Ethical Issues in Exercise Psychology

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Exercise psychology encompasses the disciplines of psychiatry, clinical and counseling psychology, health promotion, and the movement sciences. This emerging field involves diverse mental health issues, theories, and general information related to physical activity and exercise. Numerous research investigations across the past 20 years have shown both physical and psychological benefits from physical activity and exercise. Exercise psychology offers many opportunities for growth while positively influencing the mental and physical health of individuals, communities, and society. However, the exercise psychology literature has not addressed ethical issues or dilemmas faced by mental health professionals providing exercise psychology services. This initial discussion of ethical issues in exercise psychology is an important step in continuing to move the field forward. Specifically, this article will address the emergence of exercise psychology and current health behaviors and offer an overview of ethics and ethical issues, education/training and professional competency, cultural and ethnic diversity, multiple-role relationships and conflicts of interest, dependency issues, confidentiality and recording keeping, and advertisement and self-promotion.

Keywords: ethics, exercise psychology, sport psychology

The emerging field of exercise psychology consists of diverse mental health issues, theories, and general information related to physical activity and exercise. Exercise psychology encompasses approaches from the fields of psychiatry, clinical and counseling psychology, health promotion, and the movement sciences (Buckworth & Dishman, 2002a). The establishment of optimal mental health with nonclinical, clinical, and population based settings is often the primary focal point of exercise psychology practitioners. Physical activity is viewed as a treatment

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modality for mood alteration, management of psychopathology and stress, and enhanced self-worth. Exercise psychology practitioners also focus on factors related to exercise program characteristics that influence exercise adoption and adherence for individuals, groups, and communities (Berger, Pargman, & Weinberg, 2002).

The field of exercise psychology and consulting has many opportunities for growth. Potential employment opportunities can be found in the areas of colleges and universities, management of corporate fitness programs, counseling in physical rehabilitation clinics, and individual consultation with a diverse clientele. The effectiveness of exercise practitioners or consultants is often dependent on their ability to develop a collaborative relationship with their clients and other professionals.

When consulting with exercisers and/or incorporating exercise into a traditional treatment plan, mental health practitioners may feel as if they are treading in uncharted waters due to some of the unique consultation circumstances and settings in the exercise environment. Until now, the literature has not directly addressed ethical issues or dilemmas related to providing exercise adherence counseling services or including exercise as a component of a traditional treatment plan. The heightened media attention and rising mental health care costs have increased the allocation of funding by federal agencies (i.e., National Institutes of Health) to enhance physical activity patterns. Therefore, the need and opportunity for practitioners to assist with exercise adoption and maintenance is only going to increase over the next decade as we continue to search for alternative treatment options to fight physical health problems (e.g., obesity) and mental health issues. With this increased opportunity and demand, the need to provide proper guidance to practitioners implementing exercise as a component of therapy must be examined.

Thus, the remainder of this article will focus on selected ethical issues and potential ethical dilemmas facing mental health professionals who provide exercise adherence consultations and/or include exercise as a component of counseling or therapy. Specifically, this article will address the emergence of exercise psychology and current health behaviors, an overview of ethics and professional resources, education/training and professional competency, cultural and ethnic diversity, multiple-role relationships and conflicts of interest, dependency issues, confidentiality and recording keeping, and advertisement and self-promotion. In conclusion, future issues and opportunities related to the field of exercise psychology will be presented.

EMERGENCE OF EXERCISE PSYCHOLOGY AND CURRENT HEALTH BEHAVIORS

The emergence of exercise psychology is due to the decline in lifestyle and behavioral choices. In America today, choosing desirable health behaviors such as regul-
lar physical activity and a healthy diet are not typically practiced to the degree they should be. According to the U.S. Department of Health and Human Services (USDHHS; 2000) Healthy People 2010 report, only 22% of adults in the United States engage in moderate physical activity for 30 min five or more times a week, whereas nearly 25% of the population is completely sedentary. Furthermore, when people do attempt to modify a lifestyle behavior by, for example, increasing physical activity, many are unable to maintain the adapted behavior. The physical activity adherence research reports dropout rates up to 50% within the first 6 months of the start of an exercise regimen (Dishman, 1988).

The cause for weight gain in Americans has been clearly identified. Simply put, we are eating more and exercising less than ever before. Americans are eating approximately 15% more calories than in previous years (Putnam, Kantor, & Allshouse, 2000). Combine the increased caloric consumption with the previously mentioned physical activity patterns and you have a formula for weight gain for a large segment of our society.

Based on the aforementioned statistics and data regarding obesity, diet, and physical inactivity, the outlook may appear bleak. However, there is hope due to the development of effective behavioral and cognitively based intervention strategies to assist individuals with the adoption and maintenance of more active lifestyles (Buckworth & Dishman, 2002b). Currently, there is an abundance of literature indicating that the adoption of a more active lifestyle will enhance mental well-being (reduce depression and anxiety and enhance self-esteem) while decreasing the likelihood of developing obesity and other risk factors (i.e., high blood pressure and cholesterol) for chronic diseases such as cardiovascular disease and cancer (USDHHS, 1996). Furthermore, the literature clearly indicates that an individual does not have to be an athlete or exercise vigorously to engage in beneficial exercise (Public Health Service, 2001). The American College of Sports Medicine (ACSM; 2000) training guidelines for physical fitness and exercise performance recommends for aerobic activities 3 to 5 days per week of moderate-intensity exercise for 20 to 60 min (in at least 10-min sessions) and weight training that includes one or more sets of 8 to 12 repetitions of 8 to 10 exercises at least 2 days a week.

Interestingly, many practitioners are utilizing exercise as a therapeutic modality to improve traditional psychological services. Hays (1999) indicated that exercise can be utilized to cope with clinical issues (e.g., depression, anxiety, and weight management), issues of daily living, and improving self-care. Exercise psychology research supports the use of exercise as a treatment modality for both clinical and nonclinical clients (Buckworth & Dishman, 2002a). Based on the well-documented physical and psychological benefits of exercise, psychologists and counselors need to be aware of the benefits that can be gained by adding exercise to a traditional treatment plan. However, due to issues pertaining to ethical dilemmas and/or competency, some practitioners may believe it is unethical to include exercise as part of a treatment plan despite the literature supporting its use.
For most people physical activity poses minimal risks. However, it is important that all clients, regardless of ethnic or cultural background, obtain physician approval to begin an exercise regimen. In addition to the physician approval, conservative therapists desiring to add exercise to treatment should also have their clients complete the Physical Activity Readiness Questionnaire (PAR-Q; British Columbia Ministry of Health, 1978). The PAR-Q is designed to identify adults who may not be suited to participate in physical activity due to various physical ailments.

ETHICS OVERVIEW AND PROFESSIONAL RESOURCES

The purpose of an ethics code is to provide guidance and governance for a profession’s members in working settings. An ethics code provides integrity to a profession, professional values and standards, and fosters public trust through the establishment of high standards (Fisher, 2003). It should be noted that no code of conduct or set of ethical guidelines can account for all possible situations or ethical dilemmas. Ethical codes are developed from the current values and beliefs in society as related to a profession. These values and beliefs, as well as common professional practices, can and do change with the passing of time due to numerous factors, making it necessary for ethical codes and standards to also change.

The American Psychological Association (APA; 2002) ethics code is a well-developed and ever-evolving document that provides ethical principles and codes of conduct to govern and guide its membership. In contrast, the Association for the Advancement of Applied Sport Psychology’s (AAASP; 1994) ethical code is derived from the APA’s (1992) ethics code and has not been updated since its inception. It is designed to address issues specific to sport and exercise psychology work. There are differences between APA and AAASP ethical principles and codes. Those differences will be discussed later as they relate to exercise consultations. Whelan, Meyer, and Elkin (2002) provided a detailed discussion of the AAASP principles and ethical standards and serve as a good reference for a sport and exercise psychology practitioner preparing to be or currently involved with sport psychology consulting or exercise adherence counseling. Fisher (2003) and Bernstein and Hartsell (2004) also serve as good sources for both general practitioners and exercise consultants.

The ACSM is recognized by health professionals throughout the world as the leading organization and authority on health and fitness. The ACSM’s primary focus is to advance health through science, medicine, and education. Furthermore, the ACSM (2003) has established a code of ethics with the principal purpose of “generation and dissemination of knowledge concerning all aspects of persons en-
gaged in exercise with the full respect for the dignity of people” (¶ 1). To achieve its principal purpose, the ACSM (2003) established the following four sections:

1. Members should strive continuously to improve knowledge and skill and make available to their colleagues and the public the benefits of their professional expertise.
2. Members should maintain high professional and scientific standards and should not voluntarily collaborate professionally with anyone who violates this principle.
3. The College, and its members, should safeguard the public and itself against members who are deficient in ethical conduct.
4. The ideals of the College imply that the responsibilities of each Fellow or member extend not only to the individual, but also to society with the purpose of improving both the health and well-being of the individual and the community. (¶ 1)

Therefore, the ACSM is an excellent resource for mental health professionals to consult for guidance concerning issues related to exercise, health, and fitness.

EDUCATION/TRAINING AND PROFESSIONAL COMPETENCY MAINTENANCE

The field of exercise psychology is a merger between psychology and exercise or movement science. Individuals specializing in either of these areas will have different competencies and thus the ability to practice with different populations. Most professionals recognize the value of having individuals in the field from both backgrounds due to the uniqueness of their training. The APA (2002) ethics code specifies that in emerging areas such as exercise psychology practitioners should “take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm” (p. 5).

The ideal training for exercise therapists or consultants is an ongoing debate. The two primary sources of training for exercise practitioners are (a) psychology (i.e., counseling or clinical psychology) and (b) the movement sciences (i.e., kinesiology or exercise physiology). As previously mentioned, psychology and movement sciences have been meshed together to form the discipline of exercise psychology. However, these two disciplines are indeed separate and pose a complex issue concerning training. Training for exercise practitioners is complex due to licensure. Clearly, to refer to oneself as a “psychologist," an individual must satisfy the state requirements for licensure within the state in which he or she works. Most people trained in the movement sciences can specialize in exercise psychology but will likely not be able to meet the requirements for psychology licensure. Thus, practitioners can not ethically refer to themselves as “exercise psychologists” because they will not be licensed as psychologists within their state of em-
ployment. Likewise, licensed psychologists with limited or no training in the movement sciences should not ethically refer to themselves as “exercise psychologists” because of a lack of proper training in exercise science.

Education and training from both exercise or movement science and psychology is a necessity for scholar–practitioners in the field of exercise psychology. Due to the interdisciplinary nature of exercise psychology, students will most likely need to create an individualized plan of study suited to meet their future goals and career objectives by combining courses from traditional psychology, sport sciences, and sport and exercise psychology. In 1991, AAASP established certification criteria for becoming a certified consultant of AAASP. The interdisciplinary requirements of AAASP certification require coursework and practicum guidelines for students who desire or specialize in applied sport or exercise psychology (Sacks, Burke, & Schrader, 2001). The requirements appear adequate and are necessary but reflect only minimal foundational training. AAASP certification requirements should not be viewed as sufficient training to become an effective exercise consultant. Furthermore, the attainment of AAASP certification requirements does not permit an individual to ethically use the title “exercise psychologist.”

The following is a recommendation of minimal interdisciplinary coursework based on most state licensure requirements and AAASP certification, to be competent to do specialized consultation in exercise psychology. This recommendation is not a comprehensive list intended to address every possible career aspiration within exercise psychology, but it can provide some initial guidance. The interdisciplinary coursework should focus on the areas of psychology, sport science, and sport psychology. The exercise psychology curriculum should include

1. Traditional psychology courses such as human growth and development; biological, social, and cultural bases of behavior; counseling skills; psychopathology; individual and group behavior; psychological assessment; cognitive–affective bases of behavior; professional ethics and standards; statistics; and research design.
2. Sport science courses should incorporate biomechanical and physiological bases of sport, motor development, motor learning, fitness assessment, fundamentals of strength and conditioning, aerobic and weight training, and sport nutrition.
3. Last, sport psychology, performance enhancement, exercise psychology, health psychology, and social aspects of sport and physical activity should be included.

In addition to formal coursework, practical experience (i.e., internships and/or practicum) focused on the application of psychological principles, theories, and practices in the exercise setting is also a necessity. The practical experience must be supervised by a qualified specialist (e.g., licensed psychologist, licensed mental
health practitioner, or certified consultant of AAASP) within the field of exercise psychology. The aforementioned curriculum and practical training seems to provide the necessary education for mental health professionals regarding the physical and psychological benefits of exercise.

Nevertheless, this initial, formal coursework and applied experience is not in and of itself enough to allow one to practice ethically throughout his or her career. Maintaining professional competence through continuing professional education is extremely important in any field, including exercise psychology. The scientific and professional knowledge base of psychology and exercise/movement science is continually evolving, bringing with it new research methodologies, assessment procedures, and forms of service delivery. Life-long learning is fundamental to ensure that teaching, research, and practice have an ongoing positive impact on those desiring services (Bickham, 1998). Both APA and AAASP provide a variety of opportunities and methods for scholars and practitioners to maintain professional competency. Some of these methods include independent study, continuing education courses or workshops, supervision, and formal postdegree coursework.

Maintaining professional competency is also an important ethical requirement that is valued highly by the APA, the AAASP, and the ACSM. Over 96% of AAASP professionals recently surveyed by Etzel, Watson, and Zizzi (2004) believed that it is important to maintain professional competency through continuing education training. This very high percentage is a clear indication of the value AAASP members place on maintaining professional competency. Maintaining professional competence through continuing professional education ensures that the scholars and practitioners in the field of exercise psychology are providing the most current services to their clients.

CULTURAL AND ETHNIC DIVERSITY

The ethical standards of the APA (2002) and the AAASP (1994) clearly indicate the importance of recognizing that human differences such as age, gender, and ethnicity do exist and can significantly impact a practitioner’s work. The standards emphasize the responsibility to develop the skills required to be competent to work with a specific population or to be able to make an appropriate referral. The importance of understanding the culture and background of a variety of populations is vitally important in both exercise and therapeutic settings.

Research indicates high rates of obesity and inactivity among women and minority groups. About 33.4% of all women are obese, compared to 27.5% of men (Goldsmith, 2004). The age-adjusted prevalence of overweight and obesity in racial/ethnic minorities, especially minority women, is generally higher than in Whites in the United States (Flegal, Carroll, Ogden, & Johnson, 2002). More specifically, among women, non-Hispanic White women have the lowest occurrence
(30.7%) of obesity, non-Hispanic Black women have the highest (49.0%), and Mexican American women are in the middle (38.4%; Hedley et al., 2004).

The importance of cultural sensitivity and awareness is clearly underscored by the aforementioned data. Barriers to exercise adherence are often directly or indirectly related to personal and cultural factors. Therefore, when working in the area of exercise consulting, a practitioner needs to consider the impact, positive and negative, of factors associated with gender, ethnicity, socioeconomic status, and other potentially relevant culturally based factors.

In traditional counseling and clinical settings, the impact of factors associated with gender, ethnicity, and culture is also highly relevant for successful outcomes. In 1972, the Association of Multicultural Counseling and Development (AMCD), was established to assist with recognizing the assets of culture and ethnicity, and other social identities and to address concerns about ethical practice (Arredondo & Toporek, 2004, p. 45). These factors are also pertinent for practitioners who desire to include exercise as a component of treatment. A series of essential questions to address prior to prescribing exercise as a therapeutic modality include: Is exercise valued in the culture and/or by the client? What is the prior exercise history of the client? What types of social support are available to assist the client with exercise adherence? Does the client’s culture create any additional barriers for adherence for exercise and traditional treatment?

MULTIPLE-ROLE RELATIONSHIPS AND CONFLICTS OF INTEREST

Multiple-role relationships are often viewed as occurring when the therapeutic connection has moved toward a friendship relationship (Bernstein & Hartsell, 2004). Multiple-role conflicts in therapy and consultations for exercise adherence may be encountered when clear boundaries have not been established. When the relationship boundary between the professional and client becomes clouded, the likelihood of multiple-role conflicts greatly increases. Every practitioner needs to maintain ethically proper professional boundaries. Establishing and maintaining such boundaries can be difficult due to the casual atmosphere that surrounds the exercise environment. The casual environment is created by the type of clothing worn during exercise, music being played, and the social atmosphere of many exercise and rehabilitation facilities.

A first step in maintaining appropriate boundaries is to establish a common protocol when communicating with all new clients. Instead of using first names, which seems to be a more common custom, it might be helpful to be consistent with the practice of referring to clients by last name and title (Miss, Ms., Mrs., and Mr. Brown). This practice encourages clients to maintain a distance from the therapist.
Maintaining this distance becomes even more difficult when exercising with clients. Exercising together can be a great vehicle for building rapport and developing communication between practitioner and client. Conversely, exercising with clients may cloud the boundaries and thus cause some confusion or ambiguity regarding the nature of the relationship between client and practitioner. There are no current guidelines and/or laws relative to this specific situation. However, both the APA (2002) and AAASP (1994) ethic codes indicate that multiple roles can be inappropriate and unethical if handled in the wrong way and need to be maintained with great caution. Clarifying the nature of the relationship during the intake and informed consent process, prior to exercising with the client, is of primary importance. It is the practitioner’s ethical responsibility to have a candid discussion with the client that clearly defines a therapeutic relationship and the limitations concerning nontherapeutic personal contact. For example, personal contacts such as engaging in recreational or competitive athletic teams, attending sporting events, and other general social functions together are in violation of maintaining therapeutic boundaries. The practitioner should have a clear rationale for prescribing exercise in a client’s treatment plan. In addition, the rationale for exercising together (i.e., to develop rapport) should be clearly communicated and understood between practitioner and client.

When exercising with clients, a common dilemma the practitioner faces is determining what type of physical activity should be implemented. As previously mentioned, research has found a variety of activities (aerobic and anaerobic) that provide physical and psychological benefits (USDHHS, 1996). In regard to adherence, it is vital to have clients’ input concerning activity selection. When clients have input into the selection process, they will likely select/choose a physical activity they enjoy. Enjoyment of the activity has been positively correlated to adhering and maintaining an exercise regimen (Wankel, 1993).

Walking is one of the most commonly reported types of physical activity (USDHHS, 1996). Walking is an excellent choice of physical activity for numerous reasons. First and foremost, many people are able to walk. Furthermore, the risks associated with walking are minimal due to the low to moderate intensity level. Also, most people are able to walk and talk simultaneously, which is necessary for therapeutic consultations. Last, walking can be performed inside or outside and requires minimal equipment or modification of clothing. For clients who are able to and desire a more intensive level of activity, jogging is a viable alternative to walking. When selecting jogging, a major requirement is for the therapist and client to have a high level of cardiovascular fitness. A high level of cardiovascular fitness allows them to talk with each other while exercising.

Anaerobic activities such as strength training provide clients and therapists with another viable option for activity selection. During strength training, there is ample time for communication and discussion between practitioner and client. However, there are a few limiting factors when choosing strength training. Most
strength training activities require specialized equipment and facilities and present increased potential for risk of injury. In addition, a couple of potential ethical dilemmas when including strength training are competency and confidentiality. The therapist may not have the knowledge base and/or experience to supervise a strength training program that would accomplish desirable health and therapeutic objectives. It may also be difficult to maintain confidentiality due to other people exercising in very close proximity.

The mental health practitioner should not assume the role of a physician, exercise physiologist, or personal trainer in terms of providing or modifying an exercise prescription. Furthermore, practitioners should be cognizant of their primary role, which is to assist with exercise adherence and consultation. Exercise psychology practitioners ethically need to be aware of their professional limitations and competence boundaries vis-à-vis their education and training.

Maintaining an appropriate distance is sometimes useful in diverting inappropriate attempts at amorous and other nonprofessional relationships. Sexualizing the relationship with a client is clearly unethical as well as very unsound professional practice that harms both the client and practitioner (APA, 2002; AAASP, 1994). Practitioners often hold an advantage of power over the people with whom they work. Furthermore, practitioners occupy a position of trust and are expected to advocate the welfare of those who depend on them.

Physical contact within the counseling and exercise setting is often ethically appropriate. However, contact that is intended to express emotional support, reassurance, or an initial greeting can be misinterpreted as an invitation for advances. The social environment, revealing clothes, and close proximity that surround the exercise setting can lead to inappropriate advances by clients or practitioners. Recognition of signs, both in clients and in therapists, and dealing with these feelings immediately and objectively is the best approach. The practitioner should discuss these feelings with an experienced, respected, and trusted colleague. If the practitioner is unable to control his or her feelings, termination and referral are recommended as a method of protecting both the client and practitioner. However, on termination of the relationship, the two individuals are not ethically “free” to pursue a more social or intimate relationship. It is strongly suggested to have a cooling off period (several months to years) in which both parties agree to wait prior to pursuing a relationship at a different level. A more conservative approach suggested by Bernstein and Hartsell (2004) is to follow the belief of once a client, always a client. With the adoption of this approach, once a professional relationship is initiated it must always be maintained, thus reducing the notion or intention of modifying any professional relationship.

### DEPENDENCY ON THE THERAPIST

Another issue that must be discussed in collaboration with multiple-role relationships is a client’s level of dependency on a therapist’s services and influence. With-
out question, as human beings we live in a world where dependency on others is crucial to an individual’s survival. Memmi (1984) explained that the level of dependence on others should be presented from three perspectives: “1) according to the identity of the dependent (e.g., child, adult), 2) to that of the provider (e.g., human being, animal, or object), and 3) to the object provided (e.g., winning a medal versus establishing a friendship)” (p. 18). For example, children (dependent) rely on their caregivers (provider) for acquiring and supplying food, water, and shelter (objects provided) to survive within our society. Therefore, as children develop into adults, they must acquire the knowledge and skills from a caregiver to successfully gain the necessities to survive independently. Similarly, clients attend counseling sessions in hopes of gaining the appropriate knowledge and skills so they can effectively cope with issues that currently disrupt their quality of life.

Another view of examining the level of a client’s dependence on a therapist is intertwined within attachment theory. “John Bowlby’s attachment theory is based on an attachment behavioral system—a homeostatic process that regulates infant proximity-seeking and contact-maintaining behaviors with one or few specific individuals who provide physical or psychological safety or security” (Sperling & Berman, 1994, p. 5). Bowlby (1980) indicated that the level of continuity, which is a key component of attachment theory, is the way children construct attachment behaviors into a strategy for relating with others and how these behaviors greatly influence succeeding behaviors across the life span. An individual’s attachment behavioral system can become activated through various activities and events, including stressful periods (Sperling & Berman, 1994). Interestingly, a therapeutic relationship has the potential for activating an adult client’s attachment expectations and behaviors (Bowlby, 1988; Woodhouse, Schlosser, Crook, Ligiero, & Gelso, 2003).

As previously stated, it is important to realize that individuals who seek therapeutic services are usually attempting to alter their behaviors and/or emotions to manage problems interfering with their daily lives. In other words, clients may seek the services of mental health professionals because they believe therapists have the ability and knowledge to provide care, comfort, and guidance to relieve their debilitating issues (Bowlby, 1988; Farber, Lippert, & Nevas, 1995; Riggs, Jacobvitz, & Hazen, 2002; Slade, 1999).

Specifically, within the realm of exercise psychology, individuals may solicit a therapist for psychological services to assist in the quest of achieving their desired outcomes (e.g., losing weight, increasing their levels of physical activity, mood alteration). During these counseling sessions, clients may complete physical activities (e.g., walking, jogging, strength training) with their therapist. Some therapists believe conducting therapy while exercising with their clients is beneficial to the overall treatment plan and objectives (Hays, 1999). For example, mental health practitioners can monitor clients’ behavioral and emotional states while completing the physical activities together. During these physical activities, a therapist gains an immediate perception of how the client is progressing.
with the assigned tasks. Therefore, alterations to the treatment plan can be introduced while exercising.

As clients accomplish their goals (e.g., losing the desired amount of weight, increasing the level of physical activity, mood alteration), it is probable that they will develop a new identity and/or level of self-worth (e.g., confidence, esteem). Numerous research investigations indicate that an increase in the level of physical activity will improve individuals’ mental well-being and decrease numerous health risks (e.g., cardiovascular disease, cancer; USDHHS, 1996).

Unfortunately, the realization of clients’ desired outcomes (e.g., loss of weight, positive self-image, mood alteration) potentially could produce an increased level of dependence (i.e., attachment) on the therapist and services provided. That is, clients may develop the notion that the therapeutic relationship with their exercise practitioner must continue to achieve and maintain the desired outcomes. Dishman (1988) explained adherence to exercise (i.e., physical activity) can be difficult, as up to 50% of exercisers drop out within the first 6 months of initiating an exercise program. This may be a reason why some individuals who maintain an exercise regimen become dependent on the services provided by fitness trainers. For example, certain individuals are unwilling to work out alone or require motivation, social support, and guidance from a fitness trainer to complete physical activities and pursue their physical fitness goals. Thus, a level of dependence is established, and possibly strengthened, as the individual continues an exercise routine under the supervision of a fitness trainer. Despite the lack of research, a similar level of dependence for a client may develop during a therapeutic relationship with an exercise therapist. To date, no research investigations have examined the level of clients’ dependence on their exercise therapist. However, “exercising with clients during therapy could promote dependency” (Hays, 1999, p. 61). Therefore, exercise practitioners should be aware that clients’ level of dependency may become an issue even if the sessions produce the desired healthy outcomes.

CONFIDENTIALITY AND RECORD KEEPING

Confidentiality is another central ethical issue that often arises in a variety of traditional and exercise counseling settings. Confidentiality is directly addressed in both the APA (2002) and AAASP (1994) ethics codes of conduct. Standard 4.01 of the APA (2002) ethics code states that practitioners “have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or scientific relationship” (p. 7). Clients value privacy, and it is not uncommon for a client to begin an initial interview by asking about confidentiality (Zaro, Barach, Nedelman, & Dreiblatt, 1994). Because the limits of confidentiality differ from state to state, it is
essential to learn the specifics in your own area. Presented in the following paragraphs are some general recommendations for maintaining confidentiality across a variety of activities as they relate to exercise consultations.

Within the dynamic of exercise consultations it is common to collaborate with a variety of professionals (e.g., physicians, trainers, exercise physiologists, dieticians). Collaboration with colleagues is an important means of ensuring and maintaining the competence of one’s work and the ethical conduct of psychology. When consulting with colleagues, one should not disclose confidential information that reasonably could lead to the identification of a client. Even when prior consent has been granted by the client, the disclosure of information should be only to the extent necessary to achieve the purposes of the consultation. Maintaining confidentiality and respect for the client’s privacy should be upheld at all times and is vital in maintaining a collaborative and trusting relationship with clients.

When using the Internet or other sources of electronic media, it is the practitioner’s responsibility to become knowledgeable about employing appropriate methods for protecting the confidentiality of records concerning clients (Fisher, 2003). The Internet and other electronic media are vulnerable to breaches in confidentiality that may be beyond an individual’s control. For example, when personal files or therapy notes are stored on a common server or university system server, security measures such as the use of password protection and firewall techniques should be in place. Conducting assessments, exercise adherence, or traditional counseling via e-mail, secure chat rooms, cell phone, or providing services on a Web site are all mediums in which confidentiality can be violated. Clients should be informed of the risks to privacy and limitations of protection when utilizing an electronic medium to deliver exercise consultation services. Similarly, safeguards should also be used for handwritten therapy notes, treatment plans, or client records. These types of records and documents should be stored in locked file cabinets.

**ADVERTISEMENT AND SELF-PROMOTION**

Most individuals do not become involved in the field of psychology—whether it is general, clinical, sport, or exercise psychology—due to their abilities for self-promotion. However, these skills become important when trying to increase one’s exposure and attracting potential clients. Without development or training in ethical marketing or self-promotion, it is quite common for the issues pertaining to self-promotion and marketing to be discomforting (Heil, Sagal, & Nideffer, 1997).

The APA (2002) ethics code (Ethical Standard 5) addresses advertising and other public statements more thoroughly than does the AAASP (1994) ethics code (i.e., General Ethical Standard 16). Clearly identifying one’s credentials or certifications is the first step in understanding the process of advertising and public statements. It is the professionals’ responsibility to appropriately identify their creden-
tials and take the initiative to correct misrepresentations when mistakes are made. In addition, it is unethical to solicit testimonials from current clients or other influential individuals due to their position, title, or status. For example, Dr. White prescribes exercise as a component of counseling for a famous actress. She attains her desired therapeutic goals through proper exercise adherence and counseling. Based on this scenario, it is unethical for Dr. White to solicit a testimonial from the actress promoting the benefits of his counseling.

There are ethical and appropriate methods of enhancing one’s visibility. These methods include, but are not limited to, speaking at various rehabilitation clinics, exercise facilities, and civic organizations. Providing information through speaking engagements about the nature and benefits of exercise psychology and adherence counseling will be professionally beneficial by creating the opportunity for practitioners to integrate and synthesize theories and research findings into practice for their specific audience. Another vehicle to enhance exposure is through public interviews with local radio, television, and newspapers. The establishment of a Web site is another possible source of exposure. Speaking engagements, interviews, and the development of a Web site are excellent methods of “getting your name out there,” but there is no guarantee that these methods will lead to clients and referrals.

The development of a client and referral base is an ongoing challenge. However, the practitioner who is able to interact with colleagues from various settings (e.g., physicians, athletic trainers, physical therapists, personal trainers, exercise physiologists, and other mental health professionals) will have an advantage in developing a wide range of referral sources. Furthermore, there is no substitute for word-of-mouth referrals. This means those practitioners who develop an effective working relationship and provide effective strategies to assist their clientele in reaching their desired goals will be able to maintain and expand their client list.

**FUTURE ISSUES AND OPPORTUNITIES**

Issues related to the most desirable qualifications for the exercise psychologist or consultant will continue to be debated. However, it appears that interdisciplinary training is vital and will positively contribute to the development of collaborative and effective professionals within the field of exercise psychology. A movement toward accreditation of programs also adds to the establishment of quality training for future professionals.

Employment in the field of exercise psychology and consulting, which bridges the areas of psychology and movement sciences, can provide a challenging and rewarding career. Within the challenges lie numerous ethical considerations and behaviors that should be clearly conceptualized prior to and while involved in this emerging field. The previous discussion of potential ethical issues and dilemmas is
by no means a complete guide. This article is just a starting point for future dialog regarding ethical issues related to exercise psychology and consulting.

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