her to construct a spiritual/religious timeline to explore her developmental process. Larissa might talk with her pastor or a counselor who shares her faith to clarify whether there is room for acceptance of differences within its belief system or, if not, whether she feels the interior freedom to question the beliefs with which she was raised.

Constructing a sexual orientation development timeline (Dobmeier et al., 2013) might also help Larissa to recognize the sexual orientations of others as normal. Because the United States is a heteronormative society (i.e.,
heterosexual norms are advantages), a first step toward LGBTQ-affirmative counseling is for counselors to actively self-reflect on their own gender, sex, and sexual orientation. Larissa could ask herself questions such as: “How did I learn to perform my gender?” and “What were the consequences for stepping outside of norms ascribed to my gender, sex, and sexual orientation?” This may help her to identify her internalized stereotypes that can affect her work with LGBTQ clients. Counselors who have not identified these stereotypes will be operating on assumptions that can mask the actual issues and needs LGBTQ people bring to counseling.

Second, Larissa will need to learn how to set aside her personally held values and beliefs so that she does not impose them in the counseling relationship (ACA, 2014, Standard A.4.b.). It will be important for Dr. Charles to clarify to Larissa that the counseling faculty will not ask her to change her beliefs, only to learn to bracket them so they do not enter into the counseling relationship (Kocet & Herlihy, 2014). She will need to learn how to respect the diversity of clients and avoid imposing her own values. Larissa’s “client,” the doctoral student who is role-playing Tamara, can give her feedback on how she experiences Larissa as a counselor during their sessions. This may help to increase Larissa’s awareness of how her values and assumptions affect the client and the counseling process.

Third, Larissa needs to gain knowledge and skills in working with diverse populations, and with LGBTQ clients in particular. Larissa will need to develop facility with language that is affirmative and understand the definitions, similarities, and differences among words such as sex and gender. Society has previously understood sex as being defined as “male” or “female,” whereas we now know there are multiple configurations of sex. Most important, counselors should know that sex is assigned at birth and that no one is “born a girl” or “born a boy.” In addition, counselors should know that gender identity has expanded from terms such as man and woman to include transgender and genderqueer. Counselors who work with young LGBTQ people should be prepared to hear language to describe one’s gender identity that may be evolving and new (e.g., gender blender, gender fluid). The goal for ethical treatment around issues of identity and language is for counselors to be open and ask LGBTQ clients which words and pronouns they use to best describe their identities.

Larissa will need to become familiar with language related to these identities. Transgender people, for instance, may have been assigned a sex at birth that does not align with their gender identity and expression. Cisgender people do identify with the sex they were assigned at birth, as it is in alignment with their gender identity and expression. Transgender and cisgender people have sexual orientations that may range from gay (typically male-identified people attracted to other male-identified people) to lesbian (typically female-identified people attracted to other female-identified people) and bisexual or queer (attracted to a range of gender identities and expressions). Because the LGBTQ community is dynamic and vibrant,
Managing Value Conflicts

counselors should seek to become aware of constantly evolving terms to use in working with LGBTQQ clients.

As Larissa continues to gain knowledge, she will learn that LGBTQQ people are not a monolithic group; they have a diversity of identities related to race/ethnicity, age, gender identity and expression, migration status, social class, ability status, and religious/spiritual affiliation (Chun & Singh, 2010). When counselors assume that all LGBTQQ people have the same values, feelings, experiences, and behaviors, there is risk for a rupture in the counseling process. As Larissa continues her role-play sessions with Tamara, who as an African American lesbian encounters multiple forms of oppression, she will need to develop a strong understanding of intersectionality theory, which asserts the interdependence of multiple identities (Warner, 2008). LGBTQQ clients of color, for instance, may have very different value systems and experiences than White LGBTQQ clients because of the intersection of racism and heterosexism in their lives (Singh, 2013).

Even after Larissa has developed increased self-awareness and knowledge related to working with a diversity of LGBTQQ clients, she may find it challenging to work with the “coming out” process. Counselors need to have skills in creating a safe space for LGBTQQ clients to explore issues of coming out related to friends and family at home, in the workplace, and at school. Larissa’s client expressed a desire for assistance in coming out, so Larissa will need to become competent in carefully and collaboratively assessing the variety of issues that LGBTQQ clients may face in the coming out process. Because issues of homophobia, transphobia, and biphobia are embedded in U.S. society, LGBTQQ youth face numerous negative consequences from this societal discrimination, such as being kicked out of their homes (Haas et al., 2011) and being bullied at school. The skills counselors need in supporting LGBTQQ people in coming out include being able to connect clients with resources to support systems such as support groups, online resources, and media. Research has shown that LGBTQQ youth and adults face significant societal discrimination that affects well-being and has negative consequences such as suicidal ideation, substance abuse, unsafe sexual practices, homelessness, and job loss (Haas et al., 2011; Singh, 2010). Counselors should be prepared to conduct a thorough assessment of suicidal ideation, self-injury, and other behaviors and environments that place clients at risk for harm. LGBTQQ people have developed multiple strategies of resilience related to navigating this oppression (Singh, 2010, 2013). Therefore, any assessment of safety and risk for LGBTQQ clients should also include an assessment of resilience and strengths clients may use to increase their well-being.

Another issue to be addressed is related to Larissa’s comment to Dr. Charles that she had heard of and wanted to learn more about “conversion therapy” or “reparative therapy,” which attempts to “change” a person’s gender identity and gender expression and/or sexual orientation. Dr. Charles can make Larissa aware of the positions of the major helping profession organizations
(such as ACA and the American Psychological Association) that have deemed these types of therapy as harmful to LGBTQQ clients. As Larissa continues her studies, she will learn that counselors do not use techniques “when substantial evidence suggests harm, even if such services are requested” (ACA, 2014, Standard C.7.c.). Larissa will need to develop the ability to talk with LGBTQQ clients and others about the importance of LGBTQQ-affirmative counseling, as research has supported the benefits of this approach for the well-being of LGBTQQ people. Addressing issues of heterosexism and exploring the ways this heterosexism has been internalized become the goals of ethical LGBTQQ-affirmative counseling practice.

As Larissa moves through her training program, she will learn that a central component of ethical and affirmative practice with LGBTQQ clients includes becoming an ally for this group across the life span. When working with family members who are struggling with supporting their LGBTQQ child, the counselor should be able to ally with the child and provide helpful educational resources on the natural diversity that exists across sexual orientation and gender identity. When Larissa completes her field experiences, and when she practices as a school counselor, ally behavior will include assessing her work environment to determine the extent to which her counseling office is safe for LGBTQQ students. What these student clients see in the counseling environment (books, media, a Safe Zone sticker) signals to them the presence of affirmative support.

Questions for Further Reflection

1. How would you assess your own competence to work with diverse client populations?
2. What personally held values and beliefs do you hold that you might inadvertently impose on clients?

Case Study 10
A Parental Dilemma: Hastening the Death of a Child

Karen Swanson Taheri

Naomi and Roger are the parents of a 4-year-old son, Markus. They have been married for 10 years and sought counseling approximately 1 year ago after their son had experienced several medical issues. Naomi and Roger felt a need for support from an individual outside of their family, and they explained that their initial goal for counseling was to “learn how to better cope with Markus’s health problems and to have some extra support throughout his medical treatments.”

During their initial session with their counselor, Trevor, the parents stated:
We have been through so much trying to figure out what is going on with his health so we can help him get better. We’ve been financially strained because we cannot really afford all of the medical bills we have been receiving, and we are so stressed! At the very least, we want to know what is going on with his health. We’ve been to three doctors, and no one has been able to give us a straight answer. He has been sick off and on since he was very young, but lately he has had a high fever and seems to get infections much more easily.

Shortly after the couple began therapy, Markus was diagnosed with leukemia. He has undergone two rounds of chemotherapy and has never entered remission. About 4 weeks ago, Markus’s oncologist informed Naomi and Roger that Markus’s leukemia had progressed beyond treatment and gave Markus a 6-month prognosis, contingent on Markus continuing to receive regularly scheduled blood transfusions. In addition to the transfusions, the doctor recommended a morphine and benzodiazepine regimen and stated that he would steadily increase the dosage of both medications to ensure Markus’s comfort as death approached.

Naomi and Roger disagree about what medical treatment is best for their son. Naomi, who strongly believes in utilizing medication only when it is absolutely necessary for curative purposes, does not want Markus to receive pain medications that could potentially hasten his death. She views the morphine and benzodiazepine regimen as one such combination and states that she has read several articles online that describe the possibility that higher dosages of this combination of drugs can hasten death in terminally ill patients. Naomi also communicates that she does not want Markus to continue receiving blood transfusions because, from her perspective, these transfusions may be prolonging unnecessary suffering in her child by extending his life “for a short while.”

Roger wants to keep Markus “alive as long as possible” to lengthen the time he has with his son. Roger also would like Markus to be “as comfortable as possible” throughout the dying process, even if it means his death is hastened by the pain medication. Roger has declared several times, “I do not want my son to suffer unnecessarily, and I think his not receiving the morphine would be harmful to him.”

Both parents have repeatedly communicated their sadness regarding Markus’s impending death, and neither is ready to say goodbye to their son.

Questions for Thought and Discussion

1. If you were the counselor for this couple, how might your own values contribute to or hinder your ability to remain effective throughout the counseling process?
2. Do you consider yourself competent to provide counseling to the couple throughout the end-of-life decision-making process for their son? How would you determine your competence? If you do not
Issues and Case Studies

consider yourself competent to continue to work with them, how would you proceed?
3. What is your role as the counselor for this couple? Is it necessary to redefine the goals of counseling now that Markus has received a terminal diagnosis?
4. Considering the moral principle of “do no harm,” what do you think would constitute harm to each individual (Naomi, Roger, and Markus) in this situation? How does each of Markus’s parents define harm? If your definition differs from theirs, how would you handle that difference as their counselor?
5. Does the term neglect apply to this situation? Under what circumstances might neglect apply?

Analysis

When it comes to deciphering whether to break confidentiality because someone may cause “serious and foreseeable harm” to another, the ACA Code of Ethics (ACA, 2014) states that “additional considerations apply when addressing end-of-life issues” (Standard B.2.a.). Standard B.2.b. addresses confidentiality regarding end-of-life decisions and provides guidelines for working with terminally ill clients, but it provides no guidance for working ethically with parents or caregivers who are the end-of-life decision makers for a terminally ill patient. Refusal of medical treatments for terminally ill minors legally may be considered to be neglect, so Trevor will need to consult the law in his state and consult with other mental health professionals who work with terminally ill children.

Naomi and Roger are the legal guardians of Markus, and because of Markus’s legal status as a minor, he is unable to consent to his own medical treatment. The decision regarding medical treatment belongs to Markus’s legal guardians. In this case, Trevor’s role is to be with the parents as they come to a decision about Markus’s end-of-life care and to provide a safe and supportive environment for Naomi and Roger to consider all of their options.

It is extremely important that Trevor remain aware of his own personal values regarding the end-of-life treatment of Markus and that he maintain appropriate boundaries throughout the counseling process. It is not Trevor’s role to sway one parent or the other but to provide a supportive environment for the couple to explore this dilemma together.

Questions for Further Reflection

1. How might cultural considerations come into play in this situation or in other situations regarding the end-of-life decision-making process for minors?
2. If Markus was 13 years old instead of 4 years old, would your intervention be different? If so, how?