

# Variations in the Implementation of Ethical Guidelines among Mental Health Professionals in the United States and Denmark

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*This study focused on the differences and similarities in how mental health professionals in the United States and Denmark implement their ethical guidelines set forth by the American Counseling Association and the Danish Psychological Association (Dansk Psykolog Forening), their specific work settings' rules and regulations, and their personal values and beliefs when working with clients. Survey packets were developed in English and Danish and administered to 30 United States citizens and 27 Danish mental health professionals. Results indicated that U.S. mental health professionals adhere to their professional ethical guidelines more often than Danish mental health professionals. Results also revealed a positive relationship among professional ethical guidelines, work setting rules and regulations, and personal values and beliefs. Implications for future international, cross-cultural research are considered.*

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Mental health professionals in the United States are bound by professional ethical codes set forth by the American Counseling Association (ACA, 1995; 2005). Similarly, in Denmark, mental health professionals are bound by professional ethical guidelines set forth by the Danish Psychological Association (Dansk Psykolog Forening [DPF], 2008). The four overarching ethical guidelines in Denmark include: The Counseling Relationship; Confidentiality, Privileged Communication and Privacy; Professional Responsibility; and Relationships with other Professionals (DPF, 2008). These four Danish areas mirror the ACA's *Code of Ethics'* first four of eight sections (ACA, 2005).

Mandatory training in professional ethics for mental health professionals in the U.S. was implemented 28 years ago by the Council for Accreditation of Counseling and Related Educational Programs (CACREP, n.d.). However, the European Federation of Psychologists' Association (EFPA) only established a set of ethical guidelines in 1995 in response to the growing need for protocol and procedures mental health professionals could follow when difficult ethical questions arise. The EFPA ethical codes and guidelines were also an attempt to unify ethical standards across European countries (Lunt, 1999). In 1996, the DPF established a set of ethical guidelines in Denmark that were comparable not only to the ethical guidelines of the EFPA but also those of the ACA.

In addition to the sets of professional ethical codes and guidelines set forth by the ACA and the DPF, mental health professionals who work within agency/institutional settings, such as in-patient and out-patient counseling organizations and residential treatment facilities, are often bound by an additional set of rules and regulations unique to these work settings (Gottlieb, 1995; Vandenburg & Eastman, 1999; Wilson, DeJoy, Vandenburg, Richardson, & McGrath, 2004).

These work setting-specific rules and regulations are often referred to as "codes of conduct" or "organizational culture" and have been implemented for the safety of clients and mental health professionals working in these settings (Wilson et al., 2004). Interestingly, very little research has focused on the rules and regulations of professional counseling work settings and how the regulations correlate with the ethical guidelines of mental health professionals. The potential dilemma that arises for mental health professionals is the incongruence between their ethical responsibilities set forth by their respective professional associations and the demands of their

work setting/employers (Koocher & Keith-Spiegel, 2008). The questions that arise include: 1) How do mental health professionals ensure they are in compliance with their work setting rules and regulations and also remain ethical as required by their professional organizations, especially if there are discrepancies between work setting regulations and professional ethical codes?; and, 2) How do Danish mental health professionals navigate these issues in comparison to United States mental health professionals?

Moreover, mental health professionals who are not sufficiently aware of their work settings roles and responsibilities may find themselves in dilemmas regarding which regulations to follow: Their professional ethical codes or their work settings' regulations? The research of Vandenburg et al. (1999) focused on the impact of high involvement work (i.e., employees feel they have a say in what rules and regulations are implemented) and its impact on organizational effectiveness. Results implied that one aspect of employee satisfaction is high involvement, which indicated that work setting rules and regulations are part of employee satisfaction (i.e. employees feel satisfied with their jobs).

In addition to professional ethical codes and guidelines and work-setting rules and regulations, mental health professionals are also guided by their own personal values and beliefs about their working relationship with clients. These personal values and beliefs steer perceptions of what may be "good" and "bad" for clients and ultimately may influence goals for treatment (Jensen & Bergin, 1988). Jensen and Bergin focused on which personal values were most important for mental health professionals and whether these values were incorporated into their clinical work. Results indicated that mental health professionals who, as an example, were more religious would likely consider religious values to be important in therapy and to their clients' mental and emotional health. The study concluded that the mental health professionals' values are embedded in therapeutic theory and practice.

These three variables—professional ethics, work-setting rules and regulations, and personal values and beliefs—have been addressed in the professional literature. With the founding of the ethical guidelines came unanticipated dilemmas (Brown, 1994). The first unanticipated dilemma is the discussion of whether or not to consider the ethical principles. Within this discussion there are three different responses (Kitchner, 1984). The first response is that mental health professionals should always adhere to

the principles, regardless of the circumstances. The second stance is the idea that the principles are relative to the individual. Kitchener (1984) stated, "...what is ethical is relative to time, place and situation" (p. 52). If mental health professionals adhere to this claim, then it may be argued that there is no need for ethical guidelines, since mental health professionals rely solely on the certain type of situation or their own ethical judgment. "Such claims would preclude judging an act as moral or immoral by any group or moral code" (Kitchener, 1984, p. 52). The third response argues for a combination of the two aforementioned stances. This third thought has been termed *Prima Facie*, which means that principles are neither absolute nor relative. This point of view purports that the principles are always relevant for making sound ethical decisions, but circumstances may arise where another ethical obligation becomes superior (Kitchener, 1984).

A second unanticipated dilemma is whether strict adherence to the ethical guidelines mediates the therapeutic relationship. Some mental health professionals believe that strict adherence to the ethical guidelines will render mental health professionals safe from potential lawsuits. Within this debate, the literature uses the term risk-management (Koocher & Kieth-Spiegel, 2008), which suggests that mental health professionals should avoid certain behaviors, not because the behaviors are wrong, but to ensure they will not be sued (Williams, 2002). Koocher and Keith-Spiegel also suggested that risk-management implies that mental health professionals should take as many steps as possible to avoid an unethical situation that could result in a lawsuit. Lazarus (1994) stated that, "Those anxious conformists who go entirely by the book, and who live in constant fear of malpractice suits, are unlikely to prove significantly helpful to a broad array of clients" (p. 255).

In a study conducted by Pope and Bajt (1988), "77% of respondents felt that formal ethical standards should be broken when necessary for client welfare 'or other deeper values'" (p. 34). Responding to Lazarus' (1994) article, Brown (1994) stated that the problems do not lay within the development of the ethical guidelines, but rather that mainstream mental health professions do not realize the power dynamics that exist within therapeutic relationships. She further contended that the ethical guidelines are not imposed as laws that mental health professionals must follow at all cost, but rather they have been implemented "...as a series of decision rules that allow for careful, informed considerations of the meanings of our actions in a manner that allows us to avoid abuses of the power of the

psychotherapeutic relationship” (p. 276). In addition, the third aspect of this dilemma is that ethical guidelines are seen as something that mental health professionals must worry about, confront, or simply ignore, rather than as a core aspect of the profession (Brown, 1994). Pettifor (2004) concurred with Brown, “The goal of ethics is to encourage ethical thinking rather than rule following” (p. 264). This discussion presents a division within the mental health profession where both sides offer valid points. Rubin (2002) contended that “When the analysis of ethics and ethical behavior is considered from perspectives permitting alternative views of desirable behaviors serving constructive goals, then dialogue underlying professional training and practice is enriched” (p. 106).

A third unanticipated dilemma is the issue of boundaries between clients and mental health professionals. Within the ACA’s 1995 ethical codes, section A.6 Dual Relationships states “Counselors make every effort to avoid dual relationships with clients that could impair professional judgment or increase the risk of harm to clients” (p. 1). According to Koocher and Keith-Spiegal (2008), there are many situations in which mental health professionals should refrain from entering into a dual relationship with their clients. Some of these consist of 1) delivering services to close friends and family members, 2) socializing with clients and students, or 3) accepting acquaintances as clients.

Multiple relationships are often created by unclear boundaries between clients and mental health professionals. Some mental health professionals say that strict adherence to the ethical guideline of *Dual Relationships* helps mediating the boundaries of the therapeutic relationship, while others contend that multiple relationship boundary blurring may be therapeutic (Lazarus, 1994). The core issue is the power differential within a mental health professional-client relationship. To not cause harm to the client, mental health professionals must be aware of this power differential and the unequal status that exists between the client and mental health professional (Koocher & Keith-Spiegal, 2008). For example, clients who reside in an institutional setting may have an inability to refuse therapy, which renders them powerless and creates an even greater power differential (Rubin, 2002, p. 104). According to Rubin, “The need to recognize the potential disadvantage of the client who may not be able either to recognize or resist the ‘power’ elements of the relationship is a part of the professional responsibility” (pp. 104-105).

Other mental health professionals have stated that strict adherence to the ethical guidelines related to *Dual Relationships* renders the therapeutic relationship less effective (Lazarus, 1994, 2002a, 2002b; Rubin, 2002). Lazarus (1994) stated that, "Certain well-intentioned ethical guidelines can become transformed into artificial boundaries that serve as destructive prohibitions and thereby undermine clinical effectiveness. Rigid roles and strict codified rules of conduct between therapist and client can obstruct a clinician's artistry" (p. 255). Furthermore, Greenspan (2002) noted that, "While it is comforting to think that boundaries keep everyone safe, it is clear that the rigid adherence to boundaries can bring harm as well as help in therapy" (p. 431). She further suggested that instead of focusing on rigid boundaries, mental health professionals should focus on safe connections with their clients to optimize the therapeutic relationship. While there are many views on how mental health professionals should think about multiple relationships and adherence to the ethical guideline, Rubin (2002) suggested that mental health professionals find and use a middle ground when talking about multiple relationships: "...either extreme-too lax or too strict a view of multiple-role relationships-undermines and compromises the complexity of the therapeutic enterprise" (p. 105).

A fourth unanticipated ethical dilemma that has been studied is that of mental health professionals being able to recognize unethical actions but being unwilling to implement ethical solutions (Wilkins, McGuire, Abbott, & Blau, 1990). Wilkins et al. examined four different unethical situations that involved dual role sexual abuse, alcohol related impairments, referral concerns, and confidentiality issues. While mental health professionals were able to recognize unethical conduct and stated that some ethical action should occur, they were less willing to follow through with the action that they stated was necessary. In Europe, researchers in countries such as Sweden, Norway, and Finland replicated a 1992 study conducted by Pope and Vetter that asked mental health professionals to name a troubling ethical incident they had experienced (Pettifor, 2004). The results of these studies showed that issues of confidentiality and dual relationships were among some of the most common dilemmas encountered by mental health professionals (Pettifor, 2004). The literature further suggested that there may be a link between mental health professionals' willingness to implement ethical actions, their ability to recognize unethical dilemmas, and

the amount of training mental health professionals have had in ethics (Robinson & Gross, 1989; Stadler & Paul, 1986).

In reviewing the literature it became clear that mental health professionals view the role of their professional ethics differently. It seems as if there are many grey areas and many unanswered questions in terms of how and when mental health professionals apply their professional ethics, how much or how little do their personal values and beliefs influence their practices, and how do work-setting rules and regulations affect their work. Are these issues universal or culturally specific? It may be that when working with clients, mental health professionals around the world are guided not only by their professional ethical guidelines and their work setting rules and regulations, but also their personal values and beliefs.

No research, however, has focused on the relationship among these three critical areas and how they may affect mental health professional-client relationships. Also, no research was found that compared how mental health professionals from differing countries respond to these critical concerns. Therefore, the purpose of this study was to examine: a) potential cross-cultural differences between U.S. and Danish mental health professionals' perceptions about their professional ethical codes, the rules and regulations of their work settings, and personal values and beliefs; b) how they may or may not adhere to each of these; and c) how they experience the intersection of these three professional areas.

Specifically, the research questions were: 1) Is there a positive relationship among reported use of professional ethics, personal values and beliefs, and work setting rules and regulations?; 2) Will U.S. mental health professionals report greater adherence to their professional ethical codes and to their work setting rules and regulations than Danish mental health professionals?; and 3) Will Danish mental health professionals report greater use of their personal values and beliefs when making ethical decisions than will U.S. mental health professionals?

## **Method**

### ***Participants***

For the purposes of this study, it is important to highlight that the terms counseling and counselor are interpreted differently around our world.

Remaining true to the Danish mental health profession, we surveyed a sample of psychologists in Denmark for this study because after required educational training, Danish mental health professionals are known as “psychologists” versus “counselors.” Therefore, there is a clear difference in the professional terms used cross-culturally in Denmark and the U.S. Also, there is no direct Danish translation for the word “counselor” as it is used in the English language, although the roles and responsibilities of professional members of the Danish Psychological Association mirror the education and roles required for U.S. master’s level counselors.

The final study’s participants included 30 (11 men, 19 women) mental health professionals/licensed mental health counselors from the southwestern United States and 27 (6 men, 21 women) mental health professionals/psychologists from Copenhagen, Denmark. All participants were licensed mental health professionals who worked at in-patient and/or out-patient treatment facilities. The two groups of participants were comparable in age, counseling experience, and working experience (see Table 1 for demographics).

Table 1

*Group Means and Standard Deviations for Participants’ Demographic Variables*

	<u>U.S. Citizens</u>		<u>Danish Citizens</u>	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Age	46.03	12.07	45.89	11.37
Years Degree	12.83	10.50	14.22	9.31
Years in Mental Health	13.95	10.80	13.72	10.70
Years in Position	6.41	6.51	5.39	6.54

When asked if they had taken a class in professional ethics, 26 (87.7%) of the U.S. and 16 (59.3%) of the Danish mental health professionals reported yes. Two (7.4%) Danish mental health professionals reported that professional ethics had been integrated into other classes. When asked if a professional ethics class was required as part of their university curriculum, 23 (76.7%) of the U.S. participants responded yes, while only 12 (44.4%) of the Danish participants responded yes.



In addition, the participants were asked whether they knew why the professional rules and regulations of their work settings had been implemented. Among U.S. participants, 27 (93.1%) reported they knew why, while 17 (65.4%) of the Danish participants reported they knew why. When asked whether they believed that the professional rules and regulations of their work settings were applicable to working with their clients, all ( $n = 29$ , 100.0%) of the U.S. participants reported yes, while about half ( $n = 12$ , 52.2%) of the Danish participants reported yes.

### ***Procedures***

The study questionnaire was developed by the first author for use in this study which was the first of its kind between mental health professional in the U.S. and Denmark, and the questions targeted the three main variables. Two versions of the questionnaire were created, one in Danish and one in English. The Danish questionnaire was created by translating the English version into Danish. This was done by the first author (who is bilingual) and by two other bilingual, Danish- and English-speaking individuals. Because this was the first use of the study questionnaire, there is no reliability information available; however, both Danish and English speaking mental health professionals offered confirmation of the questionnaire's face validity.

In the United States, participants were recruited by sending "blind" recruitment emails to southwestern community counseling agencies and requesting mental health professionals to participate in the study. A recruitment email was sent out to the listserv of the southwestern state's counseling association. When a member of this association indicated a willingness to participate, a survey packet and informed consent form were mailed along with an addressed stamped return envelope to be used for returning completed questionnaires. The questionnaire required about 15-20 minutes to complete.

The first author visited Copenhagen, Denmark where two licensed psychologists helped recruit possible study participants. The first author then mailed a survey packet (including a recruitment letter, informed consent form, demographic questionnaire, and the study questionnaire) out to the different agencies in Copenhagen and surrounding suburbs, along

with an addressed stamped envelope to be used for returning completed questionnaires.

### ***Instrumentation***

Once participants signed the Danish or English version of the informed consent form, they were asked to fill out a background demographic form. The demographic form included information on gender, age, race, ethnicity, highest educational degree, the year the degree was attained, how long they had been a mental health professional, what was their current position was, why they chose the position, and their primary counseling theoretical orientation. The question about ethnicity was not asked on the Danish demographic form as Danes do not categorize individuals by their ethnicities.

Seven questions were used to create the *Rules and Regulations Scale*. Questions such as, "To what extent does the rules and regulations of your work setting hinder your work as a mental health professional?" were included. The first six questions were answered using a Likert-type response format ranging from 1 = *not at all* to 7 = *all the time*. The last question, "Do you, as a mental health professional, feel restricted in your work with clients due to the rules and regulations of your work setting?" was answered *yes* or *no*. The possible range of scores for these seven items was six to 43, with higher scores indicating greater adherence to work setting rules and regulations. The Cronbach's alpha for the study participants for these seven items was .73.

Five items comprised the *Professional Ethics Scale*. Four questions were answered using a seven-point Likert-type response format ranging from 1 = *not at all* to 7 = *all the time*. A sample item is "To what extent are you familiar with the ethical guidelines of your professional association?" One question was answered either *yes* or *no*. A total scale score could range from four to 29, with higher scores reflecting more reliance on professional ethical codes when making work-related decisions. The Cronbach's alpha for responses for the study participants was .72.

The third instrument, the *Personal Values and Beliefs Scale*, was comprised of three items answered on a seven-point response format. These items were: "To what extent do your personal beliefs as a mental health professional concur with the rules and regulations of your place of

employment?" "To what extent do your personal ethical beliefs concur with those of your professional organization?" and "To what extent do you adhere to the following: Your personal beliefs?" Total scores ranged from three to 21 with higher scores reflecting greater use of personal beliefs and values when making work-related decisions. The Cronbach's alpha for this study sample was .63.

## Results

### *Preliminary Analyses*

The purpose of this study was to examine the relationships among professional ethics, work setting rules and regulations, and personal values and beliefs of mental health professionals, and to identify potential cross-cultural differences between U.S. and Danish participants. Prior to analyzing the study hypotheses, the two groups of mental health professionals were compared on age, how long they had held their degree, how long they had been in the mental health profession, and how long they had worked in their current position. One way analyses of variance (ANOVA) revealed no differences between the two groups. When men and women were compared on the three outcome variables (professional ethics, rules and regulations of the work setting, and personal values and beliefs), the multivariate Hotelling's Trace  $F$  test revealed no gender differences,  $F < 1.00$ . Finally, those who worked in private practice were compared to those who worked in a community agency. Again, the Hotelling's Trace  $F$  Test revealed no group differences,  $F(3.43) = 1.05$ ,  $p > .38$ . Based on these findings, demographics, gender, and work setting were not considered confounding variables.

### *Test of Research Questions*

Correlational analyses among the three outcome variables were conducted to examine the first research question, which asked about the relationships among the three outcome variables. The Bonferroni correction was used to control for Type I error; therefore, the  $p$  value was set at .0167 for each correlation. The Pearson's Product Moment correlations revealed significant correlations: Rules and Regulations and Professional Ethics,  $r =$

.42,  $p < .0001$ ; Rules and Regulations and Personal Beliefs,  $r = .52$ ,  $p < .01$ ; and Ethics and Personal Beliefs,  $r = .37$ ,  $p < .01$ .

The second research question asked whether U.S. mental health professionals would report greater adherence to their professional ethical codes and to their work setting rules and regulations than would Danish mental health professionals. A Hotelling's Trace  $F$  Test revealed group differences,  $F(2, 45) = 9.28$ ,  $p < .001$ . Follow-up ANOVAs indicated that U.S. mental health professionals ( $M = 24.31$ ,  $SD = 2.66$ ) reported greater adherence to their professional ethics than did the Danish mental health professionals ( $M = 19.69$ ,  $SD = 4.80$ ),  $F(1, 46) = 17.03$ ,  $p < .001$ . There were no significant differences in adherence of work setting rules and regulations.

The third research question three focused on whether Danish mental health professionals would report greater use of their personal values and beliefs when making ethical decisions than would U.S. mental health professionals. The ANOVA failed to reveal group differences: The U.S. mean was 17.50 ( $SD = 2.38$ ) and the Danish mean was 18.02 ( $SD = 2.17$ ).

## Discussion

The overall purpose of this study was to examine potential cross-cultural differences in the relationships among professional ethics, work setting rules and regulations, and personal values and beliefs of mental health professionals' in Denmark and in the United States. As the first study of its kind in Denmark and the U.S., the overall findings present interesting patterns for mental health professionals in the two countries. Examination of the first research question revealed a significant positive relationship among professional ethics, rules and regulations of the work setting, and personal beliefs and values of the mental health professionals. This finding suggests that as mental health professionals rely more on their professional ethics, they also have greater adherence to the work settings rules and regulations, and use their personal beliefs more when engaging in ethical decision making. This finding coincides with the U.S. literature regarding ethics in psychology. Gius and Coin (2000) and Jensen and Bergin (1988) reported that mental health professionals are guided by their own ethical values and beliefs when they work with their clients. In her 1984 model of ethical decision making, Kitchener suggested that mental health professionals will resort to their own personal values and beliefs when

professional ethical guidelines are limited. The current findings indicate that the use of the three outcome variables covaries and that practitioners may relay on each to some extent.

Analysis of the second research question indicated that U.S. mental health professionals reported greater adherence to their professional ethics when making ethical decisions than did Danish mental health professionals. It may be that U.S. mental health professionals adhere more to their professional ethics due to the rise in litigation in the field and in the U.S. or it may be an issue of professional ethical training. Most (86.7%) of U.S. mental health professionals said they had had an ethics class, while only 59.3% of the Danish mental health professionals reported they had taken a class in professional ethics. Perhaps if more Danish mental health professionals had taken formal ethics classes, their professional ethics may be more in the forefront of their thoughts and play a greater role in their therapeutic decision making. This explanation is supported by research by Stadler and Paul (1986) who found that master and doctoral students who had taken a class in ethics, rated themselves as being better at responding to an ethical issue than did students who had not taken an ethics class. It is also supported by research by Wilson et al. (2004) and Robinson and Gross (1989) who found that students who had received formal training in ethics were more competent in recognizing ethical dilemmas and implementing sound ethical decisions.

Results for question two also revealed no significant difference between the U.S. and Danish mental health professionals in adherence to their work settings rules and regulations. Mental health professionals in both countries adhere equally to the rules and regulations of their places of employment. It may be that both Danish and U.S. mental health professionals believe that they should follow the rules and regulations of their work settings in order to remain employed. It may also be that U.S. and Danish mental health professionals are employed in agencies where the rules and regulations of their work settings are consistent with their personal beliefs. A study by Vandenberg, Richardson, and Eastman (1999) suggested that if employees do not feel that the rules and regulations of their work settings reflect their needs they become less satisfied with their organizations. Another possible reason for this finding could be that if mental health professionals disagree with the rules and regulations of the setting where they are working, they may go into private practice or choose to work at other agencies. Also,

Danish and U.S. mental health professionals may believe that the rules and regulations of their work places are valuable to their ability to practice therapeutically and may result in more satisfied clients and mental health professionals. In fact, research by Vandenberg et al. (1999) suggested that following work setting rules and regulations is positively related to employee satisfaction.

Analysis of the third research question, that Danish mental health professionals would report greater use of their personal values and beliefs when making ethical decisions than would U.S. mental health professionals, revealed no group difference. This may be related to the high positive correlations among professional ethics, work setting rules and regulations, and personal beliefs and values of mental health professionals. Since these three outcome variables were highly correlated, perhaps mental health professionals do not make distinctions among these three in their work with their clients. Hill, Glaser, and Harden (1995) developed an ethical decision-making model that suggested that mental health professionals “consider the impact of personal values, the universality of the proposed solution, and the intuitive feel of the proposed solution” (Cottone & Claus, 2000, p. 277) when making ethical decisions. It may be the nature of mental health professionals to use personal values and beliefs when working with clients and that this is a universal professional characteristic of mental health professionals regardless of nationality or culture.

### **Limitations of the Study**

The current study has several limitations that should be noted. First, the overall combined sample of U.S. and Danish participants was small when considering the quantitative approach in this study; thus, this study should be considered as a pilot study, especially because it was the first of its kind comparing mental health professionals in the U.S. and Denmark. Also, the Danish sample was a sample of convenience that was arranged via the first author’s psychologist contacts in Denmark. In contrast, the U.S. sample was recruited by sending “blind” emails to community counseling agencies in a southwestern state and by using the state’s counseling association’s membership listserv. Thus, because the recruitment of the participants differed in the two countries, the results may not be generalizable to other

Danish and U.S. mental health professionals. Also, the results may have been skewed due to the volunteer nature of the samples.

Additionally, the questionnaire created by the first author was not pilot-tested for validity and reliability, and only received confirmation of face validity from mental health professionals in the U.S. and in Denmark. Finally, only one methodology was used to examine the research questions. Some of the significant findings, or lack thereof, may be related to cultural interpretations of the questions. For example, Danish mental health professionals may interpret words such as “professional ethics” and “personal ethics” differently than U.S. mental health professionals and discussion of professional ethics in the mental health field may be different in the two countries. Qualitative methods such as observation, interviews, or questionnaires asking more descriptive questions may have proven more fruitful for isolating data that was not available with quantitative data.

### **Implications for Future Research**

Since the time that this study was conducted the first author has returned to Copenhagen, Denmark and is currently employed as a psychologist at a private agency. The primary author has observed several differences between the Danish and U.S. work setting rules and regulations. This prompted the primary author to question whether the second research question (*Do U.S. mental health professionals report greater adherence to their work setting rules and regulations than Danish mental health professionals?*) was worded inaccurately. The current observations have brought about the idea that it is not that Danish mental health professionals adhere less than U.S. mental health professionals but that the work settings rules and regulations in the U.S. are much more explicit than in Danish work settings. When the first author worked in the U.S., there was a manual to follow, which could answer any question (in theory) of how to work with a client. In Denmark, the primary author uses observational skills to learn/understand the rules and regulations of the work-setting. In organizational sociology, the Durkheimian classical view “perceives structures as behavior prescriptive norms and constraints. They serve as the blueprints for organizational activities and recalcitrance of members and are seen as a control mechanism in pursuit of a certain level of regularity and predictability” (Nijsmans, 1991, p. 2). Sociologists belonging to the

interactions or phenomenological view challenged the classical perspective and focused on the “interpretative nature of the ‘practical accomplishments’ of rules by the organizations members [and] conclude that all rules require some degree of interpretation, knowledge and utilization” (Nijsmans, 1991, p. 3).

Based on these new observations, the authors believe that future research might include: qualitative data gathering such as interviews and observations of the work settings’ rules and regulations and how they are implemented and adhered to by mental health professionals. It may be that cultural variables play a key role in how U.S. and Danish mental health professionals acknowledge adherence to work setting rules and regulations and to professional ethics. Also, interviewing Danish and U.S. mental health professionals about their understanding of the implicit or explicitly stated work setting rules and regulations may bring forth some interesting cultural differences.

Future research should also investigate the differences related to training in ethics and ethical codes and guidelines. In the U.S., litigation is a relevant concern for counselors. The same does not appear to be true among Danish mental health professionals. Future research should investigate whether Danish mental health professionals adhere less to their professional ethics due to lack of training or not being concerned with litigation issues. On the other hand, if U.S. mental health professionals are too concerned with litigation issues, what effect does that have on clients? How do we, as mental health professionals, research/measure these grey areas and what can we learn from one another?

## **Conclusion**

The current comparative study attempted to shed light on the relationships among the use of professional ethics, work setting rules and regulations, and personal values and beliefs among Danish and U.S. mental health professionals. There were strong positive correlations among the three outcome variables, with U.S. mental health professionals’ reporting greater adherence to their professional ethics than did Danish mental health professionals when making ethical decisions about their clinical work. However, U.S. mental health professionals did not adhere more to their work setting rules and regulations than did Danish mental health professionals,



nor did Danish mental health professionals adhere more to their personal values and beliefs than did U.S. mental health professionals. As we continue to internationalize the profession of counseling, researchers need to develop quantitative and qualitative investigations to generate data that can contribute to our knowledge of cultural differences and similarities across a multitude of international counseling settings, particularly when ethical decision making is present.

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