Referring Sex Offenders for Psychosexual Evaluation: A Review

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The authors of this article provide guidance to counselors who are referred identified and alleged sex offenders for psychosexual evaluations. The article reviews the critical legal, ethical, and clinical issues that counselors should consider when responding to these referral requests. Counselors can also use this article to educate referral sources about the indications and limitations of evaluations of this population.

Sexual aggression is a serious societal problem. Estimates suggest that at least 20% of American women and 5% to 10% of American men have experienced childhood sexual abuse (Finkelhor, 1994). In addition, estimates suggest that 10% to 25% of adult women are sexually assaulted (Koss, 1993). Attention to this issue has primarily focused on treatment services for victims. However, more recently, attention has become increasingly focused on perpetrator interventions (Freeman-Longo, Bird, Stevenson, & Fiske, 1995).

Intervention with sex offenders and those who are alleged to have committed sex offenses often includes referral to counseling professionals. When offenders are referred, counselors must determine what types of requests for evaluation they can adequately and responsibly address. When making these determinations, counselors should consider several important clinical, ethical, and legal issues. Failure to do so can result in evaluations that may be improper and lack credibility. Given these concerns, all parties involved should be well informed about the indications, limitations, and liabilities of a proposed evaluation (Melton, Petrila, Poythress, & Slobogin, 1987).

Although sex offenders are referred for mental health evaluations for several reasons, in this article we limited the focus to referral requests for what are often called "psychosexual evaluations." Psychosexual evaluations are psychological evaluations that primarily concern a sex offender's psychosexual characteristics. These include concerns about the nature of an identified sex offender's sexual deviancy, amenability to treatment, risk of reoffense, and supervision and treatment needs related to these issues. This article does not address other types of specialized mental health evaluations that sex offenders may undergo. For example, some individuals who have been accused of committing a sex offense

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undergo evaluations to determine if they are competent to stand trial (Appelbaum & Gutheil, 1991). A small number of individuals who have committed sex offenses undergo mental health examinations to determine if they should be found *not guilty by reason of insanity* (Appelbaum & Gutheil, 1991). In addition, some sex offenders have comorbid psychiatric problems such as depression or psychosis and require evaluation for these conditions. Evaluations for these types of concerns should be conducted by counselors or other mental health professionals who have specialized training in the appropriate areas.

This article identifies five major issues that counselors should consider when screening sex offenders for evaluation. These issues are formulated into the five questions that form the basis of this article. They are summarized in Figure 1. Although counselors may choose to address these issues in a different order, each is vital and should be considered carefully. Because most identified sex offenders are men, male pronouns are used throughout this article.

HAS THE CLIENT ADMITTED TO OR BEEN FOUND GUILTY OF COMMITTING A SEXUAL OFFENSE?

Whether or not a client who is being referred for a psychosexual evaluation has actually committed a sexual offense is a critical question. A client who has admitted to committing a sexual offense has obviously acknowledged a problem that can be assessed. However, many examinees deny committing the sexual offense for which they are being referred (Maletzky, 1996). In these cases the stated or implied referral request is often for determination of whether the examinee is guilty of committing some type of inappropriate sexual behavior. The counselor should use caution in determining whether to accept such referrals. As Melton et al. (1987) noted, counselors and other mental health professionals "should avoid being used as 'lie detectors' and should leave it to the trier of fact to determine the most feasible factual situation" (p. 357). Official legal entities that serve as triers of fact include the courts and professional practice review boards. The rationale for cautioning counselors to refrain from making judgments about an individual's guilt or innocence is based on a variety of clinical, ethical, and legal reasons.

First, from a clinical perspective, the research literature does not indicate that counselors and other mental health professionals have the ability to accurately differentiate sex offenders from nonoffenders in the general population (Becker & Kaplan, 1990; Becker & Quinsey, 1993; Hanson & Bussiere, 1996; Murphy & Peters, 1992). Certainly, group differences between sexual offenders and men who are believed to have never committed a sexual offense have been found on several psychological variables. However, the critical issue for this discussion is that attempts at classifying individuals using psychological methods produces significant error rates (Murphy & Peters, 1992).

Neither psychological testing, personality characteristics, background history, or psychophysiological responses have proven ability to accurately identify sex offenders. For example, studies using the Minnesota Multiphasic Personality Inventory that have attempted to identify distinct personality characteristics of sex

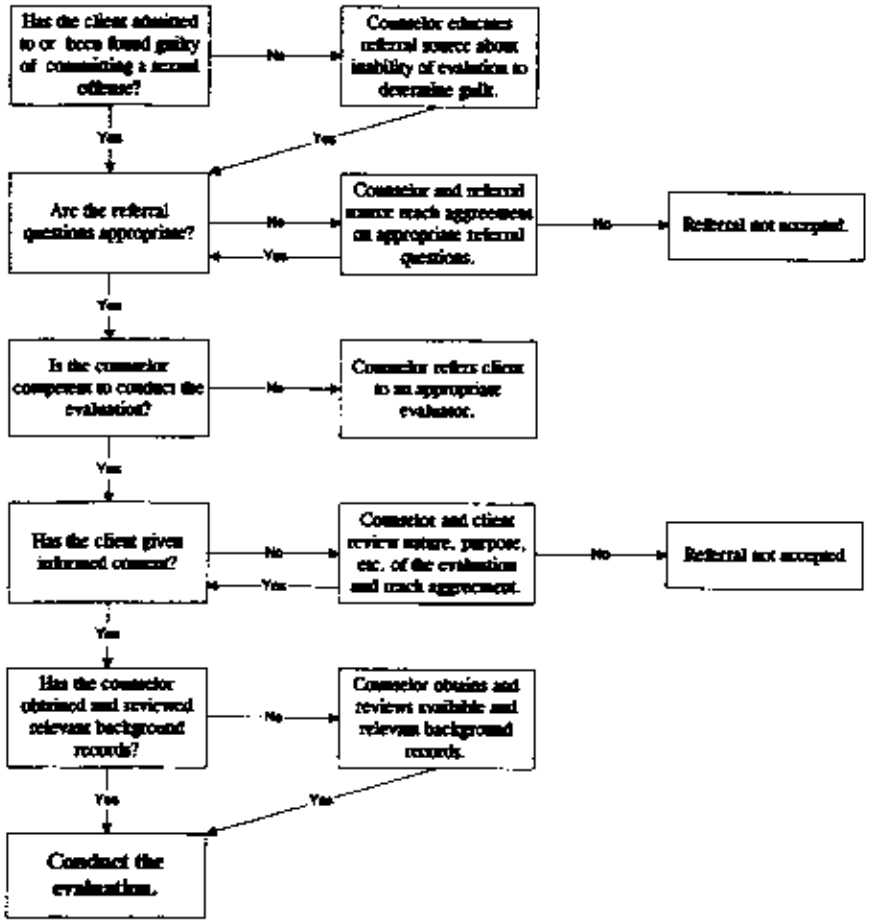

FIGURE 1

Screening Referrals for Psychosexual Evaluation

offenders have been inconclusive (Hanson & Bussiere, 1996; Levin & Stava, 1987). Although being molested as a child is implicated in the etiology of sex offending behavior, the vast majority of child sexual abuse victims do not become sex offenders (Murphy & Peters, 1992). Even an examinee's erectile responses to adult and child oriented stimuli during a phallometric assessment cannot be regarded as definitive evidence of whether an individual has actually committed a particular sex offense (Fruend & Blanchard, 1989; Murphy & Barbaree, 1994).

Second, ethical concerns arise when mental health clinicians evaluate offenders who have not been found guilty of committing a sexual offense. The ethical principles of the Association for the Treatment of Sexual Abusers, the leading inter-

national association concerned with the ethical management of sex offenders, states, "An assessment should not be used to confirm or deny whether an event or a crime has taken place" (Association for the Treatment of Sexual Abusers, 1993).

Third, from a legal perspective, the majority of courts throughout the United States prohibit psychological testimony that is used to suggest that a defendant is either more or less likely to have committed a sexual offense based on whether or not he fits a particular psychological profile. Case law that prohibits the admission of this type of profile evidence is usually based on one or more of three arguments (e.g., State v. Percy, 1992). Not surprisingly, these common appellate court arguments parallel the previously described concern with the scientific validity of efforts to identify sex offenders by psychological means. One court argument is that such profiles have not gained recognition or acceptance in the scientific community and are therefore unreliable (e.g., Tungate v. Commonwealth, 1995; United States v. St. Pierre, 1987). A second argument is that juries may place undue emphasis on profile evidence and that it therefore invades their province (e.g., State v. Miller, 1985). Third, courts have been concerned that the prejudicial effect of profile testimony outweighs its probative value (e.g., Haakanson v. State, 1988).

Some courts have allowed expert testimony that there is no profile of the "typical" child sexual offender and that such persons are found in all walks of life (People v. McAlpin, 1991). It should be noted that in Arizona, expert testimony regarding sexual offending in general, such as defining terms and listing examples of paraphilic behavior, has been allowed as long as the expert does not discuss the actual facts of the case or the particular defendant under review in their testimony (e.g., State v. Varela, 1993). These cases and other similar appellate court rulings across the United States should dissuade mental health professionals from conducting such "profile" evaluations for the purpose of attempting to determine the guilt or innocence of the person being evaluated.

Given these ethical prohibitions, clinical limitations, and legal restrictions, counselors are generally advised to limit sex offender psychosexual evaluations to individuals who have either been found guilty of, or have admitted to, committing a sex offense. It is with these identified sex offenders that referral questions concerning diagnosis, treatment amenability, dangerousness, disposition planning, and treatment can be appropriately addressed.

Some exceptions to the previously stated recommendations exist. In some work settings, counselors may be required to evaluate alleged sexual offenders. In these situations, the counselor must be clear about the limits of his or her expertise and ability to answer various referral questions. Psychosexual evaluation of alleged sex offenders may also be used as an educational intervention. Counselors can educate suspected offenders about issues such as victim impact, reoffense risk, treatment options, and prospects for benefit from treatment. Some offenders may admit their offending behavior under such conditions and seek help for their problem (Henry, Coleman, & Freeman-Longo, 1995). It is also important to note again that alleged offenders may have a variety of mental health needs, such as depression, that may be an appropriate focus for treatment.

Of course, examinees and referral sources need to recognize that admissions of unreported child sexual abuse to mental health professionals are generally not considered privileged communications. Evaluators who learn of such abuse during an evaluation must report these crimes to the authorities. Virtually all states have at least some form of mandatory reporting laws concerning child sexual abuse, and mental health professionals are universally considered mandatory reporters (Berlin, Malin, & Dean, 1991). Counselors should familiarize themselves with their local mandatory reporting requirements.

Another important issue concerns individuals who have been adjudicated guilty of committing a sex offense but deny their guilt. Indeed, no system of justice is perfect, and some of these individuals may be innocent. Yet, because counselors and other mental health professionals do not have any ability to accurately identify sexual offenders, the evaluator must take a position on how to deal with individuals who have been adjudicated guilty but maintain their innocence. It seems eminently reasonable to accept the "trier of fact's" finding of guilt in these cases and assume the individual is guilty of the charge or charges. The assessment and subsequent evaluation opinions can proceed under this assumption.

ARE THE REFERRAL QUESTIONS APPROPRIATE?

Once a counselor has determined that the examinee has either been found guilty of or admits to committing a sex offense, several appropriate referral questions for a psychosexual evaluation can be identified. Typical and appropriate referral questions generally focus on one or more of five issues: diagnosis, treatment amenability, dangerousness, disposition recommendations, and treatment recommendations.

Diagnosis

Referral sources generally want an explanation and analysis of the offender's psychosexual problems. Psychiatric diagnosis is one method of accomplishing this goal. Unfortunately, the standard reference for psychiatric diagnosis, the recently updated *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fourth edition* (*DSM-IV*; 1994), has limitations for diagnosing sex offenders. For example, there is no specialized diagnosis for several types of sex offenders such as men who have a sexual preference for adolescents or who sexually assault adult women. Of course, two new diagnoses contained in the *DSM-IV*, Sexual Abuse of a Child or Sexual Abuse of an Adult, can be used. However, these new diagnoses do not have any diagnostic criteria except that the client has committed a sexual offense. Nonetheless, *DSM-IV* remains the most widely accepted authority for psychiatric diagnosis. Given these limitations, descriptions about a sex offender's problems that go beyond a formal diagnosis are often very helpful to the referral source.

The counselor can describe the psychological problem of an examinee to identify areas of concern in a manner that is more detailed than *DSM-IV* diagnoses provide. Several methods can be used to identify an offender's psycho-

sexual problems. First, the counselor should review relevant past records before the evaluation, a process that is addressed in a subsequent section of this article. Past records include police affidavits or court findings that detail the types of illegal sexual behaviors for which an offender has been charged or convicted.

Second, clinical interviews play a central role in the assessment of this population. The clinical interview should include a mental status exam and a full history of the examinee's personal and social development, sexual and sex offending behaviors and fantasies, criminal justice involvement, and medical history (O'Connell, Leberg, & Donaldson, 1990). Several specialized interview strategies may enhance the examinee's honesty and openness in the interview process (McGrath, 1990). For example, underneath many sex offender's defenses of denial and minimization there may often be feelings of shame, embarrassment, confusion, inadequacy, and hopelessness. The counselor who can communicate genuine respect and understanding to the offender without condoning his behavior is in an ideal position to create an atmosphere in which the offender can feel free to discus his problem.

A third evaluation method is psychological testing. Psychological testing should assess or screen for problems in personality and cognitive functioning, and sexual attitudes, knowledge, and behavior. A comprehensive critique of tests and questionnaires used with sex offenders can be found in Hanson, Cox, and Woszcsyna (1991). The general conclusion of their review is that the psychometric properties of most of the measures examined are weak and that further work is needed to improve the utility of these measures. Nevertheless, they recommend the most promising instruments in several of the major domains that should be assessed. More recently, Prentky and Bird (1997) compiled information on tests used with the general mental health population that may also be appropriate for use with sex offenders as well as instruments designed specifically for assessing sex offenders. Although their review provides information on how to obtain each of these instruments, and in many cases copies of the instruments, they do not critique any of the measures.

A final evaluation method is the laboratory assessment of an examinee's changes in penile tumescence as he views or listens to depictions of various deviant and nondeviant sexual stimuli. The results of such phallometric testing are used to make inferences about an examinee's sexual preferences and can assist in diagnosis and problem identification (Murphy & Barbaree, 1994). Perhaps due to the expense, technical nature, and intrusiveness of this procedure, only about one third of sex offender programs in the United States use phallometric testing (Freeman-Longo et al., 1995). Alternative methods of assessing an offender's sexual arousal can be used. Offenders' self-reports about their sexual preferences can be used, and counselors can sometimes infer an offenders' sexual preferences by his past behavior or collateral reports. For example, it can reasonably be assumed that an offender who has several young male victims, has never married, and does not date or socialize with adults has at least a strong sexual interest in and probably a sexual preference for young boys.

A particularly specialized type of referral request focuses on whether an offender can be designated as a "sexual psychopath," "mentally disordered sex offender," or other similar classifications. These classifications are related to statutes that are currently active in about 12 states that enable authorities to involuntarily commit individuals from a select group who are deemed likely to engage in sexually violent behavior (e.g., Bochnewich, 1992). Such evaluations are quite elaborate in that they typically require that the counselor determine whether the examinee has a statutorily defined mental abnormality, committed a sexually motivated predatory offense, and is more likely than not to reoffend in a sexually violent manner (e.g., Bochnewich, 1992). The results of these evaluations are almost always scrutinized in adversarial legal proceedings.

Amenability to Treatment

If the examinee is found to have a sexual aggression problem that requires treatment, referral sources typically want to know whether the examinee is amenable to treatment for this problem. The primary consideration in this regard is whether the offender admits to committing a sexual offense. This is important because most sex offender treatment programs rely on an offender's ability to identify the thoughts, feelings, and situations that led up to his committing a sexual offense (McGrath, 1991). Obviously, to identify these precursors and develop interventions to address them, the offender must admit to committing a sexual offense. In addition, to engage in treatment the offender should express motivation to stop offending and be willing to participate in treatment.

Although it is quite common for sex offenders to deny any sexual activity with the victim (Maletzky, 1996), an offender's attitude about his offenses can change over time. For example, an individual who initially denies his offense may admit it and desire treatment at a later date. The counselor's role can be to assist those individuals who are known to have committed a sexual offense in overcoming their denial. Model programs for intervening with sex offenders who deny their guilt have been developed (e.g., Schlank & Shaw, 1996; Winn, 1996). These programs typically provide psychoeducation to offenders about the nature of sexual offending, strategies for preventing sexual reoffenses, and the impact of sexual abuse on victims. They also attempt to develop a therapeutic culture in which peer pressure and positive reinforcements encourage offenders to admit to their problems.

Dangerousness

Perhaps one of the most important referral questions concerns the offender's risk of committing a sexual reoffense. Although prediction of future behavior is very difficult, those who sentence, treat, release, and supervise sex offenders make determinations about dangerousness on a regular basis. Perhaps the best strategy for predicting a sex offender's risk of reoffending is to determine how he is similar to other identified subgroups of offenders for whom the risk of reoffending is

known (Quinsey, Lalumiere, Rice, & Harris (1995). Recent reviews have identified variables that are associated with risk to sexually recidivate among known sex offenders (Hanson & Bussiere, 1996, McGrath, 1991). Researchers have combined these and other variables to develop several promising actuarial methods of predicting sexual reoffense. For example, Hanson (1997) has developed an empirically derived instrument combing four risk factors (i.e., prior sexual offenses, offender age 25 or less, extrafamilial victims, and male victims) that yield a statistical prediction of the likelihood of sexual reoffense at 5- and 10-year intervals. A similar instrument has been developed by Epperson, Kaul, and Hout (1995). Of the 21 variables included in the instrument, the ones that correlated most strongly with rearrest for a sex offense are multiple sex offense convictions, multiple nonsex offense convictions, offender young, multiple victims, long history of offending, failure in previous sex offender treatment, and discipline history while incarcerated. Another promising actuarially derived prediction instrument developed by Quinsey et al. (1995) has also found that several similar variables can be used in combination to predict the likelihood of sexual reoffense among known sex offenders.

It is important to note that although these recent actuarial sex offender prediction instruments have proven able to correctly classify recidivists at levels well above chance, they are by no means perfect. Absolute predictions that an examinee will or will not reoffend are never warranted (Monahan & Steadman, 1996; Mossman, 1994; Quinsey et al., 1995). Rather, risk predictions are necessarily probabilistic. Evaluators and referral sources must recognize that risk prediction is not an exact science and that a proportion of the sex offenders assessed will be incorrectly classified as to their sexual reoffense risk. Thus, counselors (American Counseling Association, 1995) and other mental health professionals (e.g., American Psychological Association, 1992) have an ethical obligation to inform referral sources and other consumers of evaluations about the limits of their accuracy.

Although a more detailed review about the ethical and clinical complexity of conducting and communicating risk assessments is beyond the scope of this article, the interested reader can review several recent articles that examine these issues in depth (Borum, 1996; Grisso & Tomkins, 1996; Monahan & Steadman, 1996; Quinsey, et al., 1995; Rice, 1997; Schopp, 1996).

Because predicting reoffenses is so difficult, sometimes the most that a counselor can do is identify the conditions under which a reoffense is most likely to occur. Conditions such as victim availability might well apply to all offenders, whereas risk factors such as depression or alcohol abuse might be specific to certain subgroups of sexual offenders. Identification of conditions related to sexual reoffense has been a major emphasis of relapse prevention treatment and supervision efforts with sex offenders (Cumming & Buell, 1997).

Disposition Recommendations

Another typical referral question concerns disposition recommendations. Disposition recommendations primarily serve the purpose of educating the referral source

about possible placement and supervision options. These recommendations are informed by findings about an offender's diagnosis, treatment amenability, and dangerousness. The counselor's task is to analyze this information and recommend possible courses of action to the referral source. In general, the counselor should not directly prescribe a particular course of action. Ultimate issues such as whether an offender should be incarcerated or supervised in the community or whether an offender should be allowed to live with his children are the province of judges, parole boards, or probation and parole officers. What the trained, experienced counselor can offer is analysis of the risks and benefits of various courses of action.

This type of analysis can be presented in the form of "If/then" statements for each likely disposition (Melton et al., 1987). For example, a presentence psychosexual evaluation might read as follows:

> If the court places Mr. Jones on probation in the community, then his risk to reoffend sexually against children will be significantly greater than that of other child molesters who are typically considered appropriate for community placement. The factors upon which this risk assessment is based are. . . . If he is placed in the community on probation, then several supervision conditions may reduce his risk to reoffend. These are. . . . If a goal of sentencing is to provide Mr. Jones with treatment in an incarcerated setting, then he would need to have at least a 5-year sentence to be eligible for admission into the Northwest State Correctional Center's Sex Offender Treatment Program.

Treatment Recommendations

Although the efficacy of treatment in reducing sex offender recidivism rates has been the subject of considerable debate (e.g., Furby, Weinrott, & Blackshaw, 1989), recent advances in treatment approaches have yielded promising results. Evaluators should make treatment recommendations based on information from this emerging literature. Broad principles of effective correctional treatment have been identified (Gendreau & Goggin, 1996), and specialized approaches with sexual offenders have proved very encouraging (Alexander, 1994; Hall, 1995; Laws, 1989; Marshall, Jones, Ward, Johnson, & Barbaree, 1991).

Specifically, cognitive-behavioral and hormonal treatment have shown significant treatment effects with sex offenders (for reviews see Alexander, 1994; Hall, 1995; Marshall et al., 1991). Hormonal treatments are used to reduce selected offenders' serum testosterone levels in hopes of reducing their sex drive, thus giving them more control over their deviant sexual impulses (e.g., Fedoroff, Wisner-Carlson, Dean, & Berlin, 1992). Cognitive-behavioral treatments with this population typically are designed to help offenders achieve the following goals: (a) accept responsibility for offending, (b) modify cognitive distortions, (c) develop victim empathy, (d) control sexual arousal, (e) improve social competence, and (f) develop relapse-prevention skills (Marshall et al., 1991; McGrath, Hoke, & Vojtisek,1998). In addition, an important element in most state-of-the-art sex-offender treatment programs is community supervision designed to limit offender access to potential victims and other high risk behaviors such as alcohol or pornography use (Cumming & Buell, 1997).

IS THE EVALUATOR COMPETENT TO CONDUCT THE EVALUATION?

Based on a review of the referral questions and the legal context of the case, the counselor should assess his or her own competence to conduct the proposed evaluation. Counselors, and virtually all other mental health disciplines have codes of ethics that prohibit their members from practicing outside their area of expertise (American Counseling Association, 1995). At a minimum, mental health professionals who evaluate sex offenders should have an advanced degree in a mental health discipline and documented training and supervised experience in evaluating this population (Coleman & Dwyer, 1990). On an international level, the Association for the Treatment of Sexual Abusers (1993) has formulated standards of care and ethical guidelines for the assessment of sexual offenders. In addition, several states have developed guidelines in this area. For example, the State of Washington (1991) has passed legislation that requires sex offender treatment and assessment professionals to obtain a certificate to practice. Requirements for the state certificate include passing a written test and meeting strict education, experience, and supervision standards.

Even well trained counselors who specialize in sex offender assessment and treatment may find some cases beyond their expertise. For example, sex offenders who evidence major neuropsychological disorders or major mental illness may require the services of specialists in these areas. Counselors who are referred such complicated cases may refer the case to a specialist or collaborate with a specialist to complete the evaluation.

HAS THE OFFENDER GIVEN INFORMED CONSENT?

During the referral process and before commencing with an evaluation, written informed consent should be obtained from the examinee. Informed consent protects an examinee's liberties. Through informed consent the examinee and evaluator reach a mutual understanding about the nature of the proposed evaluation. Obtaining informed consent is good clinical practice. In fact, the American Counseling Association's (1995) *Code of Ethics and Standards of Practice* mandates that clients be given informed consent and encourages that this consent be given in writing. Such written informed consent, discussed and signed by the examinee, can serve to document how the parties involved in the case understood the parameters of the evaluation. When the referral has been made by a third party, that person can also be involved in reviewing the written evaluation agreement.

Examinees must also be deemed competent to give informed consent. Legally, minors are not considered competent to give informed consent and so it must be obtained from their parents or a legal guardian. Individuals whose cognitive abilities are so impaired that they are incapable of understanding the nature of the evaluation process should also be deemed incompetent to give informed consent. The cognitive impairments of some potential examinees may be permanent, as in the case of some mentally retarded individuals. In such cases, informed consent must

be obtained from the individual's legal guardian. In other cases, an individual may be temporarily incompetent because of circumstances such as the acute symptoms of a mental illness or the influence of alcohol or drugs. Informed consent can be obtained from these individuals when their cognitive faculties are restored. Even when consent is obtained from a legally authorized individual to evaluate a person who is legally incapable of giving informed consent, the counselor should still consider the examinee's preferences and best interests and seek the examinee's assent, to the extent possible, for the evaluation. Such an approach is mandated in the recently revised ethical guidelines for counselors (American Counseling Association, 1995) and psychologists (American Psychological Association, 1992).

Several sources have set forth recommended components of informed consent (Bennett, Bryant, VandenBos, & Greenwood, 1990; Pope & Vasquez, 1991; Schwitzgebel, 1979). Proper informed consent for the examinee should include the following: (a) the purpose of the evaluation, (b) the nature and duration of the evaluation, (c) the confidentiality of the evaluation, (d) fees, (e) the risks involved, (f) the advantages of undergoing evaluation, (g) possible disadvantages if the evaluation is not undertaken, and (h) how and to whom evaluation results will be communicated. The content of information reviewed with the offender regarding each of these eight elements will vary according to the context and purpose of the evaluation.

HAS THE EVALUATOR REVIEWED THE APPROPRIATE BACKGROUND RECORDS?

As a final referral step, the counselor should request and review relevant past records. These include documents such as victim statements, police reports, offender statements, criminal record checks, psychological and medical records, and other related records. Although these records are sometimes difficult to obtain, referral sources should generally be responsible for providing them to the counselor. Past records are critical because many sex offenders have a propensity to lie about, deny, and minimize their deviancy. Past records provide a collateral account of an offender's offense and background history and are important sources of data. By reviewing this information before the evaluation, the evaluator can select appropriate assessment tools. In addition, the counselor can develop interview questions and strategies that will increase the likelihood that the offender will honestly discuss his history (McGrath, 1990).

If counselors do not receive these documents from the referral source, they should consider whether or not to commence the evaluation before all proper documentation has been received and reviewed. The counselors' insistence on delaying an evaluation until receipt of relevant documents should generally be viewed by the referral agent as evidence of the counselor's competence and thoroughness. Counselors are not mind readers and psychological assessment is not magic. Thorough and effective evaluation of sex offenders requires multiple data sources of which background information and related documents are critical components.

CONCLUSION

The psychosexual evaluation of a sex offender is an important procedure. The results of such an evaluation can determine issues of basic liberty for the offender and affect the emotional well-being and physical safety of victims. Evaluation results can influence decisions concerning criminal sentencing, probation and parole conditions, rehabilitation plans, civil commitments, child custody, child visitation agreements, and professional practice board decisions. Given the magnitude of these issues, counselors must exercise special care in conducting such assessments. This article provided five critical referral questions that must be considered when accepting such a referral. It is hoped that the information and suggestions outlined in this article will contribute toward helping counselors appropriately address the important clinical, ethical, and legal challenges of this important task.

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