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Ethical Dilemma Resolution in HIV/AIDS Counseling: Why an Integrative Model?

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In this study the authors provide an in-depth analysis of each of the eight categories of ethical dilemmas faced by professionals counseling individuals living with HIV/AIDS. The eight ethical dilemma categories involve disclosure, vocational, legal, health, family/social, sexual, death, and counselor/client relationship issues. This study builds on previous research conducted by the authors by discussing the basic components of the Integrative Decision-Making Model of Ethical Behavior and analyzing reasons for making this approach the model of choice in resolving ethical dilemmas faced by counselors working with this particular population.

KEY WORDS: HIV/AIDS; ethical issues; counseling.

INTRODUCTION

Ethical dilemmas are situations where professionals face two or more competing courses of action. By choosing one course of action, they may compromise the ethical principles supporting the other competing courses of action (Beauchamp and Childress, 1983; Jordan and Meara, 1995; Wilson *et al.*, 1991). To resolve these conflicts, professionals traditionally have resorted to an ethical dilemma resolution model based on cognitive reasoning that utilizes primarily principle ethics (Beauchamp and Childress, 1983; Forester-Miller and Davis, 1995). Under this model, professionals first identify the principles underlying a dilemma, typically autonomy, beneficence, nonmaleficence, justice, or fidelity. Once professionals have identified the principle, they determine several viable courses of action and select one based on a rational evaluation of the advantages and disadvantages of choosing one course of action over another. This implies making a rational justification for choosing one ethical principle (e.g., autonomy) while compromising another (e.g., client beneficence) (Bersoff, 1996).

Other ethical dilemma resolution models involve moral reasoning approaches based primarily on virtue ethics (Jordan and Meara, 1995). The intuitive method developed by Kitchener (1984) is an example of such a model. Virtue ethics models rely on the personal characteristics and moral beliefs of the professionals making an ethical decision instead

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of relying on the ethical principles involved. Proponents of this model claim that it is very difficult to reach an agreement as to what principle should prevail in a particular situation. Furthermore, professionals should not be oblivious to the human and historical characteristics of the parties involved in an ethical quandary.

Yet other ethics researchers have suggested an integrative model for ethical dilemma resolution that incorporates elements of moral and cognitive models, as well as principle and virtue ethics, into one model. Tarvydas and Cottone (1991) and Tarvydas (1998) described the Integrative Decision-Making Model, which combines an analysis of the morals, beliefs, and experiences of the individuals involved along with a rational analysis of the ethical principles underlying competing courses of action. To proceed effectively with this model, professionals need to develop the attitudes of reflection, balance, attention to context, and collaboration. We discuss these models of ethical dilemma resolution in detail in a later section of this article.

Professionals have applied ethical conflict resolution models to dilemmas arising in different counseling settings and with a variety of client populations. Perhaps the most challenging dilemmas are those faced by professionals counseling clients living with HIV/AIDS, which is the primary focus of this article.

Several studies concerning counseling clients living with HIV/AIDS have described ethical dilemmas involving professional responsibility and competence, particularly as they relate to confidentiality and disclosure (Garcia *et al.*, 1999; Garrett, 1995; Harding *et al.*, 1993; Peterson and Siddle, 1995; Stanard and Hazler, 1995; Walther and Mason, 1994). These studies reported ethical dilemmas faced by professionals working in different settings such as hospitals, rehabilitation facilities, schools, mental health clinics, and prisons. These dilemmas usually entail confidentiality versus disclosure of information about one's HIV/AIDS status to other parties such as sex partners, family members, or employers. Although the focus on this conflict is understandable because of its large impact on the counselor/client relationship and the need to protect the different parties from serious harm, counselors might face dilemmas pertaining to client actions or decisions of a different nature. For example, a dilemma can occur for counselors when clients decide to discontinue work and rely instead on welfare or disability benefits. Counselors may either support this decision under the principle of client autonomy or confront it under the principle of beneficence (e.g., clients can increase their income and quality of life). Other examples illustrating the same conflict could include refusal of medical treatment or adopting an unhealthy lifestyle.

Garcia *et al.* (1999) conducted a study to identify the nature of ethical dilemmas presented to HIV/AIDS counselors due to some of their clients' decisions. Their hypothesis was that there were eight categories of ethical dilemmas. These categories included legal, vocational, health, family, sexual, death, counselor/client relationship, and disclosure. Through a 62-item Ethical Dilemma Survey (EDS) mailed to professionals counseling clients with HIV/AIDS, the researchers investigated the extent to which respondents believed that each of those 62 client actions or decisions constituted an ethical dilemma. The researchers used confirmatory factor analysis to analyze the data, and results indicated that the eight-factor design was a plausible model.

The occurrence of such breadth of ethical dilemmas in HIV/AIDS counseling warrants further research to develop methods of ethical dilemma resolution that can be effective in this area of counseling. The purpose of this article is to contribute to this line of research by exploring use of the integrative model in helping resolve ethical dilemmas faced by counselors working with this population. Specifically, we first expand the Garcia *et al.* (1999)

study by examining each of the eight ethical dilemma categories in depth. Second, we summarize the basic components of the integrative model to resolve ethical dilemmas. Third, we provide reasons for its utilization by professionals facing ethical dilemmas encountered in their counseling clients living with HIV/AIDS. We provide examples as appropriate.

ETHICAL DILEMMA CATEGORIES

Many published articles have addressed various types of disclosure issues that can become ethical dilemmas for counselors working with individuals with HIV/AIDS. The literature specifically focuses on confidentiality issues and the duty to warn (e.g., Cohen, 1990; Harding *et al.*, 1993; Lynch, 1993; Schlossberger and Hecker, 1996; Stanard and Hazler, 1995). Although disclosure issues are certainly important issues on which to focus, the authors of the Garcia *et al.* (1999) study hypothesized that counselors working with this population face several other ethical dilemmas that warrant examination. Based on a review of the literature and the authors' experiences working in rehabilitation and mental health settings with people living with HIV/AIDS, the authors developed the eight hypothetical categories of ethical dilemmas. The eight ethical dilemma categories were disclosure, vocational, legal, health, family/social, sexual, death, and counselor/client relationship issues. In this section, we describe each of these eight ethical dilemma categories and the specific themes found under each of these categories, as described in the study by Garcia *et al.*

Disclosure

This category contains a total of 12 items grouped into three major themes. The first theme includes those items related to clients' refusal to reveal their HIV status to relatives and friends, sexual and drug partners, and children. The second theme relates to those items that refer to clients' indirect communication of their HIV status to other parties. The third theme involves situations where disclosure may lead to potentially harmful consequences to clients.

An example under the first theme involves refusing to disclose one's HIV/AIDS status to family members and friends, which in turn may isolate individuals living with HIV/AIDS from needed support and assistance. In this case, a key question that counselors need to ask themselves is how to act in the best interest of the client by helping the client to understand the benefits of disclosure. Applying the principle of beneficence could compromise the principle of autonomy. Another situation under this theme involves clients who will not disclose their HIV status to sex partners or drug partners, thereby endangering the welfare of these third parties because of risk of infection. A question for counselors facing this dilemma would be how best to protect those third parties under the principle of nonmaleficence. The principle of nonmaleficence seems to be in conflict with the principle of client autonomy. A third situation under this theme involves parents' refusal to disclose to children that they are HIV positive. This decision may have the consequence of preventing children from participating in their own treatment. At the same time, this raises the theoretical issue of whether children have the right to autonomy and even the right to know such information. Critical questions for the counselor may include "How much should children know about their condition?" and "What are the potential consequences of this disclosure?" In this case, exercising the principles of autonomy and justice could potentially compromise the principle of beneficence or nonmaleficence.

A second major disclosure theme relates to the ethical dilemmas that may arise when clients decide to communicate their HIV status only in an indirect manner. Examples of indirect communication are practicing safe sex and avoiding sharing needles under the assumption that this behavior eliminates need for disclosure by reducing risk and clients' partners would eventually get the message that the clients are HIV positive. An indirect form of communication may protect clients from social harm of disclosure, such as loss of love partners or social isolation, but at the same time may compromise the welfare of their partners or compromise their partners' right to know this information. A question for counselors would be, "To what extent does the benefit of indirect communication outweigh the potential harm for the third party?" The principle of beneficence is in opposition to the principle of nonmaleficence or justice in this situation.

The third disclosure theme involves situations where clients' disclosure of their HIV status may lead to potentially harmful consequences for them. Deciding to disclose one's HIV status to sexual partners with a history of violence who may react in life-threatening ways against clients is an example of a client situation that may lead to this dilemma. A question for counselors is, "To what extent is the duty to protect the client more important than the duty to protect the third party?" In this case, the principle of nonmaleficence to clients would be in opposition to the principle of nonmaleficence to others. Another situation in which this dilemma may arise is with clients involved in custody suits in which clients avoid disclosing their HIV status to the court. In this case, disclosure may lead to loss of custody of children, but nondisclosure may lead to harmful consequences for children if a custodial parent becomes too ill to care for the children. One key question for counselors would be, "Whose interests should prevail, those of the client or those of the child?" The principle of justice would be in opposition to the principle of beneficence or nonmaleficence for both clients and children.

Vocational Issues

Five items on the EDS comprised the vocational issues category. Themes found under this category include items depicting situations that involve client decisions that could lead to harm and items depicting situations that involve client decisions that may be unfair to others.

The first vocational theme, situations that involve client decisions that could lead to client harm, included scenarios such as clients choosing a job that may be harmful to them (e.g., excessive physical demands or emotional stress), deciding to stay at work despite a decline in health, and refusing work accommodations provided by their employer (e.g., reduced hours). In each of these situations, a question for counselors is, "Do the principles of beneficence and nonmaleficence prevail over the principle of autonomy?" Counseling clients who are working at jobs that may cause harm to themselves may lead counselors to feel torn between promoting client autonomy and promoting the well-being of their clients.

The second vocational theme relates to client decisions that may be unfair to others. A situation included under this theme may be one that involves clients who are seeking to leave a job and apply for disability benefits despite still being able to work. A question for counselors in this situation is, "Does the principle of autonomy prevail over the principle of justice?" In this case, counselors must decide whether a client's right to make an autonomous choice should take precedence over the right of taxpayers to have their dollars spent with fairness.

Legal Issues

This category of ethical dilemmas included three items. Each legal item represents a distinct legal theme. Working with clients who have decided to take legal actions against an employer related to their HIV/AIDS status can be an ethical dilemma for counselors because, although this action may remedy discrimination, it also could lead to blacklisting by other employers. The dilemma for counselors is whether to give precedence to the principle of justice or to the principle of nonmaleficence. Counselors also may face a dilemma when working with clients who engage in financially irresponsible behaviors such as exceeding their credit card limit amount or borrowing large sums of money that they have no intention of repaying. A question for counselors may be, "Whose rights should take precedence, the client's or society's?" There is a conflict between the principle of autonomy as it relates to clients and the principle of justice as it applies to society. Another legal dilemma occurs when clients request a counselor's assistance with making legal decisions in relation to issues such as power of attorney and wills. This would be a role that counselors do not typically assume and one in which the average counselor does not have expertise, but counselors who want to help their clients may face a dilemma here. It seems important that counselors not go beyond their counseling role. The dilemma for counselors would be to help clients in these matters under the principles of paternalism or fidelity versus encouraging clients to exercise autonomy.

Health Issues

Six questions comprise the health category of ethical dilemmas. These questions consist of two themes: client actions and decisions that indicate that they are not taking good care of their own health and client actions that constitute risky behavior.

Clients who continue to use alcohol or drugs, refuse to seek medical care for treatment of HIV, or refuse to comply with a medication regime are examples of situations where clients are not taking adequate care of themselves. A dilemma for counselors here may be whether to encourage personal autonomy or to act on behalf of the principles of beneficence and nonmaleficence and provide an intervention to help clients take better care of their health.

The second theme of health-related dilemmas relates to counseling clients who are engaging in risky behavior in relation to their health. Examples of situations under this theme include clients who decide to conceive children despite their HIV/AIDS status or clients who participate in clinical research trials. A dilemma for counselors in these cases would again relate to the principle of autonomy versus the principles of beneficence and nonmaleficence.

Family/Social Issues

The family/social issues category included six questions sorted into two themes: client actions that involve family members and client actions that involve significant others. Client actions related to family issues that may pose ethical dilemmas for counselors are avoiding family contact due to their HIV/AIDS status, refusing to accept assistance with personal care from loved ones, refusing to have their children tested for HIV/AIDS, and refusing to return home where increased family support may be available. Client actions regarding

their significant others that may create ethical dilemmas for counselors are choosing to discontinue a committed and positive relationship due to one's own HIV/AIDS status and choosing not to enter a positive committed relationship due to one's own HIV/AIDS status.

The above client actions can generate ethical dilemmas for counselors based on the competing principles of client autonomy and beneficence. Clients' actions to withdraw from family support is in conflict with counselors' actions to promote clients' welfare by strengthening such support. A question for counselors in this case is, "Which principle should prevail, client autonomy or beneficence?"

Sexual Issues

Sexual issues are the focus of six questions on the EDS. Five questions deal with HIV-positive clients having some form of unsafe sex, such as having sex with intravenous drug users or multiple partners, and one question deals with individuals abstaining from all forms of sex with their partner. The ethical dilemmas that may arise for counselors again reflect conflicts between the principle of autonomy and the principles of beneficence and nonmaleficence. Although it is important to respect clients' decisions, in this case such decisions may conflict with each counselor's duty to promote the welfare of clients and prevent harm from occurring to clients or others. Clients who are having unprotected sex can be inflicting harm onto others and may be inflicting additional harm onto themselves. Counselors have a duty to warn identifiable third parties in this case, but that presents a dilemma because it can cause irreparable harm to the counselor–client relationship. A key question for counselors would be, "Which party does the counselor have the first priority to protect, the client or a third party?" Counselors may face the dilemma of which ethical principles take precedence, client autonomy or nonmaleficence to society.

Death Issues

Seven questions on the EDS are in the death category of ethical dilemmas. There are two themes under this category: issues related to suicide and assisted suicide and issues related to clients' denial or avoidance of death-related issues.

The first theme, issues related to suicide and assisted suicide, includes situations such as clients who ask counselors for assistance with committing suicide, request counselors' presence at clients' assisted suicide, or refuse life support measures. When working with clients who are considering suicide or assisted suicide, counselors must be aware of the particular laws of their state as well as the ethical codes for one's profession. Counselors must also be aware that laws and ethical codes may be in conflict. Some questions that counselors may face are, "Which ethical principle should prevail when a client is facing death due to an advanced stage of AIDS and the client wants to end his or her life?" and "Should the counselor respect the client's autonomy or should the principles of beneficience and nonmaleficience prevail to protect the client from harm and promote his or her well-being?"

The second theme, issues related to clients' denial or avoidance of death-related issues, includes situations such as working with clients who refuse to discuss death, refuse to make any death-related plans, or discontinue counseling services in the final stages of AIDS. Although people with HIV are living significantly longer today with new antiretroviral drug

combinations than they did previously, current drug treatments do not work for everyone and therefore some clients are still facing death (Carpenter *et al.*, 1998). A dilemma for counselors in this situation is whether or not to discuss the issue of death or respect clients' choices to focus on issues other than death. Here the principle of beneficence is in conflict with the principle of client autonomy.

Counselor/Client Relationship

The category of the counselor/client relationship includes nine ethical dilemma items contained under a single theme of whether to accommodate clients' particular requests during counseling sessions even though such accommodation could theoretically lead to incompetent or unprofessional practices. Examples of these items include situations in which clients expect counselors to modify counseling sessions or counselors' standards of practice, bring uninvited relatives into counseling sessions, ask for prayers during counseling, request on-line counseling, pressure counselors to act beyond typical counselor-client boundaries, and request free or reduced counseling fees. Questions for counselors would be, "Should I risk violating the principle of nonmaleficence to the client in order to accommodate the client's needs?" and "Would a departure from proven standards of practice result in harm or damage to the client?"

In the next section, the authors discuss different models of ethical decision making, with an emphasis on the integrative approach. These models provide different strategies to address the questions stated above.

THE INTEGRATIVE DECISION-MAKING MODEL OF ETHICAL BEHAVIOR

Different models of ethical decision making are already in existence. These consist of three model categories: (a) moral discourse or moral development (Kitchener, 1984; Van Hoose and Hottler, 1985), (b) cognitive problem-solving (Forester-Miller and Davis, 1995; Rest, 1984), and (c) integrative (Tarvydas, 1998). The moral models utilize one's ordinary moral sense originated in a person's beliefs and professional experiences. These models do include a reasoning level based on analysis of the ethical principles involved in a dilemma, but only if the issue has not reached resolution at the intuitive or moral level first (Kitchener, 1984).

The cognitive model incorporates a problem-solving approach that utilizes a rational analysis of the ethical standards, principles, and consequences of competing courses of action (Forester-Miller and Davis, 1995) or an interaction of cognitive and affective elements that lead to completion of ethical behavior (Rest, 1984). Even though it is also possible to conceptualize Rest's seminal work as a moral model, current conceptualizations categorize it as a primarily cognitive model of moral reasoning that involves cognition and emotion (Tarvydas, 1998). The moral models are compatible with virtue ethics in that the primary factor in arriving at a decision is the moral sense or personal beliefs of professionals. Relative to the moral models, cognitive models make more extensive use of principle ethics and professionals' cognitions and emotions instead of professionals' moral virtues.

The integrative model proposed by Tarvydas (1998) is a combination of principle and virtue ethics as well as an integration of cognitive and psychological processes. In addition, it considers a contextual level of analysis based on a four-level model of ethical practice

developed by Tarvydas and Cottone (1991). This integrative model is the focus of this section as discussed in detail below.

The foundational idea underlying the Integrative Decision-Making Model of Ethical Behavior described by Tarvydas (1998) is the merging of different ethical decision-making models as suggested by several authors (Corey *et al.*, 1998; Meara *et al.*, 1996). This model comprises several aspects of various decision-making conceptualizations previously described. One concept that serves as a foundation for the Integrative Model is the model of psychological processes of morality first designed by Rest (1984). Rest developed a four-component model which is primarily a cognitive design because its core is a critical analysis of how professionals' actions will affect others. Other components of this model involve formulation of moral courses of action, identification of the ideal moral course of action, and execution and implementation of the selected course of action.

Kitchener (1984) created another seminal ethical dilemma resolution model focusing on levels of moral reasoning, which expands on Rest's (1984) model to include a level of moral reasoning with an element of critical evaluation. She stated that this addition to Rest's existing model was "necessary to guide, refine, and evaluate our ordinary moral reasoning" (Kitchener, 1984, p. 44). She defined the critical-evaluative model according to the ethical principles of autonomy, beneficence, nonmaleficence, justice, and fidelity. Under her model, professionals must abide by a principle unless there are extraordinary circumstances that may question implementation of the action supported by that principle.

Tarvydas and Cottone (1991) expanded on Kitchener's moral reasoning model and suggested that in certain circumstances counselors must consider contextual forces when making ethical decisions. They divided those contextual forces into four levels: (a) the client/counselor relationship, (b) the multidisciplinary teams, (c) agencies or institutions counselors represent, and (d) the societal or policy level. In this model of decision-making, the authors suggest that counselors must move between levels, considering all four levels before making a decision in an ethical dilemma.

Tarvydas (1998) blended both principle and virtue ethics into the four-stage Integrative Decision-Making Model of Ethical Behavior. This four-stage Integrative Model contains subcomponents. The first stage implies that counselors closely examine situations and be aware of what types of situations constitute ethical dilemmas. If counselors are not aware of the latest information in their field of expertise, it is their responsibility to gather relevant information. This stage calls for an increase in sensitivity and awareness in counselors' fields of specialization. The fact-finding process assists counselors in labeling situations as ethical dilemmas and determining the individuals directly affected by these types of situations. If dilemmas occur, counselors not only are aware of the situations, but also recognize the parties affected and their ethical stance in the situations.

Once counselors have completed Stage I of the Integrative Decision-Making Model of Ethical Behavior, they move to Stage II under which they begin to formulate an ethical decision. First, counselors again review the problem specifically to determine what ethical codes, standards, principles, and institutional policies are pertinent to the particular type of situation. Second, after a careful review and consideration of these regulations, counselors generate a list of potential courses of action along with positive and negative consequences for following each course of action. Third, counselors consult with supervisors or other knowledgeable professionals to determine the most ethical course of action.

Stage III is imperative for deciding which is the best course of action. In this stage, counselors must balance competing nonmoral values against their own values and beliefs.

This requires that counselors analyze and reflect on their own values against potentially competing values held by peers, professional teams, institutions at which they work, or society at large.

In Stage IV counselors determine concrete actions they and others need to take, with consideration given to potential obstacles for taking those actions. Finally, counselors must carry out those actions and then document and carefully evaluate the consequences of the ethical dilemma resolution. The next section addresses reasons why the authors contend that the Integrative Model should be the method of choice in resolving ethical dilemmas arising while working with clients living with HIV/AIDS.

REASONS FOR USING THE INTEGRATIVE MODEL IN HIV/AIDS COUNSELING

Counselors who work with individuals living with HIV/AIDS frequently confront significant ethical dilemmas. The manner in which counselors resolve these dilemmas may impact on the lives of their clients as well as others. Because of its contagious nature, epidemic proportions, and the fact that its spread depends on human behavior, HIV/AIDS forces professionals not only to look after the welfare of their clients infected with this disease, but also to find ways to protect third parties and society in general. It is the belief of these authors that the Integrative Decision-Making Model of Ethical Behavior should be the tool of choice for professionals facing ethical dilemmas derived from their clients' behavior. We have outlined reasons for supporting this model below, including considerations such as involvement of at-risk third parties, multiple stakeholders, and contextual factors in implementation of ethical courses of action, all of which play a large role in counseling individuals living with HIV/AIDS.

Involvement of At-Risk Third Parties

There is probably no AIDS-related ethical and legal issue that concerns counselors working with this population more than those related to the duty to protect third parties from clients living with HIV. Since the landmark case of Tarasoff v. Regents of the University of California involving the duty to warn on the part of therapists, case law and statutory law have not been consistent. An analysis of case law by Mills *et al.* (1995) concluded that the trend is to continue imposing a duty to warn even in cases where counselors or other professionals could not specifically identify the victim or in cases where the victim was not the intended target of violence. However, these cases did not relate to HIV/AIDS and usually involved acts of violence against others, such as murder, mass shootings, and arson committed by persons undergoing psychotherapy.

Even though there is a lack of case law regarding HIV/AIDS duty to warn decisions, there are several state laws that make it illegal to disclose a client's HIV/AIDS diagnosis to an unauthorized third party. Counselors or therapists who make such disclosures are subject to criminal charges and malpractice liability (Corey *et al.*, 1998). In cases where there is an existing statute, there is no dilemma because there is a clear legal mandate, unless a professional perceives the law as unjust or unfair on moral or ethical grounds and is willing to challenge it. The dilemma becomes most apparent in situations where state law is absent. Here, clients may sue professionals disclosing the HIV/AIDS diagnosis to other parties on

the grounds of breaching confidentiality or victims may sue professionals if victims became infected with HIV; the basis for this suit would be not disclosing clients' HIV/AIDS status and thereby placing the victims at risk. In the absence of a statute, the dilemma becomes primarily ethical in nature.

The American Counseling Association established guidelines to help counselors contemplating whether or not to breach confidentiality in cases involving clients living with HIV/AIDS who engage in behaviors that put others at risk of infection. The central recommendation is nondisclosure, but counselors may consider breaching this mandate when third parties are identifiable, at high risk of contracting the disease, and it is not foreseeable that clients will inform the victims about their diagnosis. Making this decision involves defining dilemmas in terms of the ethical principles involved (e.g., autonomy versus justice) and identifying a course of action after weighing consequences of different possible courses of action, as defined under the typical rational and principle-based ethical resolution model.

According to Cohen (1997), resolving the above dilemma implies acting at different levels. First, at a theory level, one can approach it from both deontological and utilitarian perspectives. A deontological approach, also conceptualized as Kantian ethics, would apply the concept of universal law, meaning that the same standard should apply to others and ourselves. Exposing others to a fatal, contagious disease is not the standard which counselors would find acceptable. Under a utilitarian perspective, preventing an infection would be a reasonable argument for promoting maximal utility or benefit. Second, at the ethical standards level, Cohen advocates for inclusion of virtue ethics in order for counselors to achieve the high standard associated with personal virtues or characteristics such as altruism, courage, integrity, reflection, and others. Third, Cohen defined a set of implementation conditions for counselors deciding in favor of disclosure. These conditions include defining when to disclose and the form of disclosure. He described four requisite conditions that need to be present for deciding when to disclose: (a) gathering information and becoming aware of conclusive medical evidence proving that a client is in fact HIV-seropositive, (b) compiling evidence that a third party is actually at high risk of contracting HIV based on medical standards, (c) making sure that no one else has disclosed or is willing to disclose this information to the third party in an appropriate manner, and (d) contacting the third party directly, without having to resort to law enforcement or investigative agencies.

Finally, Cohen (1997) acknowledges that having morally good reasons for disclosure does not mean that there is an absence of morally good reasons for nondisclosure. This means analyzing competing reasons as values as well, which is consistent with State III of the Integrated Model described earlier. As for procedural guidelines for disclosure, he defined six steps to ensure an appropriate form of disclosure: (a) making the disclosure in a timely fashion; (b) providing necessary encouragement, understanding, education, and support to clients making the disclosure because this is the method of choice; (c) avoiding coercion by not making disclosure a condition for continuing counseling or therapy; (d) limiting disclosure to general medical information sufficient to prove imminent danger; (e) taking reasonable measures to protect clients from potential self-harm resulting from disclosure; and (f) offering at-risk third parties a referral for counseling.

This model provided by Cohen (1997) is not exclusive of other theoretical or implementation elements that counselors can incorporate into a strategy to make reasonable ethical decisions that lead to a feasible course of action. In addition, it applies to one course of action only, which is disclosure. However, it provides a specific illustration of the reasons to include the components of the Integrative Decision-Making Model of Ethical Behavior

described earlier when dealing with ethical dilemmas stemming from behavior of clients living with HIV/AIDS. Particularly, it addresses issues of sensitivity and awareness, engaging in fact finding, analysis of principles and virtue standards, analysis of competing morals and values, and implementation conditions when counselors have chosen a particular course of action. These are all elements found in Stages I–IV of the Integrated Model described earlier.

Multiple Stakeholders

Another reason for using the Integrative Model is the need for concurrence by the stakeholders commonly involved when making an ethical decision pertinent to clients living with HIV/AIDS. This is a key element under Stages I and III of the Integrated Model. Ryan and Rowe (1988) identified some of the potential stakeholders, including colleagues, caregivers, social service agencies, and professional organizations. Colleagues working in the same agency who serve the same clients may have personal biases that prevent them from serving this population effectively or may lead to an opposite ethical course of action. Caregivers may have concerns about their right to know their clients' positive status that may lead to differing interpretations and implementations of confidentiality and disclosure. Social service agencies may fail to provide adequate staff training, which may lead to adopting courses of action that do not meet minimal ethical standards. Finally, professional organizations advocate for the rights of people with HIV/AIDS but may develop regulations or policies that are not congruent with the principles advocated by organizations representing consumers with this disease. Other stakeholders are relatives or significant others, friends, and other unrelated professionals such as lawyers who are helping clients with legal issues. All of these different stakeholders may have a strong impact on clients' lives, and these stakeholders' actions may then facilitate or impede a particular ethical course of action.

The following is an example to illustrate this point. Mr. A. initially was reluctant to work after learning of his HIV-positive status but finally agreed with his counselor, Ms. J., that the best vocational course of action was to return to work instead of seeking disability benefits. However, Ms. P., who was providing vocational rehabilitation services to Mr. A., told the client that the best course of action for him was to return and live with his parents who reside in his country of origin because he would not be capable of work. Mr. A. met with the counselor after his meeting with the rehabilitation specialist and appeared depressed, confused, and angry. This is a clear case of opposing courses of action that can be detrimental to a client's welfare. It also illustrates the need to incorporate ethical claims of stakeholders in deciding the best possible course of action. This is an essential component of the Integrated Model and makes the case for choosing this approach over the other traditional ethical resolution methods described earlier.

Contextual Factors

The Integrative Decision-Making Model of Ethical Behavior considers contextual influences in choosing an appropriate ethical course of action, and it is possible to make a case that decisions concerning behavior of individuals living with HIV/AIDS get influenced strongly by contextual factors. These factors influence both the decision to choose a specific course of action and the implementation of such a plan. Tarvydas (1998) mentioned collegial,

team, institutional, and societal factors as contextual factors, which we have already covered in the section above on multiple stakeholders. This section focuses primarily on societal factors, including legal, health care, social, and cultural variables.

In the preceding section we discussed the importance of the legal framework in which counselors operate in that case law and state law often define the course of action professionals facing ethical dilemmas must follow. If these laws or legal precedents were in opposition to the ethical standards of the counseling profession, then this conflict would become a barrier in the implementation of a particular course of action (Tarvydas and Cottone, 1991).

The availability of appropriate health care can also influence selection of a course of action as well as its implementation. The last decade has witnessed a sharp reduction in the mortality rate associated with HIV/AIDS, and this is due largely to emergence and availability of new medical treatments that drastically reduce presence of the virus in blood of infected individuals (Cadman, 1997; Gilden, 1997). Those individuals who react favorably to new drugs can exercise options, such as planning a career or a family, that would not have been available to them just a few years ago. Courses of action that imply a return to work are feasible for these individuals, whereas others who do not benefit from this treatment may not have this as an option.

In their study about psychosocial issues affecting rehabilitation of individuals living with HIV/AIDS, Garcia *et al.* (1997) mention some social factors such as attitudinal barriers, social support, discrimination, and legal impediments to work. Attitudes such as racism, sexism, and homophobia can become significant barriers for minorities, women, or gay individuals living with HIV/AIDS. This may limit development of courses of action related to vocational, family, and safe sex planning. Social support plays a vital role in enhancing quality of life of these individuals and prolonging their life, which also effects the degree to which certain courses of action are feasible or not. Discrimination can greatly reduce employment, housing, and educational opportunities for this population, and that may be a major impediment to achieving vocational or educational goals. Under an immigration law, foreigners infected with HIV/AIDS are unable to immigrate to the United States. This means, for example, that immigrants applying for jobs that require medical testing may face deportation if found to have HIV present in their blood.

In the study by Garcia *et al.* (1997), the authors discussed some key cultural factors influencing the lives of people living with HIV/AIDS, particularly those from minority backgrounds. Among these factors are acculturation and ethnic identity, language, and gender, among others. For minority groups, the degree to which they identify with the dominant culture has a significant impact on their psychological adjustment and their ability to become competent and successful in this society. Birman (1994) concluded that those individuals who become bicultural by identifying themselves psychologically with their own culture while having the ability to be behaviorally competent in the dominant culture exhibit better adjustment than those who are not bicultural.

A deficit in English language comprehension or expression may cause Latinos or other groups whose language of origin is not English to avoid using health, rehabilitation, or other human services otherwise available to them. At the same time, this language deficit may pose a barrier for employment. Finally, gender is another variable that requires attention because minority women have the highest rates of new HIV infections. Dependence on male partners and the expectation of assuming traditional gender roles are some of the cultural

variables that may dictate which course of action is most appropriate for members of this group.

Because the Integrative Decision-Making Model of Ethical Behavior provides for inclusion of these contextual factors in reaching an ethical course of action and then implementing it successfully, these authors advocate for this as the model of choice when counseling clients living with HIV/AIDS. An example illustrating the influence of contextual factors in making an ethical decision is the case of Ms. C., a 21-year-old African American female. She tested seropositive 5 years ago and has occasional sexual intercourse with an African American male about her same age. Because of his strong homophobic and sexist values, she was afraid to disclose her condition to him. In addition, she was afraid to request safe sex precautions because he would become angry and violent. Moreover, she feared that an eventual disclosure would result in violent retaliation by her partner that could even be life threatening. Such a reaction was also highly possible if he sought testing and realized that he had the HIV in his blood.

Given this set of contextual factors, counselors must be aware of the danger posed to clients if they disclose this information to a third party and, instead, recommend that clients develop a safe strategy for themselves and third parties. This requires assessment of dangerousness to third parties as well. After clients have decided to stop a sexual relationship for the safety of a third party and themselves in the future, the overall strategy of counselors is to empower clients to decide how and when to disclose this information and monitor implementation of this action. The question that remains is to whom the counselor was first responsible; clients, third parties, or both? In the case of Ms. C above, the solution was to find a strategy that would protect both her and her partner in the future while giving responsibility of disclosure to the client, thus preserving confidentiality and the client's autonomy. Seeking legal counsel, consulting with colleagues, and assessing imminence of infection to the third party by seeking advice from health experts were all measures warranted in this case.

CONCLUSIONS

Garcia *et al.* (1999) identified eight ethical dilemma categories faced by counselors working with individuals living with HIV/AIDS. These eight categories encompass disclosure, vocational, legal, health, family or social relationships, sexual, death and counselor/client relationship themes. Due to the nature of this disease, counselors face ethical dilemmas that might present difficulties in resolution using a traditional ethical dilemma resolution model that relies exclusively on a rational method and principle ethics. Often, working with this population involves third parties, multiple stakeholders, and contextual factors that counselors need to consider to arrive at the best possible resolution that they can implement effectively. Given that in most states there are no statutes regulating the duty to warn or to protect third parties, counselors must resolve these dilemmas at the ethical level.

We recommend that counselors utilize the Integrative Decision-Making Model of Ethical Behavior, which allows for incorporation of the particular variables involved in counseling individuals living with HIV/AIDS. This model is unique in its integration of deontological and utilitarian theory, principle and virtue ethics, analysis of competing values among different stakeholders, and evaluation of contextual barriers for implementation of

an ethical course of action. Such elements make this model a particularly fitting approach for professionals attempting to find the most appropriate ethical solution to dilemmas they face in their work with this client population. Future research is necessary to provide an empirical foundation for this assertion. Future work must compare the Integrative Model against the other existing moral or cognitive ethical decision-making models described in this article. Preferred measures must include professionals' knowledge, skills, and overall satisfaction with the outcomes of using such models. To undertake such research, we believe that the Integrative Model needs full and systematic standardization to facilitate its use and replication in the future.

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