Ethics in Psychotherapy and Counseling

A PRACTICAL GUIDE

THIRD EDITION

KENNETH S. POPE • MELBA J.T. VASQUEZ

Critical Praise for the Current and Previous Editions

"Drs. Pope and Vasquez have done a masterful job in their third edition in helping practitioners think through how to respond to complex ethical dilemmas and assume personal responsibility for their actions. This book also provides an excellent articulation of best practices in negotiating and clarifying complex ethical dilemmas. The authors explore the complexities of ethical decision making in creative ways that encourage mindful awareness and continual inquiry. They use an active approach with scenarios followed by a set of questions to explore each topic. This is an essential book for every clinician—from trainees to seasoned practitioners. It will have a powerful impact on the field for many years to come by providing practitioners a solid foundation and road map upon which to provide competent and ethical treatment."

—Linda Garnets, psychology, women's studies,
and LGBT studies, UCLA

"Moving away from the idea of 'ethics' as an abstract set of prescriptions for being good, the authors skillfully locate their discussion at the intersection of a host of practical themes such as self-scrutiny, sound decision making, creation of a professional will, and responding to a variety of complaints. Though labeled under the rubric of ethics, the book is actually a superb and comprehensive discourse on what constitutes professionalism in clinical work. Backed by useful appendices of the ethical codes of various organizations, the book leads the reader on a thoughtful exploration of a central organizing principle in our work."

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"This dynamic third edition invites the reader into an active questioning process that goes well beyond ethics codes and standards. The engaging autonomy-based approach empowers practitioners to discover the most ethical and positive response to a unique client with unique needs and resources in a unique context."

—Carol D. Goodheart, treasurer and member of the board of directors,
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"A splendid book. . . . This is essential reading for all those in psychotherapy and related fields."

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"An updated version of a classic text on ethics in psychology. Drs. Pope and Vasquez provide the reader with an outstanding set of tools for enhancing ethical behavior in an increasingly complex professional world."

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—Allen Webb, former president, American Board
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"A wonderfully insightful and unique book for all therapists, supervisors, and students; an affirmation of our rich scientific and professional heritage and values."

—Jack Wiggins, former president,
American Psychological Association

"The talents of Drs. Pope and Vasquez relative to their abilities to translate difficult and sensitive material into a user-friendly resource continue to shine forth in this latest work. Their appreciation of the multiple contexts (multicultural, social, political, historical, and intrapersonal) within which ethical decision making is framed and their attention to the emotion-laden human component that fuels a professional's response to the ethical circumstances and dilemmas they confront adds a shining touch to their impeccable scholarship. This text represents an invitation to mental health professionals across levels of academic and clinical experiences to sharpen their service-provider talents and tools, and a response in the affirmative to these distinguished authors is highly encouraged."

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Association; dean, Graduate School of Professional
Psychology, John F. Kennedy University

"An excellent blend of case law, research evidence, down-to-earth principles, and practical examples from two authors with outstanding expertise. Promotes valuable understanding through case illustrations, self-directed exercises, and thoughtful discussion of such issues as cultural diversity."

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"A wonderful, helpful guide to the complexities of modern-day ethics. As hard as it is to imagine, this revision by Drs. Pope and Vasquez of their landmark text is even more timely, insightful, and important."

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American Psychological Association

"The Pope and Vasquez text will stand as a premier reference source for ethics codes, practice guidelines, and leading-edge topics of expanding practice. The authors do a masterful job of blending relational aspects of practice (e.g., power, trust, cultural and contextual differences, self-care, and boundaries) with areas of continuing competency development (e.g., practice in electronic services, evolving skills in assessment and evaluation, and procedures for responding to complaints). The result is a powerhouse of resources and tools for practice today and into the future."

—Linda Campbell, professor, counseling and
human development, University of Georgia

"This unique volume provides invaluable ethical guidance for psychologists engaged in professional practice. The scenarios and accompanying questions added to most chapters will prove especially helpful to those who offer courses and workshops concerned with ethics in psychology."

—Charles D. Spielberger, former president,
American Psychological Association

"A wise and useful book that should be in every practitioner's library and be required in all clinical and counseling training programs."

—David Mills, former director, APA Ethics Office

"An excellent analysis of the meaning of ethics in the everyday life of practicing therapists."

—Patricia Keith-Spiegel, former chair, APA Ethics Committee

"An outstanding book. The chapter on testing, assessment, and diagnosis is heartening; it identifies the ethical responsibilities as well as dilemmas and pitfalls we face as practitioners."

—Philip Erdberg, former president,
Society for Personality Assessment

"A comprehensive and practical guide for practitioners who strive to have an ethical, competent, and caring practice, this book is a practical resource for those who aspire to be excellent psychotherapists and counselors. Useful and relevant, it will not gather dust."

—Jessica Henderson Daniels, Children's
Hospital, Boston; APA Board of Directors

"Pope and Vasquez's expansion of this enormously useful ethics book is a resounding success. A practical, engaging, empowering guide to ethical practice."

—Laura Brown, psychologist in independent practice, Seattle

"This is an excellent, well-written blend of scholarship, common sense, and wise counsel that is easy to read and full of practical illustrations likely to benefit both the novice and experienced psychotherapist."

—Gerald Koocher, dean, School for Health Studies at Simmons College;
2006 president, American Psychological Association

"A necessary book for those who want to take their risk management strategies to the next level."

—Eric Harris, risk management consultant, American
Psychological Association Insurance Trust

"Useful to every psychologist. I expect it will land on everyone's bookshelf as a well-thumbed source of important information on such topics as working with suicidal clients. We will use it in training at our Center."

—Norman Farberow, cofounder and codirector,
Los Angeles Suicide Prevention Center

"At last the working clinician has concrete, down-to-earth help to resolve issues of ethics and professional responsibility that one confronts daily. This book is a must for faculty . . . should be required for all clinicians in training.

—Jerome Singer, professor emeritus, psychology, Yale University

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JOSSEY-BASS

Kenneth S. Pope

Melba J. T. Vasquez

Ethics in Psychotherapy and Counseling

A Practical Guide

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BICENTENNIAL
1807
WILEY
2007

John Wiley & Sons, Inc.

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Published by Jossey-Bass
A Wiley Imprint
989 Market Street, San Francisco, CA 94103-1741 www.josseybass.com

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Page 459 constitutes a continuation of the copyright page.

Library of Congress Cataloging-in-Publication Data

Pope, Kenneth S.
Ethics in psychotherapy and counseling : a practical guide / Kenneth S. Pope, Melba J.T. Vasquez. — 3rd ed.
p. cm.
Includes bibliographical references and index.
ISBN-13: 978-0-7879-9400-6 (pbk.)
1. Counseling psychologists—Professional ethics. 2. Psychotherapists—Professional ethics. 3. Counseling psychology—Moral and ethical aspects. 4. Psychotherapy—Moral and ethical aspects. 5. Counseling psychologist and client. I. Vasquez, Melba Jean Trinidad. II. Title.
BF636.67.P67 2007
174'.91583—dc22

2006036930

Printed in the United States of America
THIRD EDITION
PB Printing 10 9 8 7 6 5 4 3 2 1

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Preface

Welcome to those who are new to this book, and to those who have read the first or second edition, welcome back.

Significant changes in the ethics codes of both the American Psychological Association and the Canadian Psychological Association, new legislation and case law, new research findings, and new practice guidelines are among the developments that led to this third edition. Each of the chapters carried over from the second edition has been updated to reflect these recent developments; in addition, there are four new chapters and some new appendixes.

SEVEN BASIC ASSUMPTIONS

Although much of the material is new, this book's fundamental approach to ethics remains unchanged from the first edition. The approach is grounded in seven basic assumptions:

1. Ethical awareness is a continuous, active process. Fatigue, stress, and routine can dull our awareness, lull us into ethical sleep, put us on automatic when we need to wake up to what we are missing. It is crucial that we practice continued alertness to the ethical implications of what we do.
2. Awareness of the ethical standards and codes is crucial to competence in the area of ethics, but standards and codes cannot take the place of an active, deliberative, and creative approach to fulfilling our ethical responsibilities. They prompt, guide, and inform rather than preclude our ethical considerations. We cannot apply standards and codes in a rote, unthinking manner. Each new client, whatever his or her similarities to previous clients, is unique. (Note that the terms *client* and *patient* have different meanings and connotations for different people. In this book, we use the terms interchangeably to refer to anyone receiving clinical services.) Each situation is unique and

changes over time. Standards and codes may identify some approaches as clearly unethical. They may identify significant ethical values and concerns, but they cannot tell us what form these values and concerns will take. They may set forth essential tasks, but they cannot tell us the best way to accomplish those tasks with a unique client facing unique problems.

3. Awareness of the scientific and professional literature and evolving research and theory is crucial to competence in the area of ethics, but the claims and conclusions emerging in the literature can never be passively accepted and reflexively applied. A necessary response to published claims and conclusions is active, careful, informed, persistent, and comprehensive questioning.

4. We believe that the overwhelming majority of therapists and counselors are conscientious, dedicated, caring individuals, committed to ethical behavior. But none of us is infallible. Whatever our experience, accomplishments, or wisdom, all of us can—and do—make mistakes, overlook something important, reach conclusions that are wrong. An important part of our work is questioning ourselves, asking, "What if I'm wrong about this? Is there something I'm overlooking? Could there be another way of understanding this situation? Could there be a more creative, more effective, better way of responding?"

5. Many of us find it easier to question the ethics of others than to question what we ourselves do. It may be a red flag worth paying attention to if we find ourselves preoccupied—to the exclusion of questioning our own beliefs and behaviors—with how wrong others are in some area of ethics and certain that we are the one to set them right, or at least to point out repeatedly how wrong they are.

6. Many of us find it easier to question ourselves in areas where we are uncertain. It tends to be much harder, but often much more productive, to question ourselves about what we are most sure of, what seems beyond doubt or question. Nothing can be placed off-limits for this questioning. We must follow this questioning wherever it leads us, even if we venture into territories that some might view as "politically incorrect" or "psychologically incorrect" (Pope, Sonne, & Greene, 2006).

7. Clinicians repeatedly encounter ethical dilemmas for which a clear ethical response is elusive. The therapist confronts needs that do not match resources; values and responsibilities that clash; situations whose meaning varies according to perspective and context; limits to our scientific understanding of conditions or interventions; our own

feelings or other reactions that seem to block or sidetrack an effective response. There is no legitimate way to avoid these struggles. Clinicians must be prepared to actively examine these dilemmas as a normal and expected part of their work.

ACKNOWLEDGMENTS

We are deeply indebted to so many people who contributed, directly or indirectly, to this book. We are grateful to all but have space to mention only a few. We would never have obtained the multiyear actuarial data about malpractice suits, licensing board actions, and ethics complaints against psychologists in Canada and the United States without the generous help of the American Psychological Association (APA) Ethics Office staff, including Steve Behnke, executive director, APA Ethics Office; Stanley Jones, former executive director, APA Ethics Office; Debbie Felder, APA Ethics Code revision coordinator; Steve DeMers, executive director, Association of State and Provincial Psychology Boards; Bruce Bennett, CEO, APA Insurance Trust; John Service, executive director, Canadian Psychological Association (CPA); Daniel Berman, manager of communications, CPA; and Barry Gang, director of investigations and hearings, College of Psychologists of Ontario.

Ray Arsenault, Ursula Delworth, Kate Hays, Gerald Koocher, Lorelei Lawson, Karen Olio, and Janet Sonne are among those who read drafts of the current or previous editions and offered valuable suggestions for improvements.

We asked a number of prominent therapists with expertise in recognizing and responding to suicidal risk to discuss pitfalls of work in this area. Chapter Seventeen presents the advice that each of these experts gives to readers. We thank those who contributed discussions: David Barlow, Marla Craig, Jessica Henderson Daniel, Norman Farberow, the late Erika Fromm, Jesse Geller, Don Hiroto, Larke Nahme Huang, Nadine Kaslow, the late Helen Block Lewis, Marsha Linehan, Ricardo Muñoz, Michael Peck, David Rudd, Gary Schoener, and the late Hans Strupp.

We received exceptionally skillful and generous help from Rebecca McGovern and Xenia Lisanevich of Jossey-Bass Publishers in preparing the first edition; from Alan Rinzler, Katie Levine, Margaret Sebold, Joanne Clapp Fullagar, and Paula Goldstein of Jossey-Bass Publishers and Rachel Anderson of Satellite Publishing Services in preparing the

second edition; and from Alan Rinzler, Carol Hartland, Seth Schwartz, and Jennifer Wenzel of Jossey-Bass Publishers, along with Beverly Harrison Miller, in preparing this third edition.

We greatly appreciate the help that each of you provided to this project. Thank you *all.*

January 2007

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Ethics in Psychotherapy and Counseling

CHAPTER ONE

Helping Without Hurting

Personal Responsibility, Constant Questioning, and Basic Assumptions

Psychotherapy holds out the promise of help for people who are hurting and in need. It can change lives.

Clients can find their strengths. They can change course toward a more meaningful life. They can confront loss, tragedy, hopelessness, and the end of life in ways that do not leave them numb or paralyzed. They can discover what brings them joy and what sustains them in hard times. They can begin to trust, or to trust more wisely. They can learn new behaviors in therapy and how to teach themselves new behaviors after therapy ends. They can question what they always believed was unquestionable. They can find out what matters most to them and stop wasting time. They can become happier, or at least less miserable. They can become better able, as Freud noted, to love and to work.

Our ethics acknowledge our profession's responsibilities. We can often help, but if our ethics slip, we can needlessly hurt.

ETHICS AND PERSONAL RESPONSIBILITY

What we do can make a difference in whether a client loses hope and commits suicide or chooses to live, whether a battered spouse finds shelter or returns to someone who may kill, and whether an anorexic teenager gets help or starves to death. Even new therapists know that such dramatic examples tell only part of the story. So many people come to us facing what seem to be minor, hard-to-define problems, yet the hard, risky, unpredictable twists and turns of their therapy can lead to more meaningful, effective, fulfilling lives.

Few therapists take these responsibilities lightly. Few set aside their concern about a suicidal client between sessions. Few sit unmoved while a client talks, perhaps for the first time, about what it was like to survive an atrocity. Few turn away untroubled when a managed care company refuses to authorize treatment for someone in desperate need of help, someone who lacks enough money to put food on the table, let alone pay for therapy out of pocket.

The purpose of this book is to provide therapists with ideas, information, and resources that can help them think through these responsibilities and what they want to do about them.

Recognizing these responsibilities as they appear in our day-to-day work and deciding how to respond can be stressful and sometimes overwhelming. We may feel short of time, resources, or wisdom. The responsibilities can weigh us down, rattle us, make us want to run and hide. They can make us more vulnerable to other sources of stress.

Uncertainty causes stress for some of us. We cannot find that magical book that will tell us what to do, especially in a crisis. Research, guidelines, manuals, our own experience, and consultation help, but we cannot know the best course in all situations, or even how the "best" course will turn out. We are constantly thrown back on our own judgment. If we believe a client might kill someone but there is no explicit threat or other legal justification under the state's law to hospitalize the client or breach confidentiality, what do we do? Whether doubling the number of therapy sessions during a crisis would help or hurt (or even have no net effect) is a decision that must be made on the basis of professional judgment regarding the individual client. What diagnosis should we write down if we know that the insurance company will not cover treatment for the client's condition and believe that the client's need for treatment is urgent? Will using stress-reducing imagery techniques help a particular client (reducing stress and increasing the client's effectiveness) or cause harm (enabling the client to adapt to an abusive job or relationship) is a question without an instantly clear and infallible answer. Does informed consent make sense if all the process will accomplish is cause a patient to turn away from life-saving treatment? The inescapable responsibility of making careful, informed professional judgments regarding issues of enormous complexity and potentially life-and-death implications can push even the most resourceful therapists to their limits.

Fearing that formal review agencies will hold us accountable after the fact stresses and distresses some of us. Some agencies, such as local, state, and national professional ethics committees, focus specifically on the ethical aspects of our work. Others, such as state licensing boards and the civil courts, enforce professional standards of care that may reflect ethical responsibilities. The prospect of review agencies second-guessing us with the benefit of hindsight can make difficult judgments a nightmare for some therapists. They may suffer a debilitating performance anxiety, dread going to work, and discover that the focus of their work has changed from helping people to avoiding a malpractice suit.

Managed care has stressed some therapists. For example, capitation contracts provide a limited sum of money to cover all services for a group of patients. The agency providing services, having estimated the average number of sessions needed for each patient, must limit the total number of sessions to make a profit. Strict guidelines may limit how many sessions a therapist can provide. Therapists may feel pressure to terminate before the limit. Even if clinicians follow the agency's formal procedures, they may face charges before an ethics committee, licensing board, or malpractice court for patient abandonment, improper denial of treatment, or similar issues. Therapists may fear not only that a formal review agency will sanction them but also that the limited sessions fall far short of what their clients need. One national study found that 86 percent of the participating therapists had experienced fear that a client may need clinical resources that are unavailable (Pope & Tabachnick, 1993).

Teaching or learning therapy can stress some of us. As supervisors, we may grow uncomfortable with how the supervisee responds to the client differently from how we would, with our responsibility to evaluate the supervisee's work, and with the demands of our role as teacher and mentor. As supervisees, we may doubt our ability to carry out clinical responsibilities (especially when they involve suicidal or homicidal risks), dread making mistakes, feel uneasy about differences in values or theoretical orientation between ourselves and our supervisor, and figure that if we are completely honest in describing to our supervisor what we actually thought, felt, and did with our clients, we might be advised to look for another line of work (see Pope, Sonne, & Greene, 2006).

SEVEN SCENARIOS

We created the following seven fictional scenarios for ethics and malpractice workshops. None of the hypothetical vignettes, which follow, is based on an actual or specific case (and none of the individuals is based on an actual clinician or patient), but all the scenarios represent the kinds of challenges that therapists and counselors face. In these scenarios, the clinicians were attempting to do their best. Readers may disagree over whether each clinician met the highest or even minimal ethical standards, and such disagreements can form the focus of classroom, case conference, supervision, or related discussions. In at least one or two instances, you may conclude that what the clinician did was perfectly reasonable and perhaps even showed courage and sensitivity. In some cases, you may feel that significant relevant information is missing. But in each instance, the professional's actions (or failures to act) became the basis of one or more formal complaints.

Computer Coincidences

What happened to these therapists was so traumatic that even though they are fictional characters and never existed, they have fled into other lines of work, do not want to be recognized, and demand anonymity in this hypothetical scenario. The catastrophes seemed to start when one of them hit the Send button on his computer.

For many years these therapists had maintained a small and very successful group practice. Then they modernized, bringing in state-of-the-art computers, elegantly networked and equipped with wonderful software that made the therapists' work much easier—until one day the first therapist hit the Send button.

The therapist had carefully collected all the electronic records of one of his patients, who was involved in litigation, to e-mail to the patient's attorney. There were the billing records, results of psychological testing, records of therapy sessions, as well as the background records (employment, disability, and others) that the therapist had on file. The therapist gave one last look and then hit the Send button.

It was only after watching his computer send off the records that he realized he had used the wrong address on the e-mail. The patient records were on their way not to the patient's attorney, but to a large Internet discussion list that the therapist belonged to. This unfortunate series of events led to a formal complaint against the therapist.

By a farfetched coincidence typical of hypothetical scenarios, the second therapist walked into the first therapist's office just when the first therapist was hitting the Send button. Here is what the second therapist said: "Can you believe it!? I'm being sued, and it's all because of my computer! When my patient temporarily moved to the East Coast for a sabbatical, we thought it best to continue treatment, but because of the time difference and our heavy schedules, we couldn't find a time when we could both talk, so we decided to communicate by e-mail. But then she got mad at me about something and filed complaints against me *in the other state!* So now they're saying I was providing psychological services in that state without being licensed there and that I failed to follow that state's rules and regulations about . . . well, you'd have to read the complaints her attorney has filed with the licensing board, the courts, and the ethics committee. It's terrible!"

As if sensing that another wild coincidence was needed to keep the story moving, the third therapist rushed into the first therapist's office at that moment and cried , "You won't believe what just happened! I just got a formal notice that I'm being sued! I just found out what happened: somehow a virus or Trojan or Worm or one of those things got into my computer and took my files—you know, all my confidential case files—and sent them to everyone listed in my address book and to all the other addresses in my computer's memory. What do I do now?"

On cue, the fourth therapist ran into the room and wailed, "Help! I'm in such trouble! One of my patients is involved in a nasty lawsuit, and I received a court order to produce all my records. The patient had given me consent to turn them over because she and her attorney believe they will be the key to their winning the case. So I sat down to print them out and . . . they're gone! My hard drive crashed, and when I hired a company to rescue what they could, they retrieved some of the files. but all the files for that patient are gone. What do I do now?"

Although the room was getting crowded, the fifth therapist slouched in, collapsed in a chair, and announced, "I'm doomed. I kept all my records on my laptop. But while I was at lunch today, someone broke into my car and stole my laptop. Then I got worse news. I thought at least the files would be safe because I encrypted them, but I just found out from a colleague that since the program I used to encrypt and unencrypt them is on that computer and since many thieves have software that enables them to get past passwords and gain use of the encryption program, it would be pretty easy for a hacker to unencrypt my files."

When the final member of their group practice failed to show up with bad news, they grew concerned and went down the hall to her office. She was sitting at her desk with a big smile on her face. She chirped, "I can't tell you how good I feel! I've been so concerned about keeping records on my computer that I finally decided it just wasn't worth the worry. I printed out all my records, made extra copies that I put in my safe deposit box, and got rid of my computer. It was such a good move for me. I haven't felt this good in days."

It was only months later that she discovered, as she read the complaint filed against her, that she had done a poor job of trying to erase her hard drive before selling her computer. The person who had bought it had little trouble retrieving the supposedly erased files and reading all the details about her patients.

Life in Chaos

Mr. Alvarez, a thirty-five-year-old professor of physics, has never before sought psychotherapy. He shows up for his first appointment with Dr. Brinks. Mr. Alvarez says that his life is in chaos. He was granted full professor status about a year ago, and about a month after that, his wife suddenly left him to live with another man. He became very depressed. About four months ago, he began to feel anxious and have trouble concentrating. He feels he needs someone to talk to so that he can figure out what happened. Mr. Alvarez and Dr. Brinks agree to meet twice a week for outpatient psychotherapy.

During the first few sessions, Mr. Alvarez says that he feels relieved that he can talk about his problems, but he remains anxious. During the next few months, he begins talking about some traumatic experiences in his early childhood. He reports that he is having even more trouble concentrating. Dr. Brinks assures him that this is not surprising; problems concentrating often become temporarily worse when a patient starts becoming aware of painful memories that had been repressed. She suggests that they begin meeting three times a week, and Mr. Alvarez agrees.

One month later, Mr. Alvarez collapses and is rushed to the hospital, where he is pronounced dead on arrival. An autopsy reveals that a small but growing tumor had been pressing against a blood vessel in his brain. When the vessel burst, he died.

Months after Mr. Alvarez's death, Dr. Brinks is served notice that the state ethics committee is opening a formal case against her based on a complaint filed by Mr. Alvarez's relatives. Furthermore, she is being sued for malpractice. The ethics complaint and the malpractice suit allege that she was negligent in diagnosing Mr. Alvarez in that she had failed to take any step to rule out organic causes for Mr. Alvarez's concentration difficulties, had not applied any of the principles and procedures of the profession of psychology to identify organic impairment, and had not referred Mr. Alvarez for evaluation by a neuropsychologist or to a physician for a medical examination.

Psychotherapists and counselors in ethics and malpractice workshops (who would probably not constitute a random sample of practicing psychologists) who have reviewed this scenario have tended to conclude that Dr. Brinks may have been functioning beyond the range of her competence and violated some of the fundamental standards of assessment (see Chapter Twelve).

Evaluating Children

Ms. Cain brings her two children, ages four and six, to Dr. Durrenberger for a psychological evaluation. She reports that they have become somewhat upset during the past few months. They are having nightmares and frequently wet their beds. She suspects that the problem may have something to do with their last visit with their father, who lives in another state.

Dr. Durrenberger schedules three sessions in which he sees Ms. Cain and her two children together and three individual sessions with each of the children. As he is preparing his report, he receives a subpoena to testify in a civil suit that Ms. Cain is filing against her ex-husband. She is suing for custody of her children. During the trial, Dr. Durrenberger testifies that the children seem, on the basis of interviews and psychological tests, to have a stronger, more positive relationship with their mother. He gives his professional opinion that the children would be better off with their mother and that she should be given custody.

Mr. Cain files an ethics complaint, a civil suit, and a licensing complaint against Dr. Durrenberger. One basis of his complaint is that Dr. Durrenberger had not obtained informed consent to conduct the assessments. When Mr. and Ms. Cain had divorced two years previously, the court had granted Mr. Cain legal custody of the children but had granted Ms. Cain visitation rights. (Ms. Cain had arranged for the assessments of the children during a long summer visit.) Another basis of the complaint was that Dr. Durrenberger had made a formal recommendation regarding custody placement without making any attempt to interview or evaluate Mr. Cain. Mr. Cain's attorney and expert witnesses maintained that no custody recommendation could be made without interviewing both parents.

Although laws regarding rights of custodial and noncustodial parents differ from state to state and province to province, participants in ethics and malpractice workshops tend to conclude that Dr. Durrenberger had not fulfilled his ethical (and, in many states, legal) responsibility to obtain adequate informed consent from the relevant parent (see Chapter Eleven) and that he had failed to conduct an adequate assessment to justify his conclusion (see Chapter Twelve).

The Fatal Disease

When George, a nineteen-year-old college student, began psychotherapy with Dr. Hightower, he told the doctor that he was suffering from a fatal disease. Two months into therapy, George felt that he trusted his therapist enough to tell her that the disease was AIDS.

During the next eighteen months, much of the therapy focused on George's losing battle with his illness and his preparations to die. After two stays in the hospital for pneumonia, George informed Dr. Hightower that he knew he would not survive his next hospitalization. He had done independent research and talked with his physicians, and he was certain that if pneumonia developed again, it would be fatal due to numerous complications and that it would likely be a long and painful death. George said that when that time came, he wanted to die in the off-campus apartment he had lived in since he came to college—not in the hospital. He would, when he felt himself getting sicker, take some illicitly obtained drugs that would ease him into death. Dr. Hightower tried to dissuade him from this plan, but George refused to discuss it and said that if Dr. Hightower continued to bring up the subject, he would quit therapy. Convinced that George would quit therapy rather than discuss his plan, Dr. Hightower decided that the best course of action was to offer caring and support—rather than confrontation and argument—to a patient who seemed to have only a few months to live.

Four months later, Dr. Hightower was notified that George had taken his life. Within the next month, Dr. Hightower became the defendant in two civil suits. One suit, filed by George's family, alleged that Dr. Hightower, aware that George was intending to take his own life, did not take reasonable and adequate steps to prevent the suicide, she had not notified any third parties of the suicide plan, had not required George to get rid of the illicit drugs, and had not used hospitalization to prevent the suicide. The other suit was filed by a college student who had been George's lover. The student alleged that Dr. Hightower, knowing that George had a lover and that he had a fatal sexually transmitted disease, had a duty to protect the lover. The lover alleged ignorance that George had been suffering from AIDS.

This scenario has been one of the most agonizing and controversial for the psychotherapists and counselors who consider it at ethics and malpractice workshops. Some believe that Dr. Hightower acted in the most humane, sensitive, and ethical manner; others believe that she was wrong to accept, without more vigorous challenge, George's decision to take his own life. In this sense, it illustrates the dilemmas we face when confronted with a suicidal individual (see Chapter Seventeen). It also illustrates how such issues as confidentiality (see Chapter Sixteen) have been challenged when a specific third party or the public more generally is perceived to be put at risk by a client.

Many would argue that the main goal of therapy when suicide is an issue is to defuse the potentially lethal situation. According to this stance, we have a professional duty to take appropriate affirmative measures to prevent patients from harming themselves, a duty that may include in extreme cases seeking a civil commitment of the patient. However, there has been increasing attention to an alternate view in which the clinician may respect and accept the client's autonomy to such a degree that the client's decision to commit suicide is respected and accepted. Some would accord this "right to die" to any client; others would recognize it only in certain extreme situations (for example, if the client is suffering from a painful and terminal disease). Some would draw the line at accepting a client's decision to commit suicide and taking no steps to interfere with the client's self-destructive acts; others would consider actively assisting the person to die. These agonizing, controversial issues have become especially difficult for some who provide mental health services to those with AIDS (see Pope & Morin, 1990), as in this vignette. As is so often the case, the ethical and clinical issues are interwoven with legal standards. Some states have considered and continue to consider legislation related to the issue of assisted suicide, and the topic continues to be complex and controversial (Carter, VandeKieft, & Barren, 2005; Downie, 2004; Ganzini, 2006; Gostin, 2006; Hamilton & Hamilton, 2005; Herlihy & Watson, 2004; Kleespies, 2004; Okie, 2005; Radtke, 2005; Rosenfeld, 2004; Werth & Blevins, 2006).

The Mechanic

Ms. Huang, whose family had moved from mainland China to the United States fifteen years ago, is a forty-five-year-old automobile mechanic. She agreed, at the strong urging of her employer, to seek psychotherapy for difficulties that seem to affect her work. She has been showing up late at her job, has often phoned in sick, and frequently appears distracted. She complains to her new therapist, Dr. Jackson, of the difficulties of coping with both psychomotor epilepsy, which has been controlled through medication, and her progressive diabetes, for which she is also receiving medical care.

Although she has no real experience treating those from the Chinese culture or those with chronic medical conditions such as epilepsy, Dr. Jackson begins to work with Ms. Huang. She meets with her on a regular basis for three months but never feels that a solid working alliance is developing. After three months, Ms. Huang abruptly quits therapy. At the time, she has not paid for the past six sessions.

Two weeks later, Dr. Jackson receives a request to send Ms. Huang's treatment records to her new therapist. Dr. Jackson notifies Ms. Huang that she will not forward the records until the bill has been paid in full.

Some time later, Dr. Jackson is notified that she is the complainee in an ethics case opened by the Ethics Committee of the American Psychological Association (APA) and that she has been sued for malpractice. The complaints allege that Dr. Jackson had been practicing outside her areas of competence because she had received no formal education or training and had no supervised experience in treating people from the Chinese culture or those with multiple serious and chronic medical diseases. The complaints also alleged that Ms. Huang had never adequately understood the nature of treatment, as evidenced by the lack of any written informed consent. Finally, the complaints alleged that "holding records hostage" for payment violated Ms. Huang's welfare and deprived her subsequent therapist of having prompt and comprehensive information necessary to Ms. Huang's treatment.

Participants in ethics and malpractice workshops, asked to assume the role of an ethics committee to review this scenario, tend to conclude that Dr. Jackson was acting without adequate competence to treat someone from a different culture (see Chapter Fifteen) or with a chronic medical condition, had not obtained adequate consent (see Chapter Eleven), and had misused the power of her role as therapist in refusing to disclose records because of an unpaid bill.

The Internship

Dr. Larson is executive director and clinical chief of staff at the Golden Internship Health Maintenance Organization. For one year, he closely supervises an excellent postdoctoral intern, Dr. Marshall. The supervisee shows great potential, working with a range of patients who respond positively to her interventions. After completing her internship and becoming licensed, Dr. Marshall goes into business for herself, opening an office several blocks from Golden Internship Health Maintenance Organization. Before terminating her work at the HMO, Dr. Larson tells Dr. Marshall that she must transfer all patients to other center therapists. All of the patients who can afford her fee schedule, however, decide to continue in therapy with her at her new office. The patients who cannot afford Dr. Marshall's fee schedule are assigned to new therapists at the center. Dr. Larson hires an attorney to take legal action against Dr. Marshall, asserting that she unethically exploited the HMO by stealing patients and engaging in deceptive practices. He files formal complaints against her with both the state licensing board and the APA Ethics Committee, charging that she had refused to follow his supervision in regard to the patients and pointed out that he, as the clinical supervisor of this trainee, had been both clinically and legally responsible for the patients. He refuses to turn over the patients' charts to Dr. Marshall or to certify to various associations to which she has applied for membership that she has successfully completed her internship.

Dr. Marshall countersues, claiming that Dr. Larson is engaging in illegal restraint of trade and not acting in the patients' best interests. The patients, she asserts, have formed an intense transference and an effective working alliance with her; to lose their therapist would be clinically damaging and not in their best interests. She files formal complaints against Dr. Larson with the licensing board and the APA Ethics Committee, charging that his refusal to deliver copies of the patients' charts and to certify that she completed the internship violates ethical and professional standards.

Some of the patients sue the HMO, Dr. Larson, and Dr. Marshall, charging that the conflict and the legal actions (in which their cases are put at issue without their consent) have been damaging to their therapy.

Workshop participants have tended to conclude that both Dr. Larson and Dr. Marshall have behaved unethically in terms of misusing their power (see Chapter Three), failing to clarify in advance the conclusion of Dr. Marshall's work with the patients (see Chapter Ten), and neglecting to address these issues adequately in the supervisory contract (see Chapter Eighteen).

Staying Sober

In therapy for one year with Dr. Franks, Mr. Edwards is an alcoholic and drank heavily for four years prior to the therapy. Dr. Franks uses a psychodynamic approach and incorporates behavioral techniques specifically designed to address the drinking problem.

Two months into therapy, when it became apparent that outpatient psychotherapy alone was not effective, Mr. Edwards agreed to attend Alcoholics Anonymous (AA) meetings as an adjunct to his therapy. During the past nine months of therapy, Mr. Edwards had generally been sober, suffering only two relapses, each time falling off the wagon for a long weekend.

Now, a year into therapy, Mr. Edwards suffers a third relapse. He comes to the session having just had several drinks. During the session, Dr. Franks and Mr. Edwards conclude that some of the troubling material that has been emerging in the therapy had led Mr. Edwards to begin drinking again. At the end of the session, Mr. Edwards feels that he has gained some additional insight into why he drank. He decides to go straight from the session to an AA meeting.

One month later, Dr. Franks is notified that he is being sued. On his way from the therapy session to the AA meeting, Mr. Edwards had run a red light and had killed a mother and her child who were crossing the street. The suit alleged that the therapist knew or should have known his patient to be dangerous and should have taken steps to prevent him from driving until his alcoholism no longer constituted a danger to the public.

Although workshop participants tend to fault Dr. Franks for not adequately assessing his client's condition and the danger that the client's driving in that condition would constitute for the public, there was a common empathic response, as with many of the other scenarios. Clinicians tended to identify with the fictional Dr. Franks and thought, "There, but for the grace of God, go I." Struck by the enormous complexity and responsibilities the clinicians face in these scenarios, we wonder if we would do any better were we in their places and if we are doing any better in our own practices (our failures of responsibility perhaps being in different areas though just as serious).

The Realities of Our Practice

Each scenario tends to bring home the reality that formal mechanisms of accountability act to protect clients from unethical and potentially harmful practices, but may also increase the stress that we feel at the possibility that one day we may be the subject of a formal complaint.

Yet another source of stress for some of us is the sense that in some areas at least, the responsibilities to which we are held accountable do not seem matched by our abilities and resources. For example, society (through the courts) may hold us accountable for predicting and preventing homicide. But accurately predicting whether someone will or will not kill seems to be beyond the capacity of mental health professionals or anyone else, for that matter (see Chapter Twelve).

In the midst of all this responsibility, complexity, uncertainty, and stress, remaining alert to the ethical aspects of our work in a consistent and meaningful manner can seem overwhelming.

ETHICS AND DENIAL

If the stress overwhelms us, all of us are vulnerable to denial and other ways of dismissing, distorting, or discounting ethical questions. We all have our favored ways of making uncomfortable ethical challenges disappear, perhaps by transforming them almost magically into something else, perhaps by attacking the client or colleague who raises the ethical question, perhaps by viewing ourselves as helpless, as compelled by necessity to act in a way that we suspect may be unethical. Take a few minutes to conduct a private self-assessment of the degree to which these forms of ethical denial may have infiltrated your own practice as a therapist, counselor, supervisor, or trainee.

For the therapist, counselor, supervisor, or trainee, professional ethics represent three basic tasks (discussed more fully in Chapter

Three). First, professional ethics involve acknowledging the reality and importance of the individuals whose lives we affect. Second, they involve understanding the nature of the professional relationship and professional interventions. Third, they involve affirming accountability for our behavior. A moment of active and honest self-assessment can give us at least a general sense of how well we are accomplishing these tasks.

Are the people whom we serve real to us? To what extent do we misuse valid diagnostic and classification systems in a way that diminishes clients? Do we think of three clients we are working with not so much as people but as the two schizophrenics and the one borderline? To what extent do we view them as somehow inferior because they are clients? If we are in independent practice, have we begun thinking of our clients less as individuals to be helped than as sources of payment for office overhead? Do we treat our clients any differently than we would like to be treated if we were in their place?

To what extent do we maintain an adequate awareness of the nature and implications of the professional relationship and of our professional interventions? Have we become insensitive to the trust with which so many of our clients invest their relationship to us, of the degree to which they count on us for hope and help? Have we begun to tangle professional boundaries so that certain clients are confused about whether they are our clients, business partners, friends, creditors (from whom we get low-interest loans), dates, or lovers?

To what extent do we hold ourselves accountable not only for what we do but also for what we fail to do as professionals? Do we tend to push responsibility onto our employer, the community, the legal system? Do we blame others for keeping us from doing what we believe is right? Do we find ourselves saying nothing when we see something that is wrong because we are afraid to speak up?

BASIC ASSUMPTIONS

Our shared vulnerability to stress, denial, and human imperfection can make recognizing and meeting our ethical responsibilities hard, and yet we cannot spare ourselves from constant ethical challenges, from responsibility for how our choices help or hurt.

This book does not try to provide an encyclopedic approach to ethical aspects of every topic related to psychotherapy and counseling and does not provide “right answers” to use when approaching ethical questions in various areas. Rather, it presents an approach to ethics in the early chapters and focuses in the later chapters on a few of the major areas of practice such as assessment, working with suicidal clients, and supervision.

Seven basic assumptions inform the approach presented in this book:

1. Ethical awareness is a continuous, active process that involves constant questioning. Fatigue, habits, stress, dogma, and routine can erode our personal responsiveness and our sense of personal responsibility. They can lull us into ethical sleep, putting us on automatic when we need to wake up to what we are missing. It is crucial to practice continued alertness to the ethical implications of what we do.
2. Awareness of the ethical standards and codes is crucial to competence in the area of ethics, but standards and codes cannot take the place of an active, deliberative, and creative approach to fulfilling our ethical responsibilities. They prompt, guide, and inform rather than preclude our ethical considerations. We cannot apply standards and codes in a rote, unthinking manner. Each new client, whatever his or her similarities to previous clients, is unique. Each situation is unique and changes over time. Standards and codes may identify some approaches as clearly unethical. They may identify significant ethical values and concerns, but they cannot tell us what form these values and concerns will take. They may set forth essential tasks, but they cannot tell us the best way to accomplish those tasks with a unique client facing unique problems.
3. Awareness of the scientific and professional literature, the evolving research, and theory is crucial to competence in the area of ethics, but the claims and conclusions emerging in the literature can never be passively accepted and reflexively applied. A necessary response to published claims and conclusions is active, careful, informed, persistent, and comprehensive questioning.
4. We believe that the overwhelming majority of therapists and counselors are conscientious, dedicated, caring individuals who are committed to ethical behavior. But none of us is infallible. Whatever our experience, accomplishments, or wisdom, all of us can—and do—make mistakes, overlook something important, and reach conclusions that are wrong. An important part of our work is questioning ourselves, asking, "What if I'm wrong about this? Is there something I'm overlooking? Could there be another way of understanding this situ-

ation? Could there be a more creative, more effective, better way of responding?"

5. Many of us find it easier to question the ethics of others than to question what we ourselves do. It may be a red flag worth paying attention to if we find ourselves preoccupied, to the exclusion of questioning our own beliefs and behaviors, with how wrong others are in some area of ethics and certain that we are the one to set them right, or at least to point out repeatedly how wrong they are. It is important to question ourselves—our own ethical values, beliefs, and behavior—as much as we question others.

6. Many of us find it easier to question ourselves in areas where we are uncertain. It tends to be much harder, but often much more productive, to question ourselves about what we are most sure of, what seems beyond doubt or question. Nothing can be placed off-limits for this questioning. We must follow this questioning wherever it leads us, even if we venture into territories that some might view as politically incorrect or—much more difficult for most of us—"psychologically incorrect" (Pope et al., 2006).

7. Clinicians repeatedly encounter ethical dilemmas for which a clear ethical response is elusive. The therapist confronts needs that do not match resources; values and responsibilities that clash; situations whose meaning varies according to perspective and context; limits to our scientific understanding of conditions or interventions; our own feelings; or other reactions that seem to block or sidetrack an effective response. There is no legitimate way to avoid these struggles. Clinicians must be prepared to actively examine these dilemmas as a normal and expected part of our work. Chapters Ten through Eighteen end with a set of scenarios, each with a series of questions for readers to consider, to encourage an active approach to such dilemmas.

Because this book's approach emphasizes personal responsibility and the need to think clearly about the responsibilities emerging from each new situation, Chapter Two focuses on critical thinking.

CHAPTER TWO

Ethics and Critical Thinking

Who claims to have perfect ethical judgment and reasoning? Most of us admit the obvious: we all have weaknesses that we can strengthen. One good place to start is how we think about ethics.

The more we notice *how* we think about ethics, the more we can think critically about our own ethical judgment, reasoning, language, and justifications. When we learn to recognize major patterns and pitfalls in these areas, we can improve our approaches and avoid pitfalls (or at least recognize when we fall into pits).

This chapter looks at common problems in judgment, reasoning, language, and justifications.

JUDGMENT

Ethics requires judgment. Ethical issues as they occur in real life are rarely simple, obvious, and easy. As we emphasize throughout this book, both patient and therapist are unique, their relationship complex, and the situations they face rarely static. Subtle ethical issues may sneak by unnoticed. Ethical crises may appear with a clash of competing needs, expectations, and values. Time and resources are often scarce. No one can effectively apply the principles in the ethics code or other sources of guidance to real-life situations in an automatic, unthinking, or rote manner. There is no paint-by-numbers approach that works.

This section explores three factors that influence our ethical judgment: cognitive commitments, authorities, and groups.

Cognitive Commitments

If we commit to an approach, theory, or idea, our commitment influences our judgment. Francis Bacon described this process in 1620:

> The human understanding when it has once adopted an opinion . . . draws all things else to support and agree with it. And though there be a greater number and weight of instances to be found on the other side, yet these it either neglects or despises, or else by some distinction sets aside and rejects. . . . This mischief insinuate[s] itself into philosophy and the sciences; in which the first conclusion colors and brings into conformity with itself all that come after [1955, p. 472].

Evans (1989) noted that "confirmation bias is perhaps the best known and most widely accepted notion of inferential error." The notion "is that human beings have a fundamental tendency to seek information consistent with their current beliefs, theories or hypotheses and to avoid the collection of potentially falsifying evidence" (Evans, 1989, p. 41).

Cognitive and social psychology have explored the different forms that this influence can take. Kurt Lewin (1976; see also Gold, 1999) examined how committing to a decision often seemed to freeze the mind, hardening it against reconsideration. Ellen Langer (1989), summarizing the research she and her colleagues had conducted (for example, Chanowitz & Langer, 1981), described the common process of "forming a mindset when we first encounter something and then clinging to it when we reencounter that same thing. Because such mindsets form before we do much reflection, we call them premature cognitive commitments. . . . The mindless individual is committed to one predetermined use of the information, and other possible uses are not explored" (p. 22).

Leon Festinger's experiments focused on how commitment to an approach, theory, or idea led to a screening out of any information that would lead to cognitive dissonance. The commitment meant that there would be "less emphasis on objectivity and there is more partiality and bias in the way in which the person views and evaluates the alternatives" (1964, p. 155).

In the light of our shared vulnerability to this bias, it is useful, if not essential, to question our own views, whether snap judgments or long-held beliefs. We can balance our loyalty to our judgments if we search relentlessly for facts that do not fit, listen openly to those who disagree, and constantly ask ourselves what the other possibilities are. Otherwise we may end up holding so tightly to our ethical certainties that we miss discoveries and opportunities. We spend our energy trying to convince others (and ourselves) that we are right and others are wrong.

Authorities

When puzzling over an ethical dilemma, we often turn to authorities. The law, a supervisor, the ethics code—all can provide invaluable help. We misuse these resources, however, if we allow them to short-circuit our ethical judgment. We cannot avoid an ethical struggle by focusing only on the law and claiming, "It violates no law [or the law requires it] so it must be ethical." We cannot shrug off ethical responsibility by explaining that we were just following a supervisor's orders.

Even the ethics code gives no refuge from the search for the most ethical response. Awareness of ethics codes is crucial to competence in the area of ethics, but the formal standards are not a substitute for an active, deliberative, and creative approach to fulfilling our ethical responsibilities. They prompt, guide, and inform our ethical consideration; they do not preclude or serve as a substitute for it. There is no way that the codes and principles can be effectively followed or applied in a rote, thoughtless manner. Each new client, whatever his or her similarities to previous clients, is a unique individual. Each situation also is unique and is likely to change significantly over time. The explicit codes and principles may prohibit some acts as clearly unethical. They may call our attention to ethical concerns in different areas of practice, but they cannot tell us how these concerns will manifest themselves in a particular clinical situation. They may set forth essential tasks that we must fulfill, but they cannot tell us how we can accomplish these tasks with a unique client facing unique problems. We cannot hide from these struggles.

Groups

Like authorities, groups are a wonderful resource. They can provide support, diverse views, the opportunity to work together on an ethical dilemma, and relief from the sense of isolation. But—also like authorities—certain group processes can work to block sound ethical judgment. We get ourselves into trouble when we allow groups to shield us from ethical struggles and the sense of ethical responsibility.

In a fascinating essay we recommend to all of this book's readers, psychologist Paul Meehl (1977) described "Why I Do Not Attend Case Conferences." He pointed out the "groupthink process" (p. 228), which discourages sound judgment and may be familiar to all of us: "In one respect the clinical case conference is no different from other academic group phenomena such as committee meetings, in that many intelligent, educated, sane, rational persons seem to undergo a kind of intellectual deterioration when they gather around a table in one room" (p. 227).

Psychologist Irving Janis (1972) studied ways in which groupthink clouds our judgment. Janis and Mann (1977, pp. 130–131) identified the eight symptoms of groupthink, adapted below, to emphasize their effects on ethical judgment:

1. An illusion of invulnerability, shared by most or all members, which creates excessive optimism and encourages taking extreme risks
2. Collective efforts to rationalize in order to discount warnings
3. An unquestioned belief in the group's inherent high ethics, leading members to underestimate their ethical responsibilities or the negative consequences of their behavior
4. Stereotyped views of those who disagree about ethical issues, encouraging group members to disparage the motives, intelligence, heart, or good faith of those who disagree with the group's views
5. Pressure on any group member who dissents or raises serious questions about the group's views or behavior
6. Self-stifling of deviations from the group's approach; an inclination of each member to deny, discount, or minimize doubts or counterarguments

7. The illusion of virtual unanimity, created by self-stifling and assuming that silence means consent
8. Some members taking on the role of "mindguard—members who protect the group from adverse information that might shatter their shared complacency about the effectiveness and morality of their decisions" (p. 131)

Making Better Ethical Judgments

We can make better ethical judgments if we remain aware of how cognitive commitments, authorities, and groups can serve us well—but also sweep us off course. Errors in ethical reasoning, the focus of the next section, can also send us in the wrong direction.

LOGICAL FALLACIES IN ETHICAL REASONING[1]

Logical fallacies show up in camouflage. They hide in the background and blend in with some of our best reasoning. We rarely notice their misdirection. We often miss how they convince us in our ethical reasoning that 2 plus 2 equals somewhere in the neighborhood of 17.

Here are nineteen logical fallacies, with a brief description and example of each, that can send ethical reasoning off track. No one is magically immune to them. They trip up all of us at one time or another.

Affirming the Consequent

This fallacy takes the form of:

If x, then y.

y.

Therefore: x.

Example: "When I'm considering doing something and it's unethical, I feel uneasy about doing it. When I think about hugging a client, it makes me uneasy. So it must be unethical."

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[1] This section is adapted from "Fallacies and Pitfalls in Psychological Assessment." Copyright © 2003 by K. S. Pope, available at http://kspope.com.

Disjunctive Fallacy

This fallacy takes the form of:

Either x or y.
x.
Therefore: not y.

Example: "I feel deep down that what I'm about to do is unethical. I must feel that way either because it really is unethical or because I'm always second-guessing myself and beating myself up over nothing. Last week my therapist and I agreed that I keep second-guessing myself and beating myself up over nothing. So what I'm about to do must be ethical."

Ad Hominem

The argumentum ad hominem or ad feminam attempts to discredit an argument or position by drawing attention to characteristics of the person who is making the argument or holds the position.

Example: "My supervisor wants me to rethink the ethics of what I told that last client about his so-called religion. But my supervisor is a person of the lowest possible character and morals. She's real trash. She's into power and control, and her beliefs are rigid and unchangeable. I don't think she believes in much of anything but the righteousness of her own ideas. All she does is try to scare, intimidate, or coerce me. It's clear that nothing she says is right or even worth considering."

Nominal Fallacy

If we believe that we have explained something because we have named it, we are committing the nominal fallacy.

Example:

THERAPIST A: I find I just don't care about my patients or my work anymore. I've stopped keeping records, I ask my patients if they'd like to play some tennis or go camping or hit the bars, and I don't really pay much attention to what they say."

THERAPIST B: You're describing a classic case of burnout.

THERAPIST A: But why am I doing all these things?

THERAPIST B: Because you're burned out.

Composition Fallacy

This fallacy takes the form of assuming that a group possesses the characteristics of its individual members.

Example: "There are so many experiences in the human realm that are wonderful. Sexual intimacy between two willing adults who love each other is wonderful. A therapist helping a client is wonderful. When the relationship between a therapist and client is so deep that it could be characterized as love, it's wonderful. When all these acts become part of one process between two people, it must be exceptionally wonderful. How could anyone condemn such a wonderfully human process as unethical?"

Naturalistic Fallacy

The naturalistic fallacy takes the form of logically deducing values (for example, what is good, best, right, ethical, or moral) based on only statements of fact.

Example: "I now have twenty-three studies of the method I developed to teach ethics, and they all show that students enjoy it, value it, and remember its content. No other method has that many studies. It is clear that this is the right way to teach ethics, and we should all be using it."

Appeal to Ignorance (Ad Ignorantium)

The appeal to ignorance fallacy takes this form:

> There is no (or insufficient) evidence establishing that x is false.
>
> Therefore: x is true.

Example: "In the four years that I have been marketing my new and improved brand of past-life regressive biocognitive astral-projective hyperaffective-hypnotic-teleological-metatherapy (buy ten sessions and the next one is free!), not one person has proved it is worthless or that I am unethical for providing a therapy I just made up one day when I realized that no one was referring clients to me anymore. That makes clear what a worthwhile therapy this is and how exceptionally ethical I am to provide it."

Begging the Question (Petitio Principii)

This fallacy, one of the fallacies of circularity, takes the form of claims that simply assume or restate their own truth rather than providing relevant evidence and logical arguments.

Examples: Sometimes this fallacy literally takes the form of a question, such as, "Has your clinic stopped those unethical practices yet?" (the question assumes—and a yes or no response to the question affirms—that the practices are unethical) or, "Why must you always take such a stupid and uninformed approach to ethics?" (the question assumes that the approaches are always stupid and uninformed). Sometimes this fallacy takes the form of a statement such as, "No one can deny that [my approach to ethics] is the only valid approach" or "It must be acknowledged that providing therapy without charging a fee is always unethical." Sometimes it takes the form of a logical argument, such as, "My way of responding to difficult patients is by far the most ethical because no other way is so ethical and it is the only way that is completely ethical."

Denying the Antecedent

This fallacy takes the form of:

If x, then y.

Not x.

Therefore: not y.

Example: "If well-designed research showed that the way I do therapy caused harm, then my therapy would be unethical. But there's no well-designed research showing a causal relationship between the way I do therapy and any harm to my clients. Therefore, the way I do therapy is ethical."

Argument to Logic (Argumentum ad Logicam)

The argument to logic fallacy takes the form of assuming that a proposition must be false because an argument offered in support of that proposition was fallacious.

Example: "I thought that new psychological assessment instrument for evaluating a client's capacity to give informed consent was promising, but the study that supported its validity turned out to have critical methodological flaws, so the instrument is probably not valid."

Division Fallacy

The division fallacy or decomposition fallacy takes the form of assuming that the members of a group possess the characteristics of the group.

Example: "The Joint Commission on Accreditation of Healthcare Organizations revoked that hospital's accreditation because of its substandard work. Each of the psychologists who works there must do substandard work."

False Analogy

The false or faulty analogy fallacy takes the form of argument by analogy in which the comparison is misleading in at least one important aspect.

Example: "There were great psychologists who passed away several decades ago. If they could be ethical without reading that new ethics code that came out last week, there's no need for me to read that code."

You Too! (Tu Quoque)

This fallacy takes the form of distracting attention from error or weakness by claiming that an opposing argument, person, or position has the same error or weakness.

Example: "I have been accused of using an ad hominem approach in trying to defend my approach to ethics. But those who question my ethics are also using what I consider to be ad hominem (that is, they question *my* ethics). And they started it!!!"

Golden Mean Fallacy

The fallacy of the golden mean (or fallacy of compromise, or fallacy of moderation) takes the form of assuming that the most valid conclusion is that which accepts the best compromise between two competing positions.

Example: "In our psychology department, half of the faculty believe that the new assistant professor shows serious problems in the area of ethics. The other half believe that the new faculty member shows no problems in the area of ethics. Obviously the new professor shows mild to moderate problems in the area of ethics."

False Dilemma

Also known as the either-or fallacy or the fallacy of false choices, this fallacy takes the form of acknowledging only two (one of which is usually extreme) options from an array of possibilities.

Example: "Either we must accept that the approach to ethics that I've just described is the only legitimate view, or we must admit that we have lost our humanity, our decency, our hearts, and our common sense."

Post Hoc, Ergo Propter Hoc (After This, Therefore on Account of This)

The post hoc, ergo propter hoc fallacy concludes that because Y follows X, then Y must be a result of X.

Example: "My new way of obtaining informed consent helps prevent dropouts. I chose the three therapists in our clinic who had the highest dropout rates and taught them my new informed consent procedure. The first month that they started using it, all three had significantly lower dropout rates." (This example may also involve the statistical phenomenon of regression to the mean.)

Mistaking Deductive Validity for Truth

This fallacy takes the form of assuming that because an argument is a logical syllogism, the conclusion must be true. It ignores the possibility that the premises of the argument may be false.

Example: "I just read a book that proves that that book's author can have sex with his clients without causing any harm. He has done research with his own clients, kept careful records, and even interviewed them. His statistical analysis shows that the clients he has sex with are no worse off—and some may be significantly better off—than the clients he doesn't have sex with. He even has a chart showing how safe, ethical, and clinically helpful it can be to have sex with a client as long as it is done carefully and in accordance with his decision rules. Who am I to argue with scientific proof like that?"

Red Herring

This fallacy takes the form of introducing or focusing on irrelevant information to distract from the valid evidence and reasoning. It takes its name from the strategy of dragging a herring or other fish across the path to distract tracking dogs and to throw them off the scent of whatever they were searching for.

Example: "Some of you have objected to the ethics of my clinic's buying those new test batteries. You claim that the new tests are unreliable, have no published norms, have never demonstrated validity, cannot be used by clients who are physically disabled, have been condemned as bogus by every major scientific organization, and were developed and sold by my brother-in-law, who unfortunately cannot be with us today due to a misunderstanding with his overly controlling and rigidly judgmental parole officer. What you have apparently failed to appreciate, however, is that these new tests are much easier to learn, can be administered and scored in a fraction of the time required by the old tests, and were so inexpensive compared to the old tests that I'll be able to give you each a bonus at the end of the month."

Straw Person

The straw person (or straw man or straw woman) fallacy takes the form of mischaracterizing someone else's position in a way that makes it weaker, false, or ridiculous.

Example: "Those who disagree with my approach to ethics obviously want to use their rigid, dictatorial ethics to control every aspect of our professional life and make the rest of us live in a fascistic world in which they make all the rules and we must follow their orders."

LANGUAGE

Language shapes the way we experience the world. What we call things matters. An executive director hesitates to fire therapists who helped found a clinic and remained loyal through the lean years. Can she push these colleagues out the door and cut off their income just to raise profits by hiring less qualified therapists as independent contractors for lower pay? It is easier if she throws a word blanket over what she does and the people she does it to. She can use language to block our view.

She never mentions firings or individual colleagues. Office bulletins describe a "multitude of unfortunate but inescapable factors necessitating a substantial but temporary reduction in force in order to maximize competitive preparedness and responsiveness in a volatile and challenging marketplace." Press releases hail an "innovative and state-of-the-art intervention and development strategy of providing maximum direction, safety, and assistance activity during the discrete transitional process steps associated with the temporary downsizing implementation phase and the arrangement of management-directed outplacement services." (This means the company has hired armed guards to escort each therapist out of the building, help carry any belongings, and make sure the therapist does not reenter the building.) These descriptions hide the firings and the therapists.

Language can deceive by design. It conceals, misdirects, and creates the verbal equivalent of optical illusions. But even when used with the best of intentions, careless or bloated language makes it hard to think clearly. Many of us have gone missing in professional articles, last seen slogging our way through a paragraph packed with professional jargon, clichés, and not-quite-right words.

In his classic essay, "Politics and the English Language," George Orwell (1946) rewrote a widely quoted biblical passage in what he called "modern English." Here's the original passage from Ecclesiastes in the King James Bible:

> I returned and saw under the sun, that the race is not to the swift, nor the battle to the strong, neither yet bread to the wise, nor yet riches to men of understanding, nor yet favor to men of skill; but time and chance happeneth to them all.

See if Orwell's translation reminds you of any professional articles, lectures, or discussions:

> Objective consideration of contemporary phenomena compels the conclusion that success or failure in competitive activities exhibits no tendency to be commensurate with innate capacity, but that a considerable element of the unpredictable must invariably be taken into account [p. 163].

Too often we lose sight of ethical issues as they disappear in clouds of clichés, jargon, deceptive words, and careless language. This section looks at common language patterns that hide or confuse ethical issues, responsibilities, or consequences. We present the patterns in extreme form so that they are easy to recognize. If we learn these basic patterns in simplified form, we can spot them more easily when they try to sneak by us in the busy complexity of our day-to-day work.

Most of us will find it easy to remember seeing these patterns in the newspaper, on television, and during our professional meetings. What is much harder—but much more useful—is to try to remember when we ourselves have fallen into these patterns. Orwell emphasized how universal and persistent these word tricks are. He notes that they "are a continuous temptation, a packet of aspirin always at one's elbow. Look back through this essay, and for certain you will find that I have again and again committed the very faults I am protesting against" (1946, p. 168).

We start with Jack, our hypothetical therapist, who did something unethical, was caught and formally disciplined, knows what he did was wrong, is sorry, and wants to make a public statement to take responsibility and apologize. Here is what Jack did: he stole therapy records of the clinic's famous clients, altered them to make it look as if the clients had described lurid sexual activity to their therapists, and then sold the records to tabloids.

In his public statement, Jack says: "I stole the patient files, added some lies to them, and sold them. I have no excuses or explanations. I am solely responsible. I knew it was wrong and would hurt innocent people who trusted the clinic, and I did it anyway because I wanted the money. I apologize to everyone, especially to those whom I've hurt. I will do whatever I can to try to make things right."

Here are some alternate statements that show common language patterns that can interfere with clear thinking about ethics. As in the prior section on logical fallacies, there is a brief description and example of each pattern.

Substitute the General for the Specific

In this pattern, both the specific individual and the specific act disappear. A description of a general category of acts and a vague reference in the third person replace (and hide) the specifics.

Example: "I believe that everyone knows that taking a patient's file without the patient's permission and using it for some purpose for which it was not intended is wrong. Anyone who does something like that is out of line."

Use a Conditional Frame for Consequences

The speaker shifts the focus to the question of whether the acts affected anyone. The apology is made contingent on how others reacted or were affected.

Example: "If my actions harmed, or even just offended, anyone—and I can well understand how that could happen—I apologize."

Use Denied Motivation as Misdirection

Instead of honestly stating the motivation, the speaker seeks self-exoneration by talking about what the motivation was *not.* Denying an irrelevant charge that no one has made can be an effective rhetorical tactic. The denials are often true. For example, the person who repeatedly embezzles pension funds, uses substandard materials to build high rises, speeds while drunk, and stresses that he or she never meant to hurt anyone was probably *not* acting with the intention of making other people suffer.

Example: "I can honestly say that at no time during these unfortunate events with the clinic records did I ever intend for anyone to be hurt."

Use the Abstract Language of Technicalities

The speaker translates people and events into abstractions, using the jargon of technicalities.

Example: "I know that many of you have heard rumors and you deserve to know what happened. I want to acknowledge publicly, in closing this unfortunate chapter, that I did not fulfill all requirements in the JCAHO [Joint Commission on Accreditation of Healthcare

Organizations] manual for the handling of charts. There were instances in which I reviewed and added information without following all the bureaucratic specifications for identifying the source of additional material, and I did not always follow the precise procedures for obtaining informed consent for release of information in transferring these charts to individuals who lacked proper authorization to receive them. I regret my lack of attention to JCAHO and similar regulations, and I assure everyone that I will be reviewing those regulatory specifications and will make every attempt to conform to those guidelines in the future."

Use the Passive Voice

The speaker disappears. Things are done without reference to who does them.

Example: "I know that all of you, like me, want to know the results of the extensive, no-holds-barred investigation that was conducted in the light of recent allegations. I have been authorized to provide you with a complete report of the findings. Regrettably, the investigation confirmed that some files were taken without authorization, were altered, and were provided to those who should not have received them. Both the policies of our own clinic and the regulations of external authorities were violated. We wish to assure everyone that appropriate actions will be taken so that the problems will be addressed. Relevant steps have already been taken toward remedying this situation."

Make Unimportant by Contrasting with What Did Not Occur

The speaker anchors the presentation in scenarios of extreme consequences that did *not* occur. The contrast makes whatever may have happened seem trivial.

Example: "All of us have been concerned about the effects of recent events. As you know, allegations led to thorough investigations by several agencies. These investigations are now concluded. Let me assure you that regardless of what you may have heard, no patient died or even suffered any physical injury whatsoever, whether chronic or acute, significant or trivial. I believe that some of you have been concerned that some of the patients might, as a result of these events, become distraught and take their own lives. However, I want to assure each and every one of you that no patient has committed suicide or, to the best of our knowledge, threatened or attempted suicide. As a final note, I believe that some of you were distressed that the events may have involved serious criminal behavior of the kind exemplified by what our state terms a Class A felony. However—and I want to emphasize this!—not only were there no charges of Class A felonies for anyone involved in this sequence of events, but no one from the district attorney's office ever mentioned even the remote possibility of such charges. Although I think any of us might acknowledge that perhaps things might have been handled a bit better, it is important—and an issue of fundamental fairness—to keep what happened in perspective, to avoid the witch hunt mentality, and to remember that none of us is perfect. Thank you for your time and attention."

Replace Intentional Unethical Behavior with the Language of Accidents, Misfortune, and Mistakes

The speaker fails to mention making a conscious decision to profit by stealing charts, filling them with lies, and selling them to the highest bidder, which would strike most people as unethical. The description makes the speaker a victim of being an imperfect human, of lacking omniscience and infallibility. The speaker pushes the acts into the category of those random, inevitable mistakes that afflict us all and are beyond our control. At worst, they are a matter of having fumbled a matter of judgment, although if this construction is examined closely, it seems to assume that almost anyone would have difficulty judging whether stealing charts, inserting bogus material that will hurt patients, and selling them to those who will publish them is ethical. This may not be quite as hard a judgment as the rhetoric implies.

Example: "I wanted to address the unfortunate events that have troubled us all lately, so that you would understand what occurred and why. To my great regret, I have realized now in hindsight—hindsight being twenty-twenty—that in handling clinic records, I made some mistakes. I'm sure you all know how I feel about this, and I hope you will be understanding and chalk this unfortunate error in judgment up to youthful indiscretion, my tendency to want to take on a little too much so that this clinic will function as well as possible, and to a momentary lapse of attention in the crush of daily demands that I face as clinic director. All of us make mistakes in our work here, and I want you to know how sorry I am for this misstep."

Smother the Events in the Language of Attack

Assuming that the best defense is a good offense, the speaker avoids responsibility by attacking others. Whatever the speaker may have done becomes trivial or justifiable in the light of the terrible things other people have done. The language of attack stirs up emotional responses. It works against people joining together to examine the facts and their implications and sets people against each other, dividing them into "us" (the good people, unjustly attacked) and "them" (the bad people, who deserve what we can dish out). The speaker's rhetoric serves to draw listeners into his or her camp and to ridicule or intimidate those who are on the other side (that is, the enemy). The rhetoric encourages listeners to evaluate claims not in terms of whether they are valid and relevant, but in terms of whether they support the listener's loyalty to one side.

Example: "Thank you for coming today. I will take just a few minutes of your time with the following statement about the recent events in which I have had to endure the most vicious attacks. It is a sad sign of our 'take no responsibility' culture that several patients who came to our clinic in need and were not turned away have shown their gratitude for all we have done for them by trying to gain publicity for themselves—their fifteen minutes of fame—and to enrich themselves at our expense by filing formal complaints. This is one of the most destructive aspects of the modern mind-set: it's all me-me-me, without thinking of how such complaints might affect the rest of us who have dedicated our lives to healing the sick, comforting those in need, and helping those who turn to us in their hour of crisis. The selfishness of such formal complaints is hard to comprehend. These scurrilous complaints rob us of the time and resources that we would otherwise use to provide services to those who have nowhere else to turn. And it is for those people who have so little and suffer such great needs that this clinic has resolved to fight these complaints with every resource we can muster. We have hired some of the most skilled and successful attorneys that this nation has yet produced, and they have already filed countercharges in civil court. The support staff aiding these attorneys have discovered, in the course of their extensive background research, some facts about those who filed complaints against us that I believe will surprise the public and place these vicious complaints in their proper perspective. I've been asked by our attorneys not to reveal that material at this time, but I assure you that our attorneys will present it at the proper time—in court—should these complaints go to trial. Again, pursuant to the advice of our attorneys, I will have no more comment on this matter at this time. Thank you for your time and attention."

JUSTIFICATIONS

Justifications turn the search for an ethical response around backward. Instead of searching for an ethical response to a situation until we find it, we begin by thinking of a way we would like to respond and then search for ways to justify it.

With enough hard work and creativity, most of us can come up with justifications for almost anything we want to do. The most common justifications rely on twisted judgment, appealing fallacies, and juggled language. They can spin the most questionable behaviors into ethical ideals.

To restate a major theme of this book, we believe that the overwhelming majority of psychologists are conscientious, caring individuals, committed to ethical behavior. We also believe that none of us is infallible and that perhaps all of us, at one time or another, have been vulnerable to at least a few of these ethical justifications and might be able extend the list.

Many of the justifications appeared in previous editions of this book, and some were added when the list appeared in *What Therapists Don't Talk About and Why: Understanding Taboos That Hurt Us and Our Clients* (Pope, Sonne, & Greene, 2006):

1. It's not unethical as long as a managed care administrator or insurance case reviewer required or suggested it.

2. It's not unethical if we can use the passive voice and look ahead. If it is discovered that our curriculum vitae is full of degrees we never earned, positions we never held, and awards we never received, all we need do is nondefensively acknowledge that mistakes were made and it's time to move on.

3. It's not unethical if we're victims. Claiming tragic victim status is easy: we can always use one of two traditional scapegoats: (1) our "anything-goes" society that lacks clear standards and leaves us ethically adrift or, conversely, (2) our coercive, intolerant society that tyrannizes us with political correctness, dumbs us down, and controls us like children. Imagine, for example, that we are arrested for driving while drunk, and the person whose car we hit presses vengeful charges

against us. We show ourselves as the real victim by pointing out that some politically correct, self-serving tyrants have hijacked the legal system and unfairly demonized drunk driving. These powerful people of bad character and evil motivation refuse to acknowledge that most speeding while drunk is not only harmless—actuarial studies show that only a small percentage of the instances of drunk speeding actually result in harm to people or property—but also sometimes unavoidable, profoundly ethical, and a social good, getting drivers to their destinations faster and in better spirits. We stress that any studies seeming to show drunk driving is harmful are not just unscientific (for example, none randomly assigns drivers to drunk speeding and non-drunk-driving conditions) but hopelessly biased (for example, focusing on measures of harm but failing to include measures sensitive to the numerous benefits of drunk speeding).

4. It's not unethical if the American Psychological Association or a similar organization allows it.

5. It's not unethical if we acknowledge the importance of judgment, consistency, and context. For example, it may seem as if a therapist who has submitted hundreds of thousands of dollars worth of bogus insurance claims for patients he never saw might have behaved "unethically." However, as attorneys and others representing such professionals often point out, it was simply an error in judgment, completely inconsistent with the high ethics manifest in every other part of the person's life, and insignificant in the context of the unbelievable good that this person does.

6. It's not unethical as long as no law was broken.

7. It's not unethical if we can say any of the following about it (feel free to extend the list):

> "What else could I do?"
>
> "Anyone else would've done the same thing."
>
> "It came from the heart."
>
> "I listened to my soul."
>
> "I went with my gut."
>
> "It was the smart thing to do."
>
> "It was just common sense."
>
> "I just knew that's what the client needed."

"I'd do the same thing again if I had it to do over."

"It worked before."

"I'm only human, you know!"

"What's the big deal?"

8. It's not unethical if we have written an article, chapter, or book about it.

9. It's not unethical as long as we can name others who do the same thing.

10. It's not unethical as long as we didn't mean to hurt anyone.

11. It's not unethical even if our acts have caused harm as long as the person harmed has failed to behave perfectly, is in some way unlikable, or is acting unreasonably.

12. It's not unethical as long as we were under a lot of stress. No fair-minded person would hold us accountable when it is clear that it was the stress we were under, along with all sorts of other powerful factors, that must be held responsible.

13. It's not unethical as long as no one ever complained about it.

14. It's not unethical as long as we know that the people involved in enforcing standards (for example, licensing boards or administrative law judges) are dishonest, stupid, destructive, and extremist; are unlike us in some significant way; or are conspiring against us.

15. It's not unethical as long as it results in a higher income or more prestige (in other words, it's necessary).

16. It's not unethical as long as the client asked us to do it.

17. It's not unethical as long as it would be almost impossible to do things another way.

18. It's not unethical if we could not (or did not) anticipate the unintended consequences of our acts.

19. It's not unethical as long as there is no body of universally accepted, methodologically perfect (that is, lacking any flaws, weaknesses, or limitations) studies showing—without any doubt whatsoever—that exactly what we did was the necessary and sufficient proximate cause of harm to the client and that the client would otherwise be free of all physical and psychological problems, difficulties, or challenges. This view was succinctly stated by a member of the Texas pesticide regulatory board charged with protecting Texas citizens against undue risks from pesticides. In discussing chlordane, a

chemical used to kill termites, one member said, “Sure, it’s going to kill a lot of people, but they may be dying of something else anyway” (Perspectives, 1990, p. 17).

20. It’s not unethical as long as there are books, articles, or papers claiming that it is the right thing to do.

21. It’s not unethical as long as we can find a consultant who says its okay.

Reminding ourselves of our own unique patterns of vulnerability—particularly when we are tired, stressed, or distressed—to these justifications may help us to keep searching for the most ethical response to the complex, constantly changing challenges of our work.

CHAPTER THREE

Trust, Power, and Caring

Our ethical responsibilities are founded on the recognition that therapy involves trust, power, and caring.

TRUST

States and provinces grant therapists professional status in acknowledgment of the fiduciary relationship between therapist and client. Societies expect therapists to be trustworthy and not to exploit the trust that people invest in them and their enterprise. The social order depends on individual therapists to fulfill the trust for the benefit of individual clients as well as for the social order. (Many ethical dilemmas result from the clash between the benefit of the client and the benefit of the social order or between the benefit of the client and the benefit of the therapist.) In return for assuming a role in which the safety, welfare, and ultimate benefit of clients is to be held as a sacred trust, therapists are entitled to the privileges and power due professionals.

This concept of trust is crucial for understanding the context in which clients approach and enter into a working relationship with psychotherapists. Clients rightfully expect, or at least desperately hope, that their trust in the therapist is not misplaced. Many, if not most, clients have deep fears that their trust may be betrayed. In some cases, these clients have often struggled painfully with issues of trust. In other cases, clients may be unaware of how their concerns about the trustworthiness of others have affected their ability to love, work, and enjoy life; the issues of trust may emerge gradually during the course of therapy.

The trust underlying therapy is illustrated by the following phenomenon: clients may walk into the consulting room of an absolute stranger and begin saying things that they would say to no one else. Therapists may ask questions that would be unwarranted, intrusive, and offensive were anyone else to ask them.

Acknowledging and respecting the power of the private, sensitive, and sometimes secret information that patients tell their therapists, all states recognize some form of professional confidentiality and therapist-patient privilege. Therapists are prevented, with some specific exceptions, from disclosing to other people, other organizations, or the government what clients tell their therapists during the course of therapy.

In its reliance on trust as fundamental, therapy is similar to surgery. Surgery patients allow themselves to be physically opened up in the hope that their condition will improve. They must trust that surgeons will not take advantage of their vulnerable state to cause harm or exploit. Similarly, therapy patients undergo a process of psychological opening up in the hope that their condition will improve. They trust that therapists will not take advantage, harm, or exploit.

Freud (1952) originally noticed this similarity. He wrote that the newly developed "talking therapy" was "comparable to a surgical operation" (p. 467) and emphasized that "the transference especially . . . is a dangerous instrument. . . . If a knife will not cut, neither will it serve a surgeon" (p. 471). Recognizing and respecting the potential harm that could result from psychotherapy was, according to Freud, fundamental: "It is grossly to undervalue both the origins and the practical significance of the psychoneuroses to suppose that these disorders are to be removed by pottering about with a few harmless remedies. . . . Psychoanalysis . . . is not afraid to handle the most dangerous forces in the mind and set them to work for the benefit of the patient" (Freud, 1963, p. 179). Our personal responsibility includes respecting our clients' trust that therapists will do nothing that knowingly and needlessly places them at risk for deep, pervasive, and lasting harm.

When therapists betray their clients' trust, the betrayal of trust alone can cause pervasive and lasting damage. Mann and Winer (1991), discussing the ways that exploitation of trust can harm patients, quote Adrienne Rich: "When we discover that someone we trusted can be trusted no longer, it forces us to reexamine the whole instinct and concept of trust. For a while, we are thrust back into some bleak, jutting ledge . . . in a world before kinship, or naming, or tenderness exist; we are brought close to formlessness" (p. 325).

We all face the challenge of understanding what the careless handling of trust can mean for the person who is the client. Clients do not live their lives in abstractions like "fiduciary relationships" and "social order." Trust is a deeply personal experience as it emerges in the relationship between therapist and client.

POWER

The trust that society and individual clients give to therapists is a source of power—for example, the power to respect and honor that trust or to betray and abuse it. The role of therapist can have power ranging from the superficial to the profound, from temporary to enduring.

Power Conferred by the State

There is power inherent in the states' establishment of licensure as a requirement. Licensed professionals are permitted to engage in certain activities that are prohibited to others who do not possess the license. With the consent of patients, surgeons can cut human beings wide open and remove internal organs, anesthesiologists can render them unconscious, and many therapists can administer mind- or mood-altering drugs to them, all with the law's approval and authorization. Individuals will disrobe and willingly (well, somewhat willingly) submit to all manner of indignities when undergoing a comprehensive medical examination; they will allow the licensed physician to do things to them that no one else would be permitted to do. In a similar manner, clients will open up to a therapist and allow the therapist to explore extremely private aspects of the client's history, fantasy life, hopes, and fears. Clients will tell therapists their most personal secrets, material shared with literally no one else. Therapists can ask questions that might provoke a slap in the face if anyone else asked.

The states and provinces recognize the importance of protecting clients against the intentional or unintentional misuse of this power to invade the privacy of the person. (Metaphorically, psychotherapy, like surgery, can be an "invasive procedure," although in both cases the client or patient consents to the invasion.) Except in certain instances, therapists are required to keep confidential what they have learned about their clients through the professional relationship. Holding private information about their clients gives therapists power in relation to their clients.

In licensing therapists, governments also invest them with the power of state-recognized authority to influence drastically the lives of their clients. Therapists have the power to make decisions (though subject to judicial review) regarding the civil liberties of their clients. Some therapists have the power to determine whether a citizen constitutes an immediate danger to the life of another individual and therefore should be held against his or her will in an institution for observation or treatment. Alan Stone (1978), professor of law and psychiatry at Harvard University and a former president of the American Psychiatric Association, points out that the United States has incarcerated more of its citizens against their will for mental health purposes than any other country, that this process reached its peak in the 1950s when one out of every three hundred citizens was held involuntarily in a mental institution, and that the abuse of this power has led to extensive reforms and formal safeguards.

Power to Name and Define

Therapists possess the power of naming and defining. To diagnose someone is to exercise power. In reporting one of the most widely cited psychological research studies, "On Being Sane in Insane Places," in the journal *Science,* Rosenhan (1973) wrote, "Such labels, conferred by mental health professionals, are as influential on the patient as they are on his [sic] relatives and friends, and it should not surprise anyone that the diagnosis acts on all of them as a self-fulfilling prophesy. Eventually, the patient himself [sic] accepts the diagnosis, with all of its surplus meanings and expectations, and behaves accordingly" (p. 254; see also Langer & Abelson, 1974; Mednick, 1989; Murphy, 1976; Pope, 1996; Pope, Butcher & Seelen, 2006; Reiser & Levenson, 1984).

The potential power of diagnosis and other forms of clinical naming to affect how individuals are perceived is illustrated in Caplan's description (1995) of psychiatrist Bruno Bettelheim's analysis of student protesters: "In the turbulent 1960s, Bettelheim (1969) told the United States Congress of his findings: student anti-war protesters who charged the University of Chicago with complicity in the war machine had no serious political agenda; they were acting out an unresolved Oedipal conflict by attacking the university as a surrogate father" (p. 277).

Power of Testimony

Therapists also possess authority to influence the lives of their clients through their testimony as experts in the civil and criminal courts and through similar judicial or administrative proceedings. A therapist's testimony may determine whether someone convicted of murder is executed or paroled. A therapist's testimony may influence whether a parent gains or loses custody of a child. A therapist's testimony may influence a jury's decision about whether a defendant was capable of committing a crime, was likely to have committed it, was legally sane at the time the crime was committed, or is likely to commit similar crimes in the future. A therapist's testimony may influence a jury to believe that a very young child was sexually molested or that the child fantasized the event (or was coached to make a false allegation as part of a custody dispute). An expert witness's testimony may lead a jury to believe that the plaintiff is an innocent victim of a needless trauma who is suffering severe and chronic harm or that the same plaintiff is a chronic liar, a gold-digger, or a malingerer who is feigning or at least exaggerating dramatic symptoms.

The Power of Knowledge

The role of psychotherapist involves power beyond what a license establishes. There is power that comes from knowledge. Psychotherapists formally study human behavior and the factors that influence motivation, decision, and action. They learn methods for promoting change. Acknowledging and respecting the power of knowledge and expertise is essential to avoid the subtle ways in which it may be used to manipulate and exploit clients.

Power of Expectation

The process of psychotherapy itself elicits, creates, and uses forms of power. Virtually all therapies recognize the importance of the client's expectation that the therapist's interventions will be able to induce beneficial change. One aspect of this expectation is the placebo effect, a factor that must be taken into account when conducting research into the effectiveness of various interventions. Thus, the client's investing the therapist with power to help bring about change can become a significant facet and resource of the change process itself.

The therapist frequently becomes invested with other important meanings as well. Psychodynamic theory, for example, describes a process termed *transference:* clients transfer feelings, attachments, or styles of relationship associated with figures from their past (such as parents) onto the therapist. The client may react toward the therapist as if he or she were the client's mother or father. Deep feelings such as love, rejection, shame, guilt, longing for approval, dependence, panic, and neediness—each perhaps representing the unfinished business of development or traumatic experiences needing understanding and healing—originally experienced within an early formative relationship may emerge in the therapist-client relationship in ways that tend to shock and overwhelm the client.

Therapists' potential to elicit such profound feelings—simply by serving as a therapist—and to "feel" to the client as if the therapist were a figure from the client's past (with the client frequently functioning as if he or she were at an earlier stage of development) represent the sometimes surprising aspects of therapists' power to affect their clients.

Creating Power

In some approaches, the therapist may work to create specific forms of power. For example, a family therapist may assertively unbalance the equilibrium and alliances among family members. A behavior therapist may create a hospital ward or halfway house in which desirable behaviors bring forth a rewarding response from the staff (perhaps in the form of tokens that can be exchanged for goods or privileges); the power of the therapist and staff is used to control, or at least influence, the client's behavior.

Psychologist Laura Brown (1994b) describes another domain of the therapist's power: "The therapist also has the power to engage in certain defining behaviors that are real and concrete. She sets the fee; decides the time, place, and circumstances of the meeting; and determines what she will share about herself and not disclose. Even when she allows some leeway in negotiating these and similar points, this allowance proceeds from the implicit understanding that it is within the therapist's power to give, and to take away, such compromises" (p. 111).

An Inherent Power Differential

The power differential is inherent in psychotherapy. Although certain approaches to therapy have emphasized egalitarian ideals in which therapist and client are equal, such goals are viewed only within a narrowly limited context of the relationship. In truly equal relationships, in which there is no appreciable power differential, there is no designation of one member as "therapist" in relation to the other member, there is no fee charged by one member to the other for the relationship, there is no designation of the activity as "professional" (and falling within the scope of a professional liability policy), there is no use by one member of a license to work with the other, and so on. A defining attribute of the professional is the recognition, understanding, and careful handling of the considerable power—and the personal responsibility for that power—inherent in the role.

CARING

Both the individual client and society recognize the diverse powers of the professional role and place their trust in professionals to use those powers to benefit—never to harm or exploit—those who seek help from the therapist. The trust that society and the individual client give must be matched by the caring of the therapist. Only within a context of caring—specifically caring about the client's well-being—are the therapist's professional status and powers justified. Historically, charging high fees did not create or define professional status, nor did spending long years in training or reaching a high level of expertise. The central, defining characteristic of the professional was an ethic of placing the client's welfare foremost and not allowing professional judgment or services to be drawn off course by one's own needs.

The touchstone for the approaches discussed in this book is caring for and about people whom professional interventions are meant to serve. This book's concept of caring is not a passive, empty sentimentality. Caring includes responding to a client's legitimate needs and recognizing that the client must never be exploited. It also includes assuming personal responsibility for working to help and to avoid needlessly harming or endangering the client.

Unfortunately, this concept may not receive adequate attention in graduate training programs. As Sarason (1985) wrote:

> On the surface, trainees accept the need for objectivity—it does have the ring of science, and its importance can be illustrated with examples of the baleful consequences of "emotional over-involvement"—but internally there is a struggle, as one of my students put it, "between what your heart says you should say and do and what theory and your supervisor say you should say and do." Many trainees give up the struggle but there are some who continue to feel that in striving to maintain the stance of objectivity they are robbing themselves and their clients of something of therapeutic value. The trainee's struggle, which supervisors gloss over as a normal developmental phase that trainees grow out of, points to an omission in psychological-psychiatric theories. Those theories never concern themselves with caring and compassion. What does it mean to be caring and compassionate? When do caring and compassion arise as feelings? What inhibits or facilitates their expression? Why do people differ so widely in having such feelings and the ways they express them? It is, of course, implicit in all of these theories that these feelings are crucial in human development, but the reader would be surprised how little attention is given to their phenomenology and consequences (positive and negative) [p. 168; see also Pope, Sonne, & Greene, 2006; Pope, Sonne & Holroyd, 1993; Pope & Tabachnick, 1993, 1994].

Caring about what happens to clients is one of the strongest foundations for the formal rules and regulations that are society's attempt to hold the therapist accountable, but it also encourages therapists to look beyond those generalities. Caring is also a foundation of our personal responsibilities as therapists.

CHAPTER FOUR

Competence and the Human Therapist

When clients put their trust in us as professionals, one of their most fundamental expectations is that we will be competent. Competence is a cornerstone of ethical practice; ethical behavior is contingent on intellectual and emotional competence. Society, through the courts and licensing boards, also holds us to this standard.

Clients, of course, may have a variety of unrealistic—sometimes virtually magical—expectations. They may hope, for example, that we can always assess and intervene without error, guarantee results, and meet all of their needs. Unfortunately some clinicians may suffer from such delusions and may encourage these beliefs in their clients. One of the fundamental purposes of this chapter is to provide a simple reminder that as therapists, we are all human, imperfect, with weaknesses and blind spots that accompany our strengths and insights. In fact, failures of competence are often related to human vulnerabilities. The opening chapters of this book rejected views of ethics as rigid rule following and presented an approach to ethics in which professional codes, administrative directives, legislative requirements, and other givens mark the beginning of a process of creative questioning and critical thinking in which therapists strive to arrive at the most ethical and positive response to a unique client with unique needs and resources in a unique context.

This complex process of constant questioning and critical thinking must be carried out by fallible human beings, vulnerable at times to fatigue, discouragement, frustration, anger, fear, and feeling overwhelmed. This chapter is a reminder that therapists must not only possess the demonstrable intellectual competence (knowing about and knowing how) but also what might be called *emotional competence for therapy* (Pope & Brown, 1996).

COMPETENCE AS AN ETHICAL AND LEGAL RESPONSIBILITY

Although the omniscient, omnipotent, and error-free clinician is a myth, therapists and counselors have an ethical and legal responsibility to offer clients a basic and adequate competence. In psychotherapy and counseling, *competence* is complex and difficult to define. Licensing boards and the civil courts sometimes specify defining criteria for discrete areas of practice. More often, however, they tend to require simply that in whatever area of therapy and counseling the clinician is practicing, he or she should possess demonstrable competence. When demonstrable competence is formally and explicitly required, the clinician is prevented from merely asserting competence; evidence of the competence must be produced. Generally this evidence takes the form of the clinician's formal education, professional training, and carefully supervised experience.

The competence requirement is frequently established in the ethical, legal, and professional standards governing the work of therapists. For example, article 8 (Rules of Professional Conduct), section 1396, of California Title 16 declares, "The psychologist shall not function outside his or her particular field or fields of competence as established by his or her education, training and experience." Section 1.6 of the *Specialty Guidelines for the Delivery of Services by Clinical Psychologists* (American Psychological Association, 1981, p. 7) states, "Clinical psychologists limit their practice to their demonstrated areas of professional competence." Ethical Standard 2.01a of the American Psychological Association's "Ethical Principles of Psychologists and Code of Conduct" (2002, p. 1063) states: "Psychologists provide services, teach, and conduct research with populations and only within the boundaries of their competence, based on their education, training, supervised experience, or appropriate professional experience." The "Canadian Code of Ethics for Psychologists" (Canadian Psychological Association, 2000, p. 16) Standard II.6 states that in adhering to the Principle of Responsible Caring, psychologists would "offer or carry out (without supervision) only those activities for which they have established their competence to carry them out to the benefit of others."

To affirm the crucial importance of competence as an ethical requirement is to recognize that the power (see Chapter Three) implicit and invested in the therapist's role cannot be handled in a careless, ignorant, thoughtless manner. The complex, hard-to-define nature of therapy may tend to obscure the reasonableness and necessity of this requirement. It becomes more vivid by analogy to other fields. A physician who is an internist or general practitioner may do excellent work, but would any of us want that physician to perform coronary surgery or neurosurgery on us if the physician does not have adequate education, training, and supervised experience in these forms of surgery? A skilled professor of linguistics may have a solid grasp of a variety of Indo-European languages and dialects but be completely unable to translate a Swahili text.

COMPETENCE AND CONFLICT

Given the encouragement of clients who may hold exaggerated beliefs about our talents, it may be hard for us to acknowledge that we lack competence to intervene in a particular situation. It may be particularly hard if we do not want to disappoint or alienate a valued source of referrals who has referred a client to us or if we desperately need new clients to cover office overhead and feel that we cannot afford to turn away potential business. Managed care systems can make it difficult to turn away a client who has been assigned to us. Nevertheless, extensive education, training, and supervised experience in working with adults do not qualify us to work with children, solid competence in providing individual counseling or psychotherapy does not qualify us to lead a therapy group, and expertise in working with people who are profoundly depressed does not qualify us to work with people who have developmental disabilities.

At times, the complexity of the situation requires exceptional care and skill in determining how to respond most effectively and ethically to a client's needs while remaining within one's areas of competence.

For example, a counselor may begin working with a client on issues related to depression, an area in which the counselor has had considerable education, training, and supervised experience. But much later the therapeutic journey leads into a problem area—bulimia, for example—in which the counselor has no or very limited expertise. As another example, a client initiates psychotherapy to deal with what seem like moderately severe difficulties concentrating at work. Soon, however, it becomes apparent that the client is suffering from agoraphobia. Can the counselor ethically presume that the course on anxieties and phobias that he or she took ten years ago in graduate school is sufficient to address the problem competently? The counselor faces the decision whether there is time, energy, and commitment necessary to gain adequate competence or consultation (American Psychological Association, 2002) to provide the most up-to-date treatment for agoraphobia or whether it will be necessary to refer the client to someone who is a specialist or at least competent to work with someone suffering from agoraphobia.

Clinicians who work in isolated or small communities often face this dilemma. If the therapist or counselor is the only practitioner in an area, he or she probably will frequently encounter unfamiliar problems. Fulfilling the ethical responsibility of competence is especially difficult for these practitioners. They are constantly attending workshops and consulting long distance with a variety of experts to ensure that their clients are receiving competent care.

Despite the clear ethical and legal mandates to practice only with competence, therapists and counselors may suffer lapses. A national survey of psychologists, for example, found that almost one-fourth of the respondents indicated that they had practiced outside their area of competence either rarely or occasionally (Pope, Tabachnick & Keith-Spiegel, 1987).

INTELLECTUAL COMPETENCE: KNOWING ABOUT AND KNOWING HOW

Intellectual competence involves "knowing about." In our graduate training, internships, supervised experience, continuing education, and other contexts, we learn the kind of information about empirical research, theories, interventions, and other topics that we need for our work. We learn to question the information and evaluate its validity and relevance for particular situations and populations. We learn to create and test hypotheses about assessment and interventions.

Part of intellectual competence is learning which clinical approaches, strategies, or techniques show evidence or promise of effectiveness. If clinical methods are to avoid charlatanism, hucksterism, and well-meaning ineffectiveness, they must work (at least some of the time). Thus, the supposed competence of the practitioner has little meaning if his or her methods lack competence. In his provocative article "The Scientific Basis of Psychotherapeutic Practice: A Question of Values and Ethics," Singer (1980) emphasized the importance of clinicians remaining knowledgeable concerning the emerging research basis of the methods they use. Intellectual competence also involves learning what approaches have been shown to be invalid or perhaps even harmful. Stricker (1992) wrote, "Although it may not be unethical to practice in the absence of knowledge, it is unethical to practice in the face of knowledge. We all must labor with the absence of affirmative data, but there is no excuse for ignoring contradictory data" (p. 544).

Intellectual competence also means recognizing what we do not know. We may know about depression in adults but not about depression in children. We maybe familiar with the culture of one Asian population but not others. We may understand the degree to which the Minnesota Multiphasic Personality Inventory–2 is useful in assessing malingering but not whether it is useful in assessing leadership abilities.

Intellectual competence also involves knowing how to do certain clinical tasks. This aspect of competence is gained through carefully supervised experience. Knowing how to do psychotherapy is not something one can adequately learn solely from reading a book or sitting in a classroom. The APA Ethics Code Standard 2.01c (American Psychological Association, 2002) encourages properly trained psychologists planning to provide services new to them through relevant education, training, supervised experience, consultation, or study. In addition, both the APA Ethics Code (Standard 2.03) and the Canadian Psychological Association Ethics Code (Standards IV.3 and IV.4) recognize that knowledge becomes obsolete and that psychologists undertake ongoing efforts to develop and maintain their competence.

EMOTIONAL COMPETENCE FOR THERAPY: KNOWING ONESELF

Emotional competence for therapy, as described by Pope and Brown (1996), reflects therapists' acknowledgment and respect for themselves as unique, fallible human beings. It involves self-knowledge, self-acceptance, and self-monitoring. Therapists must know their own emotional strengths and weaknesses, their needs and resources, the abilities and limits for doing clinical work.

Psychotherapy often provides the occasion for strong emotional reactions for both therapist and client. To the degree that therapists are unprepared or otherwise unable to experience the emotional stresses and strains of therapy, their well-intentioned efforts may prove unhelpful and perhaps even harmful.

Table 4.1 presents relevant research findings about intense emotions experienced in therapy. The numbers indicate the percentage of therapists in each study who reported at least one instance of each behavior. Readers who have had experience as therapists or patients may wish to compare their own experience to these findings.

Therapists, of course, bring something to the work they do. Each therapist has a unique personal history. Table 4.2 presents national survey results showing therapists' self-reports of their experiences of various kinds of abuse during childhood, adolescence, and adulthood (Pope & Feldman-Summers, 1992). Note that these results suggest that almost one-third of male therapists and over two-thirds of female therapists experience at least one of these forms of abuse over their lifetimes.

Such experiences can affect emotional competence. It is important not to assume a one-size-fits-all theory about how any particular form of abuse (or any other experience) may affect an individual therapist. There is no research supporting the notion that all those who have a history of abuse are more competent or less competent as therapists, or that those who have no history of abuse are more or less competent as therapists. Each instance must be evaluated on an individual basis, with the full range of available information and without stereotypes. What is important is for therapists to be aware of how such events affect them and the degree to which such experiences may—or may not—affect their emotional competence.

Ethical responsibility entails continuous awareness to prevent compromised performance, especially during difficult or challenging periods. Chapter Five discusses common consequences when the therapist is distressed, drained, or demoralized. These common consequences include disrespecting clients; disrespecting work; making more mistakes; lacking energy; using work to block out unhappiness, pain, and discontent; and losing interest.

Emotional competence includes the process of constant questioning of the self: Do the demands of the work or other factors suggest

Behavior	Study 1[a]	Study 2[b]	Study 3[c]
Crying in the presence of a client	56.5		
Telling a client that you are angry at him or her	89.7	77.9	
Raising your voice at a client because you are angry at him or her			57.2
Having fantasies that reflect your anger at a client			63.4
Feeling hatred toward a client			31.2
Telling clients of your disappointment in them	51.9		
Feeling afraid that a client may commit suicide			97.2
Feeling afraid that a client may need clinical resources that are unavailable			86.0
Feeling afraid because a client's condition gets suddenly or seriously worse			90.9
Feeling afraid that your colleagues may be critical of your work with a client			88.1
Feeling afraid that a client may file a formal complaint against you			66.0
Using self-disclosure as a therapy technique	93.3		
Lying on top of or underneath a client			0.4
Cradling or otherwise holding a client in your lap		8.8	
Telling a sexual fantasy to a client			6.0
Engaging in sexual fantasy about a client	71.8		
Feeling sexually attracted to a client	89.5		87.3
A client tells you that he or she is sexually attracted to you			73.3
Feeling sexually aroused while in the presence of a client			57.9
A client seems to become sexually aroused in your presence		48.4	
A client seems to have an orgasm in your presence			3.2

Table 4.1. Intense Emotion and Other Reactions in Therapy (in percentages).

[a] A national survey of one thousand psychologists with a 46 percent return rate.

[b] A national survey of forty-eight hundred psychologists, psychiatrists, and social workers with a 49 percent return rate.

[c] A national survey of six hundred psychologists with a 48 percent return rate.

Sources: Study 1 adapted from Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, P. (1987). Ethics of practice: The beliefs and behaviors of psychologists as therapists. *American Psychologist, 42*, 993–1006. Study 2 adapted from Borys, D. S., & Pope, K. S. (1989). Dual relationships between therapist and client: A national study of psychologists, psychiatrists, and social workers. *Professional Psychology: Research and Practice, 20*, 283–293. Study 3 is adapted from Pope, K. S., & Tabachnick, G. B. (1993). Therapists' anger, hate, fear and sexual feelings: National survey of therapists' responses, client characteristics, critical events, formal complaints and training. *Professional Psychology: Research and Practice, 24,* 142–152. Copyright 1987, 1993, 1993 by the American Psychological Association. Adapted with permission.

Type of Abuse	Men	Women
Abuse during childhood or adolescence		
Sexual abuse by relative	5.84	21.05
Sexual abuse by teacher	0.73	1.96
Sexual abuse by physician	0.0	1.96
Sexual abuse by therapist	0.0	0.0
Sexual abuse by nonrelative (other than those previously listed)	9.49	16.34
Nonsexual physical abuse	13.14	9.15
At least one of the above	26.28	39.22
Abuse during adulthood		
Sexual harassment	1.46	37.91
Attempted rape	0.73	13.07
Acquaintance rape	0.0	6.54
Stranger rape	0.73	1.31
Nonsexual physical abuse by a spouse or partner	6.57	12.42
Nonsexual physical abuse by an acquaintance	0.0	2.61
Nonsexual physical abuse by a stranger	4.38	7.19
Sexual involvement with a therapist	2.19	4.58
Sexual involvement with a physician	0.0	1.96
At least one of the above	13.87	56.86
Abuse during childhood, adolescence, or adulthood	*32.85*	*69.93*

Table 4.2. Percentages of Male and Female Therapists Reporting Having Been Abused.

Source: From Pope, K. S., & Feldman-Summers, S. (1992). National survey of psychologists' sexual and physical abuse history and their evaluation of training and competence in these areas. *Professional Psychology: Research and Practice, 23*, 353–361. Copyright 1992 by the American Psychological Association. Adapted with permission.

that the therapist needs therapy in order to maintain or restore emotional competence? For many of us, creating self-care strategies that fit us as unique individuals and that sustain, replenish, and give meaning are an essential part of our work to maintain competence (see Chapter Five), particularly to maintain *emotional competence for therapy* (Pope & Brown, 1996; Pope, Sonne, & Greene, 2006).

The psychology profession now acknowledges the ethical aspects of self-care. General Principle A, Beneficence and Nonmaleficence, and Standard 2.06 of the APA Ethics Code (American Psychological Association, 2002) encourage psychologists to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work. The Canadian Code of Ethics for Psychologists, Standards II.11 and II.12 (Canadian Psychological Association, 2002), similarly encourages psychologists to seek appropriate help, discontinue scientific or professional activity, and engage in self-care activities that help to avoid or ameliorate conditions that could result in impaired judgment.

Table 4.3 presents the results of a national study of therapists as therapy patients (Pope & Tabachnick, 1994). Eighty-four percent of the therapists in this study reported that they had been in personal therapy. Only two indicated that the therapy was not helpful, but about a fifth (22 percent) reported that their own therapy included what they believed to be harmful aspects (regardless of whether it also included positive aspects).

This research suggests that most therapists experience, at least once, intense emotional distress. Over half (61 percent), for example, reported experiencing clinical depression. Over a fourth (29 percent) reported suicidal feelings, and 3.5 percent reported attempting suicide. About 4 percent reported having been hospitalized. Readers may wish to consider their own experiences in the light of these findings.

Emotional competence in therapy is no less important than intellectual competence, and it is for that reason that we have included, beginning with Chapter Ten, specific clinical scenarios at the end of each chapter. These scenarios describe hypothetical situations that this book's readers might encounter. Each is followed by a handful of questions designed to provide practice in the processes of the critical thinking explored in detail in Chapter Two. The first question in each sequence is a variant of, "What do you feel?" An honest recognition of the emotional response to clinical situations is an important aspect of emotional competence.

To the extent that these scenarios and questions form the basis of class or group discussion in graduate school courses, internships, inservice training, continuing education workshops, or other group settings, their value may be in direct proportion to the class's or group's ability to establish a genuinely safe environment in which participants are free to disclose responses that may be politically incorrect, emotionally incorrect, or otherwise at odds with group norms or with what some might consider the "right" response. Only if participants

Item	Never	Once	Rarely	Sometimes	Often
In your own personal therapy, how often (if at all) did your therapist (N = 400):					
Cradle or hold you in a nonsexual way	73.2	2.7	8.0	8.8	6.0
Touch you in a sexual way	93.7	2.5	1.8	0.3	1.0
Talk about sexual issues in a way that you believe to be inappropriate	91.2	2.7	3.2	0.5	1.3
Seem to be sexually attracted to you	84.5	6.2	3.5	3.0	1.5
Disclose that he or she was sexually attracted to you	92.2	3.7	1.0	1.3	0.8
Seem to be sexually aroused in your presence	91.2	3.7	2.2	0.8	1.3
Express anger at you	60.7	14.3	16.8	5.7	1.8
Express disappointment in you	67.0	11.3	14.8	4.7	1.3
Give you encouragement and support	2.5	0.8	6.2	21.8	67.5
Tell you that he or she cared about you	33.7	6.7	19.5	21.8	16.3
Make what you consider to be a clinical or therapeutic error	19.8	18.0	36.2	19.0	5.5
Pressure you to talk about something you didn't want to talk about	57.5	7.5	21.3	8.8	4.0
Use humor in an appropriate way	76.7	8.8	10.0	2.2	1.5
Use humor in an inappropriate way	5.2	2.5	12.5	35.0	43.5
Act in a rude or insensitive manner toward you	68.7	13.0	12.0	4.0	1.5
Violate your rights to confidentiality	89.7	4.5	2.7	1.3	1.8
Violate your rights to informed consent	93.2	3.2	1.3	0.3	0.3
Use hospitalization as part of your treatment	96.2	1.8	0.5	0.5	1.0

Table 4.3. Therapists' Experiences as Therapy Patients.

Item	Never	Once	Rarely	Sometimes	Often
In your own personal therapy, how often (if at all) did you (N = 400):					
Feel sexually attracted to your therapist	63.0	8.0	14.0	7.5	6.5
Tell your therapist that you were sexually attracted to him or her	81.5	6.2	5.5	3.0	2.7
Have sexual fantasies about your therapist	65.5	8.0	12.8	7.0	5.2
Feel angry at your therapist	13.3	9.5	32.7	28.5	15.0
Feel that your therapist did not care about you	49.5	13.0	19.0	12.3	5.5
Feel suicidal	70.0	8.5	9.5	8.3	3.0
Make a suicide attempt	95.5	2.5	1.0	0.0	0.0
Feel what you would characterize as clinical depression	38.5	15.8	16.0	16.5	12.5

Table 4.3. (*continued*)

Note: Rarely = two to four times; sometimes = five to ten times; often = over ten times.

Source: From Pope, K. S., & Tabachnik, B. G. (1994). Therapists as patients: A national survey of psychologists' experiences, problems, and beliefs. *Professional Psychology: Research and Practice, 25,* 247–258.

are able to speak honestly with each other about responses that they might be reluctant to speak aloud in other settings and to discuss such responses with mutual respect will the task of confronting these questions likely prove helpful in developing emotional competence (Pope et al., 2006).

Learning to discuss these sensitive topics and individual responses with others is important not only in developing our own emotional competence but also in developing resources for maintaining our competence throughout our careers (see Pope et al., 2006, for more thorough discussion of understanding taboos that hurt therapists and clients). Our colleagues constitute a tremendous resource for helping us to avoid or correct mistakes, identify stress or personal dilemmas that are becoming overwhelming, and provide fresh ideas, new perspectives, and second and third opinions. A national survey of psychologists, in fact, found that therapists rated informal networks of colleagues as the most effective resource for prompting effective, appropriate, and ethical practice (Pope, Tabachnick, & Keith-Spiegel, 1987). Informal networks were seen as more valuable in promoting ethical practice than laws, ethics committees, research, continuing education programs, or formal ethical principles. Our colleagues can help sustain us, replenish us, enrich our lives, and play an important role in our self-care, the focus of the next chapter.

CHAPTER FIVE

Creating Strategies for Self-Care

A major theme of this book is personal responsibility. We are personally responsible for our ethical decisions, our actions, and the times we choose to remain silent and do nothing. We cannot hand over responsibility for what we do or fail to do to an ethics code, our colleagues, our government, our employer, an insurance company, a managed care organization, a professional association, or any other source outside ourselves. Ethics is an active process that involves increasing awareness and constant questioning. Few of us can engage in this process effectively if we are personally drained, overwhelmed, or demoralized. Self-care is crucial.

We strongly recommend creating strategies for self-care as early as possible in your education, training, and practice. Neglecting self-care early on can drain the enthusiasm, joy, resilience, and meaning out of a career, sometimes interfering with the therapist's ability to practice ethically. It can lead to discouragement, compassion fatigue, and burnout.

WHAT HAPPENS WHEN SELF-CARE IS NEGLECTED

Neglecting self-care can have corrosive consequences for the therapist and the work. Every psychologist is unique in important ways, does work that is unique in important ways, and experiences the effects of neglecting self-care in a personal way. Yet some themes appear often. Each of the following may be a consequence of, intensified by, or a reflection of neglecting self-care, though each, of course, may have other causes.

Disrespecting Clients

Therapists who have become overwhelmed by their work may begin disrespecting their clients, talking about them in ways that are demeaning and lack fundamental respect. They may begin to spend time complaining about how unmotivated, ungrateful, selfish, insensitive, dishonest, lazy, and generally undesirable their clients are. They may become judgmental and critical toward their clients, losing empathy, kindness, and connection. They may begin dehumanizing their clients, referring to them only by labels (for example, “that schizo”). They may begin telling jokes at their clients’ expense and ridiculing them in other ways.

Disrespecting Work

Therapists who become depleted and discouraged through lack of self-care may trivialize, ridicule, or become overly self-critical about what they do. They may speak of therapy as a charade, a fraud, or a joke. They may view their work as empty, ineffective, and meaningless. They may repeatedly show up late for sessions, decide to skip some scheduled sessions altogether, or fail to return clients’ telephone calls.

Making More Mistakes

Despite our best efforts, we all make mistakes. Monitoring, acknowledging, accepting responsibility for, and attempting to address the consequences of our mistakes is one of our fundamental responsibilities as therapists. But self-neglect can lead to impaired ability to attend to work. We may begin making more and more mistakes. We find ourselves scheduling two clients at the same time, forgetting to show up for an appointment, calling a client by the wrong name, misplacing a client's chart, or locking ourselves out of our own office.

Lacking Energy

Therapists who are not taking care of themselves may run out of energy and find themselves without adequate sources of rest and renewal. They may wake up tired, barely find the will to drag themselves out of bed and to work, fight to stay awake and alert during a session, wonder how they will ever make it through the rest of the work day, leave work—*finally!*—too exhausted to socialize or do anything fun, and face the prospect of going to bed only to start the grueling process again.

Becoming Anxious and Afraid

If we fail to care for ourselves, we may fall victim to exaggerated fear and anxiety. We begin to feel that we are no longer up to dealing with the uncertainties, challenges, demands, and stresses of practice. What if our referral sources all dry up and our current clients terminate? Did we bungle that last assessment, wind up with the wrong diagnosis, and miss crucial aspects of what is going on with the client? Did we say the wrong thing when responding to a suicidal crisis, and will that person commit suicide before the next session? What if that agitated client becomes violent during a session? What if someone files a malpractice suit and a licensing complaint?

Using Work to Block Out Unhappiness, Pain, and Discontent

If our self-care has been neglected and work no longer brings meaning or satisfaction to our lives, one self-defeating response is to try to lose ourselves and our uncomfortable feelings in work—wall-to-wall work. More and more clients, projects, and responsibilities are taken on until there is little, if any, free time to reflect on our lives, spend time alone apart from work, or become aware of how empty, demoralized, or miserable we are. There are some therapists and counselors who work long hours and revel in it, deriving great joy and fulfillment, but the pattern here is different: filling the time with work brings little that is positive to the self except for its ability to distract attention from an unfulfilling life. Work is only one of the resources (others are food, alcohol, and drugs) that people may use to block out the results of neglected self-care.

Losing Interest

Neglect of self-care may lead to an empty professional life that is no longer a source of excitement, joy, growth, meaning, and fulfillment, and as a consequence, we may lose interest in it. We no longer feel the investment in the work and the connection to our clients. We go numb and try to function as much as possible on automatic pilot. We go through the motions, forcing ourselves to do as good a job as we can, but our heart is no longer in it.

MAKING SURE THE STRATEGIES FIT

Goodness of fit is as important in self-care strategies as it is in clothes. Making or buying clothes that fit our friends, or that fit the "average" person, or are the most popular sizes is unlikely to be a good approach to finding clothes that fit us. Using self-care strategies that are lifesavers for our colleagues may make us miserable. What sustains, replenishes, and gives meaning to an individual may flow far from the mainstream. Few us would advise someone who has found happiness, significance, and contentment in choosing a solitary monastic life with vows of silence and poverty, "You know, you really ought to get out and socialize more, and find ways to earn some money so that you'll have a nest egg you could rely on. I know you'd feel better about yourself and have a better life!"

Listening to ourselves, experimenting, being honest with ourselves about what works and what does not are part of creating self-care strategies that fit us as individuals. Although there is no one-size-fits-all to any self-care strategy, here are a few of the challenging areas that many therapists contend with in making sure that they are taking good care of themselves.

Isolation

A solo practice can be isolating by its very nature. We spend our days in our own office, seeing client after client. Especially if we work long hours, we can lose touch with our friends, colleagues, and the world beyond our office building. Even during those times when we do not have a patient scheduled, there are always charts to update, bills to prepare, work-related telephone calls to make, and so on. Some therapists find it helpful to place strict limits on the time they spend in their office and formally schedule activities that bring them out of isolation. Creating ways to stay connected to others seems to be one of the most basic, important, and helpful self-care strategies for many therapists.

Monotony

Even when we limit our time with clients to, say, thirty to thirty-five hours a week, spending so much time seeing clients can be too much for some therapists. Some may begin to seek out other kinds of work to break up their days and provide variety: teaching a course; consulting; leading a supervision group; getting active in local, state, regional, or national professional organizations.

Fatigue

How much time do you need between clients: Five, ten, or fifteen minutes? How many clients can you see in a row without needing a longer break of at least an hour or more? How many clients can you see in the course of a day without feeling so depleted that the quality of your work falls toward the end of the day? Therapists differ greatly in these areas. Some can work four consecutive fifty-minute sessions with a ten-minute break between each, take an hour off for lunch, and return for another four consecutive sessions without any significant lapse in their enthusiasm or competence. Others may find that they can provide adequate services to no more than five clients each day. It's important to know and respect our personal limits. Some consider twenty-five to thirty client-hours a week to be full time because of the additional hours needed to keep clinical records, return telephone calls, and so on.

Part of self-care in this area is being realistic about the workload that we can handle well and to create a schedule that accommodates our capacities. The focus must remain on the amount of work that we can do well, not the amount that we feel we should do, or used to be able to do, or that some of our colleagues can do. Sometimes there is a conflict between the number of hours we can do good work with clients and the number of hours we believe we must spend with clients in order to pay the bills, develop our practice, or please our employer.

Effective self-care strategies not only influence our patterns of breaks—everything from the breaks we take between sessions to our vacations—but also emphasize activities, attitudes, and approaches that help us recover from fatigue, that replenish and renew us.

The Sedentary Life

Psychological assessment and therapy is usually—but not always—done while the client is sitting (or lying down) and the psychologist is sitting, neither of them moving around much. For many therapists, self-care includes creating opportunities during the day for moving, stretching, and physical exercise. Physical exercise is a major self-care strategy for many therapists, not only for its physical benefits and its contrast with the sedentary nature of their work but also for its psychological benefits (see, for example, Hays, 2002).

The Dispirited Life

If a psychology practice does not provide enough physical movement and exercise for many therapists, it may also fail for many to nurture the life of the spirit adequately. Setting aside adequate time and opportunity for meditation, prayer, and other spiritual or religious practices can be an important aspect of self-care for some therapists. Some find that such diverse activities as reading or writing poetry, hiking through the woods, playing or listening to music, sitting on the river bank, acting in or viewing a play, or watching a sunset help nourish their spiritual lives.

The Unsupported Life

Graduate schools and internships place us in a network of professors, supervisors, administrators, and other students. Facing a challenge, we can talk it over with teachers and classmates. Our clinical work is closely monitored, and we receive positive and negative feedback, ideas, suggestions, and guidance. When we start an independent practice, the responsibility to create that network of support falls to us. What are some important components of a support network?

SUPERVISION, CONSULTATION, AND ADDITIONAL TRAINING Identify or create resources for talking over your work, expanding your knowledge and skills, and continuing to grow as a psychologist. Is there someone you would like to hire to provide you with supervision or consultation? Would you like to create a peer-supervision group that meets on a regular basis? What continuing education courses, workshops, and other activities would you find helpful in updating and expanding your knowledge and improving your skills? Consider what other sources of support you'll need to practice effectively.

ACCOUNTANT We recommend that all practitioners find and begin working with an accountant they can trust, reviewing your business plan, looking at your current financial resources, and advising you on tax matters. The accountant will be able to discuss issues such as the pros and cons of incorporation, what expenses will be deductible, procedures for keeping records and receipts for tax purposes, and comparing the relative financial merits of a home office compared to a separate office.

BILLING/BOOKKEEPER Many practitioners do their own billing and bookkeeping. If you choose this route, you might look into software programs that can help with these tasks. Other clinicians prefer not to take on this additional administrative task. Instead, they hire an individual or company to do their bookkeeping and billing. Some communities have services that specialize in this area for psychotherapists or for health care providers more generally. Check with colleagues to see who they use and recommend.

PSYCHOPHARMACOLOGY RESOURCES Unless you are able to prescribe medications, find someone skilled in psychopharmacology who will work collaboratively with you and your patients. Some patients, of course, do not need psychotropic medications, and others may come to you already taking medications prescribed by someone else. And some patients you may wish to refer to a psychopharmacologist with prescription authority for an evaluation to see if medications might be helpful.

EMERGENCY AND HOSPITALIZATION RESOURCES What are the emergency, inpatient, day treatment, and similar mental health services available in your community? How much do they cost, and what are their admission criteria? Visit them, and introduce yourself to the staff and administration. Find out what their policies and procedures are and if you are eligible for staff privileges. If one of your clients needs hospitalization or other crisis services, you will be familiar with what options are available and what steps need to be taken. Some clinicians include a telephone number for emergency services on their answering machine's outgoing message; others include it on their informed consent form.

MANDATORY AND DISCRETIONARY REPORTING RESOURCES Find the contact information for the agencies to which you would file mandatory or discretionary reports of such matters as suspected child abuse or elder abuse. There may be times when you are unsure of whether you are obligated to file a report. One of the sources of consultation you can draw on at such times is the agency to which you would file the report. You can call and, without disclosing any identifying information about the actual people involved, provide the agency with a hypothetical situation and ask if such a fact pattern falls under the duty to report (and then document that consultation as one of the steps you took to decide whether to report). You may also call your attorney or your professional liability carrier for guidance.

ATTORNEY We strongly recommend finding an attorney experienced in mental health issues in your jurisdiction as early as possible in your career. He or she can review your forms, policies, and procedures; answer your questions about legal requirements and pitfalls; and be a telephone call away if you are in the midst of responding to an urgent situation and need legal advice.

Neglected Health

Moving from a graduate school environment that often includes a student health service and health coverage to being suddenly out on our own in independent practice or into organizational employment that offers little or no health coverage makes it easy to neglect our health and medical needs. It becomes our responsibility to find affordable health care coverage well matched to our individual needs and a competent physician whom we trust. Medical insurance can be obtained from a variety of sources, including professional organizations, self-employment associations such as the National Association for the Self-Employed, and some local associations such as the local chamber of commerce. Colleagues and local insurance brokers may be good sources of information.

The Stressed or Distressed Life

Therapists may experience periods of extreme unhappiness and distress. Some of the themes in Chapter Four are worth reviewing here. In one national study of therapists' accounts of their own experiences as therapy patients (Pope & Tabachnick, 1994), of the 84 percent of the therapists who had been in therapy, 61 percent reported experiencing at least one episode of what they termed clinical depression, 29 percent reported having felt suicidal, and 4 percent reported having attempted suicide.

Practice itself may be stressful. In another national study of practicing therapists (Pope & Tabachnick, 1993), 97 percent reported fearing that a client would commit suicide, 91 percent reported fearing that a client would get worse, 86 percent reported fearing that a client would need clinical resources that are unavailable, 89 percent reported fearing that client would attack a third party, 88 percent reported fearing that colleagues would be critical of their work with a patient, 83 percent reported fearing being attacked by a patient, and 18 percent reported having been attacked by a patient. Over half reported having been so afraid about a client that it affected their eating, sleeping, or concentration. About 12 percent reported that a client had filed a formal complaint (for example, about malpractice or licensing) against them. Over 3 percent had obtained a weapon to protect themselves from a patient.

Anger was another major theme of the study. For example, 81 percent reported anger at a client who was verbally abusive at them, 83 percent reported anger at a client because of unpaid bills, and 46 percent reported having become so angry at a patient that they did something that they later regretted.

Effective self-care strategies take realistic account of both how stressful doing therapy can be and how distressed we can become. What resources can we develop and use to cope with the stresses of our work? How can we address our own distress, seek professional help if we need it, and become aware if we reach a point of being too distressed or impaired to work effectively?

THE NEED FOR CHANGE

Self-care strategies that support, strengthen, deepen, replenish, and enliven may, less than a year later, become a senseless obligation, distraction, and waste of time. Therapists who focus on the subtle, sweeping, and profound changes in their clients' lives may sometimes overlook changes in their own lives and how these changes can affect self-care needs and strategies. Effective self-care includes monitoring the ways in which our needs for self-care can change over time, calling us to create new strategies.

CHAPTER SIX

Creating a Professional Will

Unless a therapist is invulnerable and immortal, it is a good idea to prepare a professional will. One focus of this book is the therapist as human. Part of our humanity is our mortality and our vulnerability. Unpleasant as it is to think about, all of us are vulnerable to the unexpected. At any time a drunk driver, a stroke, a mugging, a heart attack, a fire, a plane crash, and countless other misfortunes may bring our life to a sudden and unexpected end. It is an ethic of both personal and professional responsibility to take our mortality and vulnerability into account in our planning.

A professional will is a plan for what happens if you die suddenly or are incapacitated (for example, by falling into a coma) without warning. It helps those whom you designate to respond promptly and effectively to the needs of your clients and to the unfinished business of your business. It gives others the basic information and guidance that can be so hard to come by at a time of shock and mourning.

We recommend that therapists prepare a professional will as early as possible in their careers. We cannot schedule our personal misfortunes or postpone accidents so that they happen only later in our careers. Our professional responsibilities include preparing for the possibility that something may happen to us—taking away our ability to function adequately—at any time and without warning.

There is no one-size-fits-all professional will that works well with every therapist and counselor, every kind of practice, and every situation, but here we provide some items and issues that are useful to address.

THE PERSON DESIGNATED TO ASSUME PRIMARY RESPONSIBILITY

Who would respond effectively in the event that you suddenly die or are incapacitated? Who can make necessary arrangements in a time of great stress; take care of matters sensitively, efficiently, and effectively; and make sure nothing important is overlooked? Who is the best person to talk to many, if not all, of your clients?

A good professional will clearly designates a qualified person to serve as the executor of the professional will and explicitly authorizes that individual to carry out the tasks that the will specifies.

It is useful to provide adequate information about how the designee can be contacted in the event of your sudden death or incapacitation. What are the person's telephone, fax, and pager numbers? What are the person's office and e-mail addresses? Are there others likely to know where the person is if he or she proves hard to reach?

THE PEOPLE SERVING AS BACKUPS

Life tends to be full of surprises and sometimes hesitates to cooperate with our plans. At the time he or she needs to step in and take charge, the person you designated to assume primary responsibility may be overseas at a conference or on vacation, may be attending to a family emergency, or may be seriously ill or otherwise unavailable. It is important to have a second and third designee, each ready to step in if necessary.

COORDINATED PLANNING

Coordinated planning can make for a much more useful professional will and make it easier for the executor to carry it out. You can meet with your primary designee and both backups to outline what you want done, what needs to be done, and what information the designee will need. One person may think of something that the others have overlooked, and what may seem to the therapist writing the will to "go without saying" ("You all know that bookshelf where I keep my appointment book, don't you?") may need clarification for the will's executor.

If the designees have trouble relying on a verbal description of where something essential is, they can be shown. They can be introduced to the people they will need to work with (for example, your secretary, the executor of your personal will, your accountant, your attorney, your office landlord) and exchange contact information with them. If the time comes that the designee must take charge, he or she will have detailed instructions and information in your professional will and will also know the rationale for each step (having been involved in the planning process), will know the key people to work with, and will know where the records and other materials are.

YOUR OFFICE, ITS KEY, AND ITS SECURITY

In addition to providing your office address, it is helpful to be as specific as possible about where each key to your office can be found—for example, "There are four copies of the key to my office. One is on the key ring that I always carry with me. It is the key with the blue plastic on it. My partner, whose contact information is . . . , also has a key to the office. My secretary, whose contact information is . . . , has a key. The building manager, who can be contacted in an emergency at . . . , has a key."

There may be separate keys for each of the consulting room doors, the storage room, the filing cabinets, the desks, the computer, and the door to the building itself. It is easy to overlook a key that someone will find essential to fulfilling the responsibilities outlined in your professional will.

Some offices have a security system that requires a code. Be sure to specify the necessary codes and instructions and where the system is located.

YOUR SCHEDULE

Where is your schedule kept: in a daily planner you keep with you, an appointment book at the office, on your computer or personal digital assistant? Once the record of your scheduled appointments is located, is there additional information needed to access it? For example, if you keep your schedule on your computer, what passwords are used to log on and access the schedule, where on the drive is the schedule kept, what are the names of the relevant files, and is there a backup somewhere if the copy on your computer has become corrupted or if the computer itself is unavailable (for example, destroyed in an office fire or earthquake or stolen)?

AVENUES OF COMMUNICATION FROM CLIENTS AND COLLEAGUES

How do clients and colleagues contact you: answering machine, e-mail, other methods? Clearly describe each and how the person implementing your professional will can access the messages. What codes are used to retrieve messages from your answering machine? What are the names of any relevant e-mail accounts along with the user name, password, server address for receiving and sending mail, and so on?

CLIENT RECORDS AND CONTACT INFORMATION

Depending on the method of notification you choose, the person implementing your professional will may need to initiate contact with your clients. He or she may also need to return calls from clients whose message lacks a return number. A professional will must include clear instructions about how to locate and access client records and contact information. The ability to locate treatment records promptly may become exceptionally important because the sudden death of a therapist may trigger a crisis for some clients. The professional will should also designate whether the person implementing it or someone else will maintain the client records of the incapacitated or deceased therapist. This information can be announced in the local newspapers or filed with the state psychology licensing board and state psychological association, or both.

CLIENT NOTIFICATION

Therapists may choose one or more methods to notify clients of a therapist's death, such as calling each client, placing a notice in the local newspaper, changing the outgoing message on the answering machine to include the announcement, changing the answering machine message to ask clients to call the clinician who is implementing the deceased therapist's professional will, and sending letters. It is worth spending some time considering the potential impact of each method and considering it in terms of the Golden Rule—Would any of us want to learn of our own therapist's or clinical supervisor's death by reading about it in the newspaper or hearing a recorded announcement on an answering machine?—and of how each of our current and former clients might respond. Are there resources that clients might find helpful in these circumstances (for example, designated colleagues who will make appointments available to your clients to help them deal with the immediate consequences and, if the clients choose, to locate subsequent therapists). You will have a good sense of which approaches will work best for your individual practice and the relationship you have with your clients.

It is important that the notification be made in a way that respects each client's right to privacy. Letters and telephone messages that are not carefully handled can lead unintentionally to the disclosure to third parties that a person is seeing a therapist. Family members and others may not always respect the privacy of someone's mail and may, perhaps "accidentally," open and read mail that is not addressed to them. A telephone message left on an answering machine can sometimes be heard by those for whom it was not intended. In some cases, such unintentional disclosures can place a client at great risk. The abusive partner, for example, of a client who sought therapy because she is a battered woman may become enraged at finding out, through an intercepted letter or telephone message, that the client has sought help and may react violently, perhaps lethally.

COLLEAGUE NOTIFICATION

What colleagues should be notified immediately? Are you a member of a group practice, or do you share a suite of offices? Are there clinicians who provide consultation or supervision to you on a regular basis or clinicians who receive those services from you? Do you colead a therapy group or family sessions with anyone? Are there conferences where you regularly present or workshops that you present on a regular basis? It can be helpful to look over the listings in your scheduling book for a few months to ensure that you do not overlook any colleagues who should be listed (along with contact information) in your professional will for immediate notification.

PROFESSIONAL LIABILITY COVERAGE

It is useful to include the name of the company providing professional liability coverage, contact information, the policy number, and instructions for the company to be notified immediately on the therapist's death or incapacity.

ATTORNEY FOR PROFESSIONAL ISSUES

Many therapists have consulted an attorney for professional issues. The attorney might have reviewed the therapist's office forms (informed consent, release of information, and others) to ensure that they conform to state legislation and case law requirements. The attorney might have discussed the therapist's policies and procedures, format for keeping records, or particularly troublesome cases that raised puzzling legal questions. The therapist might have sought legal consultation about how to respond to a subpoena or legal representation in a malpractice suit. It is useful to provide contact information for an attorney whom the therapist consults for practice issues.

BILLING RECORDS, PROCEDURES, AND INSTRUCTIONS

The person whom the professional will designates to take charge will need to know where the billing records are, how to access them (for example, if they are maintained by computer software), who prepares and processes the bills (for example, a billing service, accountant, or office clerical worker), and how pending charges are to be handled.

Some therapists may be both financially able (they have no large outstanding debts and there are adequate funds for their financial dependents) and desirous to forgive part or all of any remaining unpaid bills that were to be paid out of their clients' own pockets by excluding due or overdue payments from insurance companies. Some may wish to provide a session—at the deceased therapist's expense—for each client, during which the clinician serving as executor of the professional will would work with the client to discuss the situation, assess current needs, and explore options for future therapy. The professional will should include explicit instructions about any such wishes.

EXPENSES

How have the therapist preparing the professional will and the person designated to serve as professional executor decided that the executor will be compensated? Perhaps the easiest arrangement is at the executor's customary hourly rate, but other approaches can be used—for example, a flat fee, a token payment, the executor declining any compensation for rendering this service to a friend, or a contribution to a charity chosen by the executor.

A professional will needs to include clear instructions about how all business-related expenses are to be paid.

YOUR PERSONAL WILL

To avoid unintended problems and conflicts, it is helpful to review both your professional will and your personal will side by side to ensure that they are consistent. If a personal will, for example, directs all assets to be disbursed in a certain way but makes no mention of funds to be used to pay the executor of your professional will, problems can arise. It is useful if each will makes explicit reference to the other.

LEGAL REVIEW

Review of the professional will by an attorney skilled and experienced in mental health law can prevent numerous problems. The executor of the professional will can consult with the attorney should any legal quandaries arise in the days, weeks, and months after the therapist's death.

The attorney can advise on whether, in the light of state legislation and case law, the professional will is best authenticated simply by the signatures of disinterested witnesses, the seal of a notary, or other means.

COPIES OF THE PROFESSIONAL WILL

Copies of your professional will can be given to those designated as potential executors and to your attorney. Some therapists may consider making special arrangements to ensure the executor's access to such information as their passwords for retrieving e-mail and answering machine messages only after their death to avoid having this confidential information in multiple copies of the will distributed to others.

REVIEW AND UPDATE

People, practices, times, and situations change. A professional will that is perfectly suited to us when we draw it up may have out-of-date contact information and aspects that do not fit us well at all just a year or two later. It is helpful to review a professional will on a regular basis—say, once a year—and make an immediate update whenever there is a significant change in our circumstances.

CHAPTER SEVEN

Codes and Complaints in Context

Historical, Empirical, and Actuarial Foundations

As psychotherapists and counselors, we are members of the mental health profession. Exactly what we profess has been the subject for debate from the beginning. We have a hard time defining what we do.

The Boulder Conference tried to define psychotherapy so it could be effectively taught to clinical and counseling psychologists. Carl Rogers, president of the American Psychological Association in 1947,

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We greatly appreciate the extraordinary help we received from the following people who provided the actuarial data that are key to this chapter and who reviewed early drafts: the Ethics Office staff, including Steve Behnke, executive director, American Psychological Association (APA) Ethics Office; Stanley Jones, former executive director, APA Ethics Office; Debbie Felder, APA Ethics Code revision coordinator; Steve DeMers, executive director, Association of State and Provincial Psychology Boards; Bruce Bennett, CEO, APA Insurance Trust; John Service, executive director, Canadian Psychological Association (CPA); Daniel Berman, manager of Communications, CPA; and Barry Gang, director of investigations and hearings, College of Psychologists of Ontario.

appointed David Shakow to chair a committee on defining and teaching psychotherapy. The Shakow report, adopted at the 1947 APA convention, resulted in the Boulder Conference two years later. On August 28, 1949, the recorder for the Boulder task force for defining psychotherapy and setting forth criteria for adequate training provided the following summary: "We have left therapy as an undefined technique which is applied to unspecified problems with a nonpredictable outcome. For this technique we recommend rigorous training" (Lehner, 1952, p. 547).

Since the Boulder Conference, other conferences and various groups have tried to define psychotherapy and the practice of psychology. The *2002 Competencies Conference: Future Directions in Education and Credentialing in Professional Psychology* (Kaslow et al., 2004), for example, identified competencies in professional psychology and discussed effective strategies for teaching and assessing these competencies (Kaslow, 2004).

Forces outside the profession have also influenced practice. For example, managed care companies may require a diagnosis from a specific manual, may limit or deny assessment and therapy sessions, may require therapists to document that therapy is a matter of medical necessity, may require specific interventions for particular disorders, and may require that outcome be measured using a limited number of criteria defined by the company. Not surprisingly, these measures—often described as cost cutting—can create conflict between company administrators and therapists (Reed & Eisman, 2006).The requirement by some managed care companies that only certain interventions be used for particular diagnoses highlights a controversy within the profession: Should the definition and practice of psychotherapy be limited to interventions that have been supported by research and, if so, what kind of research is sufficient? Must the supportive research, for example, use random assignment in a double-blind model, be published in peer-reviewed journals, and be independently replicated by other researchers? Westen and Bradley (2005) note that "evidence-based practice is a construct (i.e., an idea, abstraction, or theoretical entity) and thus must be operationalized (i.e., turned into some concrete form that comes to define it). The way it is operationalized is not incidental to whether its net effects turn out to be positive, negative, or mixed" (p. 226; see also Westen, Novotny, & Thompson-Brenner, 2004). Psychotherapy researchers Crits-Christoph, Wilson, and Hollon (2005) believe that "randomized controlled trials remain the most powerful way to test notions of causal agency" (p. 412). On the other hand, Kazdin (2006), previous editor of the Association for Psychological Science's journal, *Current Directions in Psychological Science,* wrote: "Psychotherapy outcome research has been dominated by randomized controlled trials. . . . However, pivotal features of these trials make them not very relevant for clinical practice" (p. 170; see also Goodheart, 2006; Sternberg, 2006).

The American Psychological Association (2006) Presidential Task Force on Evidence-Based Practice noted both the limits of clinical hypothesis testing and need for clinical expertise:

> Yet clinical hypothesis testing has its limits, hence the need to integrate clinical expertise with the best available research. Perhaps the central message of this task force report—and one of the most heartening aspects of the process that led to it—is the consensus achieved among a diverse group of scientists, clinicians, and scientist-clinicians from multiple perspectives that EBPP [evidence-based psychology practice] requires an appreciation of the value of multiple sources of scientific evidence. In a given clinical circumstance, psychologists of good faith and good judgment may disagree about how best to weigh different forms of evidence; over time, we presume that systematic and broad empirical inquiry—in the laboratory and in the clinic—will point the way toward best practice in integrating best evidence. What this document [*Report of the APA Presidential Task Force on Evidence-Based Practice*] reflects, however, is a reassertion of what psychologists have known for a century: The scientific method is a way of thinking and observing systematically, and it is the best tool we have for learning about what works for whom [p. 282].

MECHANISMS OF ACCOUNTABILITY

Difficulties in defining psychotherapy and psychological practice with precision do not free the profession from the primary responsibility of setting forth its ethics. The hallmark of a profession is the recognition that the work its members carry out affects the lives of their clients, sometimes in an extremely direct, profound, and immediate way. The powerful nature of this influence makes the customary rules of the marketplace (often resting on variations of the principle "Let the buyer beware") inadequate (see Chapter Three). Society asks that the profession set forth a code to which the members of the profession agree to be held accountable. At its heart, this code calls for the professional to protect and promote the welfare of clients and avoid letting the professional's self-interests place the client at risk for harm. In addition to the fundamental code of ethics, there may be codes or statements of the rights of patients (see, for example, American Psychological Association, 1997, reproduced in this book as Appendix E) or of the ethics as applicable in a specific setting such as manages care organizations (see, for example, National Academies of Practice, 1997, reproduced in this book as Appendix F).

Perhaps because society would never put complete trust in professions to enforce their own standards and perhaps because the professions have demonstrated that they, at least occasionally, are less than vigorous, scrupulous, and effective in governing their own behavior, society has established additional means for attempting to ensure that professions meet minimal standards as they carry out their work and that those who are served by professionals are protected from the iatrogenic harm that can result from incompetent, negligent, and unscrupulous practitioners.

Four major mechanisms hold psychotherapists and counselors formally accountable to an explicit set of professional standards: professional ethics committees, state licensing boards, civil (for example, malpractice) courts, and criminal courts. Each of these four mechanisms uses a different formulation of standards, though there may be substantial overlap. Behavior may be clearly unethical and yet not form the basis for criminal charges.

In some cases, psychotherapists and counselors may feel that these different standards clash. They may, for example, feel that the law compels them to act in a way that violates the welfare of the client and the clinician's own sense of what is ethical. A national survey of psychologists found that a majority (57 percent) of the respondents had intentionally violated the law or a similar formal standard because, in their opinion, not to do so would have injured the client or violated some deeper value (Pope & Bajt, 1988). The actions reported by two or more respondents included refusing to report child abuse (21 percent), illegally divulging confidential information (21 percent), engaging in sex with a patient (9 percent), engaging in nonsexual dual relationships (6 percent), and refusing to make legally required warnings regarding dangerous patients (6 percent).

That almost one out of ten of the participants reported engaging in sex with a client (see Chapter Thirteen) using the rationale of patient welfare or deeper moral value highlights the risks, ambiguities, and difficulties of evaluating the degree to which our own individual behavior is ethical. Pope and Bajt (1988) reviewed the attempts of philosophers and the courts to address the issue of the individual's deciding to go against the law. On the one hand, for example, the U.S. Supreme Court emphasized that in the United States, no one could be considered higher than the law: "In the fair administration of justice no man can be judge in his own case, however exalted his station, however righteous his motives, and irrespective of his race, color, politics, or religion" (*Walker* v. *City of Birmingham,* 1967, pp. 1219–1220).

On the other hand, courts endorsed Henry David Thoreau's (1849/1960) injunction that if a law "requires you to be the agent of injustice to another, then . . . break the law" (p. 242). The California Supreme Court, for example, tacitly condoned violation of the law only when the principles of civil disobedience are followed: "If we were to deny to every person who has engaged in . . . nonviolent civil disobedience . . . the right to enter a licensed profession, we would deprive the community of the services of many highly qualified persons of the highest moral courage" (*Hallinan* v. *Committee of Bar Examiners of State Bar,* 1966, p. 239).

A profound decision that confronts each of us is whether to, in essence, take the law into our own hands or to affirm Edmund Burke's (1790/1961) axiom: "One of the first motives to civil society, and which becomes one of its fundamental rules, is, that no man should be judge in his own cause" (p. 71). "Neither stance may seem acceptable to psychologists who believe that compliance with a legal or professional obligation would be harmful, unjust, or otherwise wrong. Absolute compliance connotes a just following orders' mentality all too ready to sacrifice personal values and client welfare to an imperfect system of rules and regulations. Selective noncompliance connotes an association of people who have anointed themselves as somehow above the law, able to pick and choose which legal obligations and recognized standards they will obey" (Pope & Bajt, 1988, p. 828).

As Pope and Bajt note, civil disobedience (Gandhi, 1948; King, 1958, 1964; Plato, 1956a, 1956b; Thoreau, 1849/1960; Tolstoy, 1894/1951) is useful in many contexts for resolving this dilemma. The individual breaks a law considered to be unjust and harmful but does so openly, inviting the legal penalty both to demonstrate respect for the system of law and to call society's attention to the supposedly unjust law. Counselors and therapists, however, often find this avenue of openness unavailable because of the requirement of confidentiality (see Chapter Sixteen). If we as a profession and as individual practitioners are to address the possible conflicts between the law and the welfare of our clients, one of the initial steps is to engage in frequent, open, and honest discussion of the issue. The topic must be addressed in graduate courses, internship programs, case conferences, professional conventions, and informal discussions with colleagues.

The various mechanisms by which psychotherapists and counselors are held accountable for their actions can be a source of confusion for clients, who often lack adequate information about these mechanisms. They may, for example, incorrectly believe that a professional ethics committee has the authority to revoke a license or that a licensing board has the power to expel a practitioner from a professional organization such as the American Psychological Association. The following sections describe the four major mechanisms of accountability.

ETHICS COMMITTEES, CODES, AND COMPLAINTS

Professional associations of therapists and counselors are voluntary organizations; membership is not a state or federal requirement for the practice of the profession. One can, for example, be licensed (by the state) and practice as a psychologist without being a member of the American Psychological Association (APA) or any other association. An association, through its ethics committee, holds its members accountable to the ethical principles it sets forth in the code it has developed. To illustrate how such a code is developed, we will describe how two organizations approached the challenge: the American Psychological Association (which currently has about 150,000 members—90,000 members, fellows, and associates; 52,000 student affiliates; 4,000 international affiliates; and 2,900 teacher affiliates [APA Membership Office, personal communication, May 22, 2006]) and the Canadian Psychological Association (which currently has about 5,458 members, including 3,888 fellows and members, 1,346 student members, 228 honorary life fellows/honorary life members, and 334 "Other" [Canadian Psychological Association, 2006]).

American Psychological Association Approach to an Ethics Code

Founded in 1892 and incorporated in 1925, the APA first formed the Committee on Scientific and Professional Ethics in 1938. As complaints were brought to its attention, this committee improvised solutions on a private, informal basis. There was no formal or explicit set of ethical standards, so all of the committee's work was, of necessity, done on the basis of consensus and persuasion.

A year later, the committee was charged with determining whether a formal code of ethics would be useful for the organization. In 1947, it decided that a formal code of ethics would indeed be useful, stating, "The present unwritten code is tenuous, elusive, and unsatisfactory" ("A Little Recent History," 1952, p. 425). The board of directors established the Committee on Ethical Standards to determine what methods to use in drafting the code. Chaired by Edward Tolman, the committee members were John Flanagan, Edwin Ghiselli, Nicholas Hobbs, Helen Sargent, and Lloyd Yepsen (Hobbs, 1948).

Some members strongly opposed the development of an explicit set of ethical standards, and many of their arguments appeared in *American Psychologist.* Calvin Hall (1952), for example, wrote that any code, no matter how well formulated, "plays into the hands of crooks. . . . The crooked operator reads the code to see how much he can get away with, and since any code is bound to be filled with ambiguities and omissions, he can rationalize his unethical conduct by pointing to the code and saying, 'See, it doesn't tell me I can't do this,' or 'I can interpret this to mean what I want it to mean' " (p. 430). Hall endorsed accountability, but he believed that it could be enforced without an elaborate code. He recommended that the application form for APA membership contain this statement: "As a psychologist, I agree to conduct myself professionally according to the common rules of decency, with the understanding that if a jury of my peers decides that I have violated these rules, I may be expelled from the association" (pp. 430–431). Hall placed most of the responsibility on graduate schools. He recommended that "graduate departments of psychology, who have the power to decide who shall become psychologists, should exercise this power in such a manner as to preclude the necessity for a code of ethics" (p. 431)

The Committee on Ethical Standards determined that because empirical research was a primary method of psychology, the code itself should be based on such research and should draw on the experience of APA members. As Hobbs (1948, p. 84) wrote, the method would produce "a code of ethics truly indigenous to psychology, a code that could be lived." The board of directors accepted this recommendation, and a new committee was appointed to conduct the research and draft the code. Chaired by Nicholas Hobbs, the new committee members were Stuart Cook, Harold Edgerton, Leonard Ferguson, Morris Krugman, Helen Sargent, Donald Super, and Lloyd Yepsen (APA Committee on Ethical Standards for Psychology, 1949).

In 1948, all seventy-five hundred members of the APA were sent a letter asking each member "to share his experiences in solving ethical problems by describing the specific circumstances in which someone made a decision that was ethically critical" (APA Committee on Ethical Standards for Psychology, 1949, p. 17). The committee received reports of over a thousand critical incidents. During the next years, the incidents, with their accompanying comments, were carefully analyzed, categorized, and developed into a draft code.

The emerging standards, along with the illustrative critical incidents, were published in *American Psychologist* (APA Committee on Ethical Standards for Psychology, 1951a, 1951b, 1951c). The standards were grouped into six major sections:

1. Ethical standards and public responsibility
2. Ethical standards in professional relationships
3. Ethical standards in client relationships
4. Ethical standards in research
5. Ethical standards in writing and publishing
6. Ethical standards in teaching

The draft generated considerable discussion and was revised several times. Finally, in 1952, it was formally adopted as the Ethical Standards of Psychologists, and it was published in 1953.

In 1954, information on the complaints that the committee had handled for the past dozen years (during most of which there had been no formal code of ethics) was published in *American Psychologist* ("Cases and Inquiries," 1954). During this period, the ethical principles most frequently violated were

- Invalid presentation of professional qualifications (cited forty-four times)
- Immature and inconsiderate professional relations (twenty-three)
- Unprofessional advertisement or announcement (twenty-two)
- Unwarranted claims for tests or service offered usually by mail (twenty-two)
- Irresponsible public communication (six)

The most recent version of the ethical principles (American Psychological Association, 2002), the Ethical Principles of Psychologists and Code of Conduct, is the tenth version (it is reprinted in Appendix A). There were previous revisions in 1953, 1959, 1963, 1968, 1977, 1979, 1981, 1990, and 1992 (APA, 2002). The 2002 version consists of an introduction, a preamble, five general principles, and specific ethical standards. The preamble and general principles, which include beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people's rights and dignity, are aspirational goals to guide psychologists toward the highest ideals of psychology. The specific ethical standards are enforceable rules for conduct.

Canadian Psychological Association's Approach to an Ethics Code

The CPA was organized in 1939 and incorporated under the Canada Corporations Act, Part II, in May 1950. In the mid-twentieth century, Canada was a large country with relatively few psychologists. Because it would have been difficult to bring these psychologists together to create an ethics code, "the Canadian Psychological Association (CPA) decided to adopt the 1959 . . . APA code for a three-year trial. This was followed by adoptions (with minor wording changes) of the 1963 and 1977 APA revised codes" (Sinclair & Pettifor, 2001).

Discontent with the APA code and the perception that it was not a good fit for Canadian psychologists led the CPA to create its own code:

> Prior to developing its own code, there was evidence of periodic discontent by CPA members with the APA code. For example, in a 1976 document titled "Alternative Strategies for Revising CPA's Code of Ethics," the statement was made that the 10 APA ethical principles were "clearly designed for the current American social and moral climate and geared to American traditions and law." However, it was not until the 1977 revision of the APA code that the discontent became serious. Of particular concern was the fact that, in response to U.S. court applications of antitrust law to professional activities, the APA had removed some of its restrictions on advertising. Many Canadian psychologists believed such application of antitrust laws ran the risk of changing the nature of the professional relationship from a primarily fiduciary contract to a commercial one [Sinclair, Simon, & Pettifor, 1996, p. 7].

To create an ethics code, CPA began by sending out thirty-seven ethical dilemmas (Truscott & Crook, 2004). Psychologists were asked how they would act in these situations and, equally important, to describe their reasoning. The responses yielded four basic ethical principles (CPA, 1986):

1. Respect for the Dignity of Persons
2. Responsible Caring
3. Integrity in Relationships
4. Responsibility to Society

The original CPA ethics code provided not only ethical principles but also a model of ethical decision making (see Chapter Nine; see also Sinclair, 1998; Sinclair, Poizner, Gilmour-Barrett, & Randall, 1987).

The third edition of the Canadian Code of Ethics for Psychologists was approved by the CPA board of directors at its meeting in June 2000 (CPA, 2000). It comprises a preamble and four ethical principles to be considered and balanced in ethical decision making. Each principle is followed by statements of values that give definition to each principle, and those are followed by a list of standards that illustrate the application of the principles and values to the activities of psychologists (CPA, 2000; the document is reproduced in Appendix B).

Patterns of Ethics Complaints

The CPA Ethics Committee has taken no action against a member since 2001. It entered into a formal agreement to wait for regulatory bodies to adjudicate complaints. Consequently, complaints rarely get sent to the CPA Ethics Committee (J. Service, personal communication, May 26, 2006).

Processing complaints has continued to be an important focus of the APA Ethics Committee (APA Ethics Committee, 1997–2006), although in recent years it has placed more emphasis on education. APA bylaws require the Ethics Committee to report how many and what kinds of complaints they investigate each year. Table 7.1 provides data from *American Psychologist's* "Report of the Ethics Committee" for 2000, 2001, 2002, 2003, and 2004.

	2000		2001		2002		2003		2004		Totals	
Category	**P**	**M**	**P**	**M**	**P**	**M**	**P**	**M**	**P**	**M**	**P**	**M**
Cases adjudicated in other jurisdictions												
Felony convictions	2	2	2	2	1	1	2	2	1	1	8	8
Loss of licensure	25	25	10	10	19	19	20	20	18	18	92	92
Expulsion from state association												
Malpractice												
Other	3	3	5	5	4	4	1	1	0	1	13	14
Dual relationship												
Sexual misconduct, adult	1	17	5	10	3	18	1	8	0	6	10	59
Sexual misconduct, minor			0	2					0	1	0	3
Sexual harassment	1	1			0	1					1	2
Nonsexual dual relationship	1	7	4	7	0	3	0	4	0	3	5	24
Inappropriate professional practice												
Child custody	5	7	9	14	2	2	0	1	0	1	16	25
Hospitalization							0	1	0	1	0	2
Hypnosis												
Outside competence			0	2	1	2			0	3	1	7
Controlling client					0	1					0	1
Inappropriate response to crisis			0	1	1	2	11[b]				2	3
Confidentiality	0	3	2	3	0	2			1	2	3	10
Inappropriate follow-up/ termination			0	1	1	2			0	1	1	4
Test misuse			1	1	0	1	0	1			1	3
Insurance/fee problems	0	3	0	2	0	2	0	8	0	3	0	18
Inappropriate professional relations	1	2									1	2
Other	0	3	1	2	1	2	0	2	0	2	2	11

Table 7.1. Primary and Multiple Categories of Cases Opened by the American Psychological Association Ethics Committee: 2000–2004.

	2000		2001		2002		2003		2004		Totals	
Category	**P**	**M**	**P**	**M**	**P**	**M**	**P**	**M**	**P**	**M**	**P**	**M**
Inappropriate research, teaching, or administrative practice												
Authorship controversies/credits			0	1							0	1
Improper research techniques					0	1					0	1
Plagiarism	1	1	1	1							2	2
Biasing data												
Grading/violation of student rights												
Termination/ supervision			0	2					0	1	0	3
Absence of timely evaluations			1	1							1	1
Discrimination												
Animal research subjects welfare												
Other	0	1									0	1
Inappropriate public statements												
Misuse of media												
False, fraudulent, or misleading			0	1					0	1	0	2
Did not correct misrepresentation												
Public allegation about colleague	1	1									1	1
Other	0	1									0	1
Failure to uphold standards of the profession												
Response to ethics committee[a]	2	3	1	3	1	1					4	7
Adherence to standards												
Other	0	1									0	1
Total cases	43	43	42	42	34	34	25	25	20	20[b]	164	164

Table 7.1. (*continued*)

Table 7.1. (*continued*)

Note: P = number of cases with category as primary factor. M = number of cases with category as multiple factor. We thank the staff of the APA Ethics Office who offered guidance with this table, including Steve Behnke, executive director, Stan Jones, and Debbie Felder.

[a] This category was changed to “Response to APA Ethics Committee” in the Report of the Ethics Committee (APA Ethics Committee, 2002).

[b] Corrections made after publication of data (S. Behnke, personal communication, June 12, 2006).

Sources: Adapted from American Psychological Association Ethics Committee. (2001). Report of the Ethics Committee, 2000. *American Psychologist, 56*, 680–688. American Psychological Association Ethics Committee. (2002). Report of the Ethics Committee, 2001. *American Psychologist, 57*, 646–653. American Psychological Association Ethics Committee. (2003). Report of the Ethics Committee, 2002. *American Psychologist, 58*, 650–657. American Psychological Association Ethics Committee. (2004). Report of the Ethics Committee, 2003. *American Psychologist, 59,* 434–441. American Psychological Association Ethics Committee. (2005). Report of the Ethics Committee, 2004. *American Psychologist, 60,* 523–528. Copyright American Psychological Association 2001, 2002, 2003, 2004, 2005. Adapted with permission.

These figures show a declining caseload resulting from adjudicative reforms made after an extensive review of the ethics program and a discussion of the program at the February 2001 Council of Representatives meeting (Behnke, 2005). The following changes were made:

- All respondents are offered an opportunity to resign under ethics investigation (thus, a psychologist who is the subject of an ethics matter and wishes to resign from APA is not required to go through the entire adjudication process).
- Respondents in show-cause matters (matters in which an official, non-APA entity has already taken serious action against the psychologist) are expelled from APA automatically unless they request that APA review their case (thus, the committee and board do not need to follow the entire adjudication process for psychologists who are completely nonresponsive to APA notification following a significant adjudication by a non-APA body).

The rules revision were effective October 1, 2001. As a result:

- As of November 14, 2005, forty psychologists had resigned or were in the process of resigning under ethics investigation.

- As of November 14, 2005, seven psychologists had been automatically expelled or were in the process of being automatically expelled from APA.

The annual dues notice sent to all members lists the names of psychologists who resign under ethics investigation and who are automatically expelled.

Table 7.1 provides numbers of primary and multiple categories of cases opened for five reports of the Ethics Committee (APA Ethics Committee, 2001, 2002, 2003, 2004, 2005).

The Ethics Committee processes a large number of cases secondary to actions taken by state licensure boards (APA Ethics Committee, 2005). Loss of licensure continues to be the most frequent reason for complaints processed (over five years, ninety-two cases with loss of licensure as primary factor and ninety-two cases with category as multiple factor).

Multiple issues per allegations reported are important because a primary category states the basis on which APA is processing the case rather than the underlying behavior, and a secondary category is always assigned. Sexual misconduct (see Chapter Thirteen), for example, is the primary underlying behavior in sixty-two of the cases in the category "loss of licensure." Nonsexual dual relationships (five cases as primary factor and twenty-four cases as multiple factor), and child custody (sixteen cases as primary factors and twenty-five as multiple factors) are categories with higher numbers of cases. Confidentiality (three cases as primary factors, ten as multiple factors) also had moderately high cases. Insurance/fee problems, although not listed as a primary factor for those five years, are often listed as one of the multiple factors (no cases as primary factors, eighteen as multiple factors).

The most recent report of cases opened and closed from 2000 to 2004 reflects a significant decline in total active cases each year: 164 in 2000, 130 in 2001, 102 in 2002, 91 in 2003, and 75 in 2004 (APA Ethics Committee, 2005). Interestingly, only a very small percentage (barely 0.08 percent in 2004) of the APA membership have complaints filed against them through the APA Ethics Committee.

The Empirical Approach Half a Century Later

Many of the pioneers in the APA provided reasons that an empirical approach would be useful in constructing an ethics code. But a critical incident survey of APA members could also serve another purpose. While the actuarial data of ethics committees, licensing boards, and civil and criminal courts can reveal trends in ethical or legal violations as they are established by review agencies, empirical critical incident studies can reveal ethical dilemmas and concerns as they are encountered in day-to-day practice by the broad range of psychologists (that is, not just those who are subject to formal complaint).

The APA critical incident study undertaken in the 1940s was replicated in the 1990s and published in the *American Psychologist* (Pope & Vetter, 1992). In this study, 1,319 APA members randomly sampled were asked to describe incidents that they found ethically challenging or troubling: 679 psychologists described 703 incidents in twenty-three categories, as shown in Table 7.2.

Category	Number	Percentage
Confidentiality	128	18
Blurred, dual, or conflictual relationships	116	17
Payment sources, plans, settings, and methods	97	14
Academic settings, teaching dilemmas, and concerns about training	57	8
Forensic psychology	35	5
Research	29	4
Conduct of colleagues	29	4
Sexual issues	28	4
Assessment	25	4
Questionable or harmful interventions	20	3
Competence	20	3
Ethics and related codes and committees	17	2
School psychology	15	2
Publishing	14	2
Helping the financially stricken	13	2
Supervision	13	2
Advertising and (mis)representation	13	2
Industrial-organizational psychology	9	1
Medical issues	5	1
Termination	5	1
Ethnicity	4	1
Treatment records	4	1
Miscellaneous	7	1

Table 7.2. Ethical Problems Reported by a National Sample of APA Members.

Source: Adapted from Pope, K. S., & Vetter, V. A. (1992). Ethical dilemmas encountered by members of the American Psychological Association: A national survey. *American Psychologist, 47,* 397–411. Available at http://kspope.com. Copyright 1992 American Psychological Association. Adapted with permission.

Here is a sample of the ethical concerns that the psychologists described in this anonymous survey:

Confidentiality

- "The executive director of the mental health clinic with which I'm employed used his position to obtain and review clinical patient files of clients who were members of his church. He was [clerical title] in a . . . church and indicated his knowledge of this clinical (confidential) information would be of help to him in his role as [clerical title]."
- "Having a psychologist as a client who tells me she has committed an ethical violation and because of confidentiality I can't report it."
- "One of my clients claimed she was raped; the police did not believe her and refused to follow up (because of her mental history). Another of my clients described how he raped a woman (the same woman)."

Blurred, Dual, or Conflictual Relationships

- "I live and maintain a . . . private practice in a rural area. I am also a member of a spiritual community based here. There are very few other therapists in the immediate vicinity who work with transformational, holistic, and feminist principles in the context of good clinical training that 'conventional' people can also feel confidence in. Clients often come to me because they know me already, because they are not satisfied with the other services available, or because they want to work with someone who understands their spiritual practice and can incorporate its principles and practices into the process of transformation, healing, and change. The stricture against dual relationships helps me to maintain a high degree of sensitivity to the ethics (and potentials for abuse or confusion) of such situations, but doesn't give me any help in working with the actual circumstances of my practice. I hope revised principles will address these concerns!"
- "Six months ago a patient I had been working with for three years became romantically involved with my best and longest friend. I could write no less than a book on the complications of this fact! I have been getting legal and therapeutic consultations all along and continue to do so. Currently they are living together, and I referred the patient (who was furious that I did

this and felt abandoned). I worked with the other psychologist for several months to provide a bridge for the patient. I told my friend soon after I found out that I would have to suspend our contact. I'm currently trying to figure out if we can ever resume our friendship and under what conditions." [This latter example is one of many that demonstrate the extreme lengths to which most psychologists are willing to go to ensure the welfare of their patients.]

Payment Sources, Plans, Settings, and Methods

- "A seven-year-old boy was severely sexually abused and severely depressed. I evaluated the case and recommended six months treatment. My recommendation was evaluated by a managed health care agency and approved for ten sessions by a nonprofessional in spite of the fact that there is no known treatment program that can be performed in ten sessions on a seven year old that has demonstrated efficacy."
- "Much of my practice is in a private hospital that is in general very good clinically. However, its profit motivation is so very intense that decisions are often made for $ reasons that actively hurt the patients. When patients complain, this is often interpreted as being part of their psychopathology, thus reenacting the dysfunctional families they came from. I don't do this myself and don't permit others to do so in my presence—I try to mitigate the problem—but I can't speak perfectly frankly to my patients and I'm constantly colluding with something that feels marginally unethical."
- "A managed care company discontinued a benefit and told my patient to stop seeing me, then referred her to a therapist they had a lower fee contract with."

Academic Settings, Teaching Dilemmas, and Concerns About Training

- "I employ over 600 psychologists. I am disturbed by the fact that those psychologists with marginal ethics and competence were so identified in graduate school and no one did anything about it."

Forensic Psychology

- "A psychologist in my area is widely known to clients, psychologists, and the legal community to give whatever testimony is requested in court. He has a very commanding presence, and it works. He will say anything, adamantly, for pay. Clients/lawyers continue to use him because if the other side uses him, that side will probably win the case (because he's so persuasive, though lying)."

- "Another psychologist's report or testimony in a court case goes way beyond what psychology knows or his own data supports. How or whether I should respond."
- "I find it difficult to have to testify in court or by way of deposition and to provide sensitive information about a client. Although the client has given permission to provide this information, there are times when there is much discomfort in so doing."

Research

- "I am co-investigator on a grant. While walking past the secretary's desk, I saw an interim report completed by the PI [principal investigator] to the funding source. The interim report claimed double the number of subjects who had actually entered the protocol."
- "I have consulted to research projects at a major university medical school where 'random selection' of subjects for drug studies was flagrantly disregarded. I resigned after the first phase."
- "Deception that was not disclosed, use of a data videotape in a public presentation without the subject's consent (the subject was in the audience), using a class homework assignment as an experimental manipulation without informing students."

Conduct of Colleagues

- "As a faculty member, it was difficult dealing with a colleague about whom I received numerous complaints from students."
- "At what point does 'direct knowledge' of purportedly unethical practices become direct knowledge which I must report—is reporting through a client 'direct' knowledge?"
- "I referred a child to be hospitalized at a nearby facility. The mother wanted to use a particular psychiatrist. . . . When I called the psychiatrist to discuss the case, he advised me that, since he was the admitting professional, he'd assume full responsibility for the case. . . . He advised how he had a psychologist affiliated with his office whom he preferred to use."

- "I see foster children who have little control over their lives and case workers who have little time/interest in case management. How can I maintain good professional relationships with those who don't function up to their duties?"
- "A director of the mental health center where I worked was obviously emotionally disturbed, and it impacted on the whole center—quality of service to clients, staff morale, etc. He would not get professional help or staff development assistance."
- "The toughest situations I and my colleague seem to keep running into (in our small town) are ones involving obvious (to us) ethical infractions by other psychologists or professionals in the area. On 3 or more occasions he and I have personally confronted and taken to local boards . . . issues which others would rather avoid, deal with lightly, ignore, deny, etc., because of peer pressure in a small community. This has had the combined effect of making me doubt my reality (or experience), making me wonder why I have such moral compunctions, making me feel isolated and untrusting of professional peers, etc."

Sexual Issues

- "A student after seeing a client for therapy for a semester terminated the therapy as was planned at the end of the semester, then began a sexual relationship with the client. . . . I think APA should take a stronger stance on this issue."
- "I currently have in treatment a psychiatrist who is still in the midst of a six-year affair with a patient. He wishes to end the affair but is afraid to face the consequences."
- "My psychological assistant was sexually exploited by her former supervisor and threatened her with not validating her hours for licensure if she didn't service his needs."

LICENSING BOARDS

Each of the fifty United States and each of the nine Canadian jurisdictions has its own requirements and standards for practicing as (or, in some states and jurisdictions to identify oneself as) a psychotherapist or counselor. Some, but not all, administrative standards embody ethical principles. (For example, some may set forth the relatively mundane obligation to pay an annual licensing fee.) Formal licensing actions are how therapists and counselors are held accountable to these standards of practice. Violation of these standards can lead to the suspension or revocation of the practitioner's license or certification.

The data reviewed here concerning licensing disciplinary actions were collected by the Association of State and Provincial Psychology Boards (ASPPB) from actions reported to the ASPPB disciplinary data system by member boards (personal correspondence, Association of State and Provincial Psychology Boards, Central Office; the data are abstracted from the ASPPB Disciplinary Data Reports from August 1983 to November 2005; the data reports for Canadian provinces are from August 1983 to May 2006).

For at least two major reasons, the percentages that follow provide only the roughest estimations of the causes of disciplinary actions. First, as Pat Bricklin, ASPPB president in 1988, stressed in authorizing the initial presentation of these percentage data, certain paths toward resolution of licensing complaints—for example, a licensee may unilaterally surrender a license to evade formal action by the board—may not be represented in the reports (P. Bricklin, personal communication, September 8, 1988). Second, different states and provinces categorize the basis of disciplinary actions in different ways, and some of them are vaguer than others ("ethical violations" or "unprofessional conduct," for example). The staff counted each disciplinary action only once; when more than one cause of action was given, they tried to select the most salient or informative basis. Although not all disciplinary actions included in Tables 7.3 to 7.5 indicated whether a dual relationship was sexual in nature, it was clear that most dual relationship violations involved sexual intimacies.

Barry Gang (personal communication, June 14, 2006), director of investigations and hearings for the College of Psychologists of Ontario, notes that the categories used to report types of complaints change over the years.

Licensing complaints understandably make most psychologists anxious (see Chapter Eight). Montgomery, Cupit, and Wimberley (1999) surveyed Texas psychologists to explore awareness, experiences, and activities related to complaints and risk management. The participants' reports led to the conclusion that psychologists perceive a higher risk than warranted: 72 percent knew a colleague who had been the subject of a licensing board complaint, while slightly over 10 percent had

Reason for Disciplinary Action	Number Disciplined
Sexual/dual relationship with patient	866
Unprofessional/unethical/negligent practice	845
Conviction of crimes	265
Fraudulent acts	175
Improper/inadequate record keeping	155
Failure to comply with continuing education requirements	135
Breach of confidentiality	129
Inadequate or improper supervision	124
Impairment	113
Fraud in application for license	51
Total	2,858[a]

Table 7.3. Reported Disciplinary Actions for Psychologists in the United States, August 1983–November 2005.

[a] The difference in the total number of reported disciplinary actions (3,471) and this total is that some jurisdictions do not report reasons or the reason reported does not fall into one of the categories listed in this table. The total number of psychologists in the United States was 98,833 as of January 2006.

Source: Compiled by the Association of State and Provincial Psychology Boards (ASPPB) from actions reported to the ASPPB Disciplinary Data System by member boards. Obtained through personal correspondence with Executive Officer, ASPPB Stephen T. DeMers, November 11, 2005. Reprinted with permission.

ever had a complaint themselves. Although the experience was rated as unpleasant or very unpleasant for three out of four complainants, 74 percent found the complaint was resolved to their satisfaction. Only 6 percent reported a malpractice lawsuit, and only one-fifth of these psychologists reported their work was adversely affected.

Van Horne (2004) reviewed survey information about disciplinary complaints against psychologists and about psychology licensing board actions. Her conclusions provided an alternative perspective to the view that licensing boards are overzealous or that they are lax in protecting the public. Few complaints are in fact filed, many of those are not investigated, informal actions taken that are not reported to the ASPPB Disciplinary Data system are few, and even fewer formal actions are taken against psychologists' licenses; most do not lead to discipline. The actual number of complaints received, though not necessarily opened for investigation, was approximately 2 percent of licensed psychologists for every year data were collected (1996–2001).

Reason for Disciplinary Action	Number Disciplined
Unprofessional/unethical/negligent practice	39
Sexual/dual relationship with patient	35
Breach of confidentiality	5
Malpractice	4
Conviction of crimes	4
Failure to meet conditions of candidacy	3
Improper termination of therapy	3
Failure to adhere to standards	3
Improper/inadequate record keeping	2
Fraud in application for license	2
Fraudulent acts	2
Improper experimental treatment	2
Impairment	1
Failure to timely report child abuse	1
Boundary violations	1
Improper or inadequate supervision	1
Practice outside scope	1
Total	109[a]

Table 7.4. Reported Disciplinary Actions for Psychologists in Canada, August 1983–May 2006.

[a] The difference in the total number of reported disciplinary actions (142) and this total is that some actions had no reported reason for the disciplinary action.

Source: Compiled by the Association of State and Provincial Psychology Boards (ASPPB) from actions reported to the ASPPB Disciplinary Data System by member boards. Obtained through personal correspondence with Executive Officer, ASPPB Stephen T. DeMers, November 11, 2005. Reprinted with permission.

Of those, fewer than 20 percent of filed complaints led to any discipline of a psychologist, and the majority of discipline consisted of informal actions that were not reported. Formal disciplinary actions reported to the ASPPB Disciplinary Data System involved less than 0.13 percent of psychologists' licenses. Van Horne concluded that all licensing boards engage in a wide variety of activities to protect the public and that licensed psychologists benefit from attention to consumer protection and adherence to the highest standards of the profession.

Stephen T. DeMers, executive officer of ASPPB, described several projects that ASPPB is in the process of developing (personal correspondence, November 11, 2005). The Certificate of Professional Qual-

Jurisdiction	Year of Original Licensure Law	Number of Licensed Psychologists, as of January 2006	Number of Reported Actions
Alberta	1960	2,489	6
British Columbia	1977	1,007	33
Manitoba	1966	195	9
New Brunswick	1967	202	0
Newfoundland	1985	182	1
Nova Scotia	1980	380	9
Ontario	1960	2,870	49
Quebec	1962	7,020	34
Saskatchewan	1962	470	1
Total reported records		14,815	142

Table 7.5. Number of Psychology Licensing Actions, Number of Licensed Psychologists, and Year of Original Licensure Law for Each Canadian Jurisdiction.

Source: Compiled by the Association of State and Provincial Psychology Boards (ASPPB) from actions reported to the ASPPB Disciplinary Data System by member boards. Obtained through personal correspondence with Executive Officer, ASPPB Stephen T. DeMers, November 11, 2005. Reprinted with permission.

ification (CPQ) allows psychologists to avoid mobility problems and facilitates obtaining a license in a new jurisdiction. The ASPPB is also working on an online ethics course to replace the in-person workshops that it offers around the country. In addition, an interjurisdictional practice (IPC) credential is to be designed to help industrial organizational and forensic psychologists to engage in short-term practice in a jurisdiction in a sanctioned and regulated way.

CIVIL STATUTES AND CASE LAW

Each state and province has its own legislation and accumulated case law that can serve as the basis of malpractice suits against psychotherapists and counselors. Because the states and provinces differ in their legal standards, an act that one jurisdiction may require may violate the legal standards in another jurisdiction. In addition, some clinicians who work in federal institutions, such as Veterans Administration Medical Centers, may be subject to federal standards. According to the Canadian Psychological Association's executive director, John Service (personal communication, May 26, 2006), Canada is a less litigious country than the United States; Canadian psychologists rarely get sued.

What are the primary reasons clinicians are sued in the United States? The data we review here, which are provided by the Insurance Trust of the American Psychological Association, are the most recent incidence data available. The following list represents a snapshot of percentages of losses for the various major areas of claims in the Insurance Trust Professional Liability Program for ten years, using the Harris' Characterization of Trust Incidence Data (B. Bennett, personal correspondence, December 19, 2005; June 13, 2006):

Ineffective treatment/failure to consult/failure to refer	29 percent
Failure to diagnose/improper diagnosis	16 percent
Custody dispute	10 percent
Sexual intimacy/sexual harassment and/or sexual misconduct	9 percent
Breach of confidentiality	8 percent
Suicide	4 percent
Supervisory issues, conflict of interest or improper multiple relationships, all other losses less than 1 percent	3 percent
Libel/slander, conflicts in reporting sexual abuse, licensing dispute, no coverage applies	2 percent
Abandonment, premises liability, repressed memory, failure to monitor, countersuits resulting from fee disputes, client harmed others including homicide, business disputes, miscellaneous liability claims, discrimination/harassment	1 percent

Bruce Bennett, CEO of the Trust (personal correspondence, December 19, 2005), placed these data in context:

1. This is a snapshot as of September 2003.
2. The data were collected and assigned to the respective categories by untrained staff at the insurance company following a cursory review of the initial claim filed against the defendant. The staff had no specific training in assigning cases to categories of loss.

3. It is assumed that assignment of claims to a specific category is based on the primary allegation listed in the lawsuit; however, this is only an assumption.
4. Most lawsuits contain a number of counts against the defendant. The [Insurance] Trust has not reviewed these data for accuracy and cannot ensure you that the specific count listed in the claim is the most primary of all counts in each lawsuit.
5. As a malpractice suit proceeds through the judicial system, the lawsuit is frequently amended to add new counts or remove certain counts. These data do not reflect any such amendments, subsequent filings, or final dispositions.
6. Many lawsuits against psychologists are based on the shotgun approach, where the defendant is accused of multiple misdeeds, even though some of the allegations of wrongdoing may be dropped during the settlement discussions or prior to or during trial. Regardless of the underlying alleged misconduct, it is highly likely that the lawsuit will assert ineffective treatment, failure to consult, failure to refer, failure to diagnose, and/or improper diagnosis. Thus, the first two categories account for 45 percent of the claims regardless of other allegations. This would be especially true when the underlying primary issue may be something like improper financial transactions or sexual misconduct.
7. Psychologists tend to place heavy reliance on data such as provided here. In many cases, numbers tend to garner more significance than is appropriate.

With these caveats in mind, Bennett (personal correspondence, December 19, 2005) pointed out some issues in comparing these data with those previously compiled:

- The percentage of claims for custody disputes has increased from 3 to 10 percent.
- The percentage of claims for sexual misconduct has decreased from 20 to 9 percent.
- The percentage of claims involving suicide has dropped from 5 to 4 percent.
- Supervision should be a major area of concern for the practitioner (2 to 3 percent).

- Suits filed in retaliation for fee collection appear to have decreased from 4 to 1 percent, probably because psychologists, knowing the dangers associated with fee collection actions, are less likely to bring such suits against current or former patients.
- One area has become apparent: the number of licensing board complaints has increased dramatically. In fact, of all the claims filed against psychologists, 30 percent or more are for licensing board complaints, many related to forensic work on custody issues.

CRIMINAL STATUTES

Each state and province has its own set of criminal laws, generally set forth in the penal code. Although we were unable to locate any reliable actuarial data concerning psychotherapists convicted of crimes, one of the most frequently mentioned areas involves fraud, particularly related to third-party billings. Donald Bersoff, then attorney representing the APA, emphasized the importance of conforming to all rules and regulations regarding billing practices for third-party coverage, both public and private, and noted that therapists currently serving time in prison could attest to the significance of violating those rules and regulations (see American Psychological Association Ethics Committee, 1988).

Another of the areas in which therapists may face criminal prosecution is sexual involvement with patients (see Chapter Thirteen). While many of the laws are civil reporting laws and injunctive relief statutes, as of October 2005 about twenty-five states have enacted criminal statues regarding psychotherapist-patient sexual contact (see Pope, 1994; Pope, Sonne, & Greene, 2006).

CONCLUSION

Exceptional caution is appropriate in attempts to generalize, compare, or interpret this chapter's actuarial data from ethics committees, licensing boards, and malpractice courts. Various types of actual violations, as the research indicates, may only rarely lead to a formal complaint with a criminal court, civil court, licensing board, or ethics committee. Certain types of violation may be difficult to prove. Formal complaints may be informally resolved and not appear in archival data. And, as noted, there are significantly different ways of classifying complaints.

Nevertheless, the general trends apparent in the archival data as well as the data from critical incident studies reviewed here can be useful to us. They can call our attention to aspects of our own practice where there is room for improvement. They can also suggest possible topics for which we might want to take continuing education courses. These data provide a resource for us as individuals and as a helping profession seeking to maintain the high standards and integrity of our work and minimize possible harm to those whom we serve.

Exceptional caution is also warranted in considering these mechanisms of accountability and their relationship to ethical behavior. All of us may experience some tendency to confuse at some level ethical behavior with that which does not bring us before one of these review agencies (see Chapter Two). Our sense of what is ethical runs through a reductionistic mill and becomes, in the worst-case scenario, "avoiding detection" or "escaping accountability." Much that we may do that is unethical may never come to the light and may never trigger inquiry by one of these mechanisms of accountability.

As noted in Chapter One, the principles articulated by our profession, the licensing boards, and the civil and criminal courts should never serve to inhibit careful ethical deliberation or function as a substitute for thoughtful decision making and personal responsibility. They provide a framework that can help broaden our awareness and inform our thinking. They can support us in the process of ethical struggle and constant questioning that are an inescapable part of what we do as therapists and counselors.

CHAPTER EIGHT

Responding to Ethics, Licensing, or Malpractice Complaints

We might as well discuss it now, before going on to other topics. It happens. A client, former client, or someone else files a formal complaint against you. This can happen regardless of whether you have done anything wrong. In some cases, someone may file a complaint against you because you *refused* to do something wrong.

We recommend considering this possibility and how to respond to it early, as part of thinking through an approach to ethics and therapy, which is why we do not tack this chapter on at the end of the book. Preparation can enable therapists to respond thoughtfully and competently to a complaint. An ethics complaint, licensing action, or malpractice suit can stun the unprepared therapist. The initial shock, panic, and confusion often lead to impulsive moves that may cause needless damage to the therapist's career, reputation, and future prospects.

Realistic consideration and preparation also allow therapists to put the possibility of a complaint into proper perspective. Some therapists let their anxiety of being sued grow into terror or obsession. The determination to avoid a lawsuit or other formal complaint overrides their practice's original focus: helping clients, supporting themselves and their loved ones financially, spending their time doing work they find meaningful and fulfilling, doing something they enjoy and are good at. Their work is no longer doing therapy so much as it is managing risks. Intelligent risk management is part of a good practice, but that is all it is. Once a therapist starts living and working in fear of a complaint and allows that fear to dominate all decisions, something vital is lost.

Here are some considerations you may find helpful when responding to a formal complaint.

DO NOT PANIC

Okay, panic for a little while if you can't help it or it feels like the right thing to do. But then take some deep breaths, pull yourself together, and do whatever you have to do to think clearly. The decisions you make—what you do and avoid doing at this point—are crucial. And avoid letting panic drive or determine the steps you take.

CONSULT YOUR ATTORNEY FIRST

It's amazing how many therapists forget this step or experience irresistible impulses to maneuver around it. Opening an envelope to find out that a formal complaint has been filed with the licensing board, the psychologist may figure that by quickly submitting a clear time line, the relevant documents, and a clear explanation, this unfortunate misunderstanding can be resolved immediately. Receiving notice that a malpractice suit has been filed, the psychologist may hope that asking the client to come in for a free session so that all of this can be worked out "without all these lawyers" is the best way to reach a positive resolution and convince the client that a suit should never have been filed in the first place.

Responding to a formal complaint before consulting an attorney can lead to needless disasters. An attorney can help guide you through the minefields of formal complaints. In part, this is because the psychologist is moving into a different realm. Good attorneys are knowledgeable about the complex legislation, case law, and customs of the court that govern malpractice actions. Attorneys experienced in licensing and ethics hearings can interpret the numerous rules and procedures that the psychologist is now subject to and are familiar with the norms and customs of the state licensing board and ethics committee. In part, this is also because the attorney has another perspective than the psychologist does because it is not the attorney who is the object of the complaint. That perspective can be crucial. As the old aphorism has it, the person who represents him or herself has a fool for a client.

The attorney can show you the pitfalls of certain actions that can otherwise seem to make sense. A psychologist who has not consulted an attorney may talk to colleagues about the case, talk to the opposing attorney, write letters to various people mentioning the case, or blow off steam about the case within earshot of others and discover only later that these oral and written statements and outpourings are not privileged and are introduced into evidence through testimony and exhibits.

The attorney may give you strong advice—sometimes a more authoritative list of do's and don'ts. But a good part of what an attorney does is to lay out options for you and tell you what is—and is not—known about each option so that you can make informed decisions about what you want to do and what you want the attorney to do. For example, the attorney can make you aware of the circumstances, if any, under which you can discuss the case with a supervisor, a consultant, a colleague, a friend, a family member, or anyone else and have the discussion remain confidential and privileged. As another example, the attorney can explain the consequences of your declining a settlement offer from the plaintiff in a malpractice suit.

NOTIFY YOUR PROFESSIONAL LIABILITY CARRIER

Your professional liability policy may include a requirement that you notify the company immediately not only if you are sued but also if you have reason to believe that you will or may be sued. But regardless of the fine print of such requirements, it makes sense to let the carrier know if you become aware of a possible or actual formal complaint. The carrier may give you specific guidance, and under certain circumstances, even if a suit has not yet been filed against you, provide you with an attorney.

WHO IS YOUR ATTORNEY'S CLIENT?

The answer may seem obvious: *you* are your attorney's client. But if the attorney is being paid by your insurance carrier, it is worth assessing the degree to which the insurance carrier's interests may diverge from your interests. For example, what if the insurance company approves only a very limited discovery, hoping to hold down expenses? What if the carrier believes it makes sense financially (that is, it is in the carrier's financial interests) to settle a case that you believe is bogus and would be decided in your favor were it vigorously defended? The settlement of such a case, which could become a matter of public record, could be devastating to your career, particularly if a substantial portion of your professional time is spent serving as an expert witness.

In some rare circumstances, if you (or you and the attorney) are unable to persuade the carrier to litigate rather than settle the case or to provide you the kind of extensive discovery and vigorous defense to which you believe you are entitled, it may be worth considering hiring a separate attorney with your own funds to press your claims with the carrier.

IS THE COMPLAINT VALID?

When someone takes the step of filing a formal complaint against you, it is natural to feel hurt and attacked. Moreover, malpractice trials are adversarial proceedings, which can understandably generate much anger and emotional heat. Before that process goes too far, take some time to consider whether you actually did what you have been accused of doing. Setting aside defensiveness, rationalization, counterattacks, and the fact that the charges may be considerably overstated and wrong in some details, is there any truth to the allegation that you did something you should not have done or that you failed to do something that you should have done?

Being relentlessly honest with yourself under these circumstances is anything but easy. Acknowledging to yourself that you may have done something wrong may seem self-destructive, indulging a tendency to beat yourself up when you need all your survival skills to rescue your reputation and career. But holding as firmly as possible to the reality of what actually happened—not what the flattering and self-justifying revisionism of memory can create in place of the unadorned history—may enable you not only to respond effectively to the complaint but also to survive the process in a way that is the very opposite of self-destructive.

DID YOU MAKE A FORMAL COMPLAINT MORE LIKELY?

It is worth asking yourself: Regardless of whether you did or did not do what you are accused of doing, did you do (or fail to do) anything that made the complaint more likely? Did you, for example, make a normal, run-of-the-mill human error—not something illegal or unethical but just a mistake and, when confronted by the client, refuse to acknowledge it or say you were sorry? Was there a misunderstanding—perhaps a client misperceived you to have done something wrong—that you refused to clarify? In other words, as you examine the sequence of events with the benefit of hindsight, did your attitude or behavior increase the chances that this complaint would be filed?

In our experience, many (but by no means all) formal complaints seem to have less to do with the existence or magnitude of therapist's legal or ethical violation and more to do with the therapist-client relationship—the degree to which the therapist has effectively communicated respect, caring, and a reasonable ability to listen. Therapists who communicate these qualities to clients often seem to make all sorts of mistakes, misjudgments, and violations of standards without triggering a complaint, while therapists who fail to communicate these qualities must endure complaints even when they have otherwise seemed to adhere to the highest standards. (This, of course, does not imply that it is somehow okay to bumble our way into careless mistakes, misjudgments, and violations in these circumstances or that we can use what we communicate to the client to justify, discount, trivialize, or rationalize what we've done wrong and the consequences of our behavior, a process described in Chapter Two.) Formal complaints sometimes seem to represent a client's final attempt to catch the attention of and reach an otherwise unresponsive therapist.

APOLOGIZE AND ACCEPT RESPONSIBILITY?

One crucial decision facing you if the complaint is valid is whether you want to acknowledge what you have done (or failed to do), accept responsibility, and apologize. It seems to be part of the human condition that it is difficult for many of us to admit mistakes, especially when they have hurt someone, and to apologize. It can be much harder when it will go on the record, may be influential in sustaining the validity of the complaint, and is offered to someone who is angry—perhaps enraged—at you. There may also be friends and colleagues who advise you to despise the person who filed the complaint and to fight the complaint no matter what the circumstances.

We urge therapists and counselors facing a valid formal complaint to seriously consider, in consultation with their attorney, apologizing, accepting responsibility, and—if possible and appropriate—trying to make things right. These steps can be taken with the advice and counsel of the attorney. There can be strong reasons favoring and opposing this approach, and it is impossible to foresee all the consequences and implications of taking or not taking this path. Each psychologist must attempt to make the choice that is right for him or her as an individual.

WHAT ARE YOU WILLING TO HAVE DONE?

If you plan to contest the charges, consider—*before* the adversarial process heats up—what you are and are not willing to allow in defending your case. To examine an extreme hypothetical, imagine that you are sued for malpractice by an extremely fragile single mother. You believe her to be a basically good and competent person who has mistakenly but in good faith filed suit against you. Whatever your view of her, the claim she has filed threatens your reputation and career. If the verdict goes against you, referral sources for new patients may dry up, the licensing board may launch an investigation, and your work as an expert witness on the standard of care may be in jeopardy.

With all that at stake, would you be willing for your attorney to depose her and cross-examine her at trial in a way that misleadingly raises questions about her honesty? Would you be willing for the attorney to use your chart notes to create through innuendo the false impression that she is not an adequate mother and that perhaps she even neglected or abused her child?

Or would you consider "clarifying" your chart notes? Those notes may have been done hurriedly, may not have mentioned everything that was done, and may be misleading because of the way they were written. Wouldn't it be better to copy over those notes so that they include the material that you had neglected to put in the first time around on what are, really, if you come to think of it, your draft notes? Wouldn't it actually be a service to the court to remove the unintentional ambiguities along with the parts that are relatively unimportant, that clutter up your account of the treatment? In other words, stripped of its rationalization, would you be willing to hide your actual notes and submit a bogus chart more favorable to your defense?

The struggle to preserve a reputation and career is understandably intense. A question worth asking before the process builds up too much steam is: Am I willing to win at any cost? If not, where do I draw the line? What, if anything, am I unwilling to do—or to have done by others in my defense—to "win"?

RECOGNIZE HOW THE COMPLAINT IS AFFECTING YOU

A formal complaint can be a devastating experience. A malpractice suit or other formal complaint can bring all of the following and more for a therapist or counselor:

- A numbing shock that suddenly reputation and career may be at stake
- A sense of betrayal that someone we tried to help has turned against us
- Fear of uncertainty and the horrors in store for us
- Reflexive self-blame, assuming that we must have done something terrible or else we would not be in this fix
- Embarrassment, imagining that our colleagues now think the worst about us
- Self-doubt; if we did so poorly with this patient that we wound up in court, what if our other patients sue us?
- Depression
- Suspicion of our other patients (are they going to sue us?) and colleagues (who can we trust to talk this over with?)
- Anxiety about what is going to happen, all the unknowns, being deposed and cross-examined, who will be in the courtroom during the trial (the media?), and on and on and on
- Obsessive and intrusive thoughts, finding it hard to think about anything else

- Insomnia, tossing and turning, thinking endlessly about what has happened and what may happen
- Catastrophizing, that is, seeing only the most horrible possibilities unfolding
- Loss of appetite or taking in too much food, alcohol, or other substances as a response to the stress

We believe that for some therapists, being sued can bring on reactions similar to those of posttraumatic stress disorder. If we can be rigorously honest about our reactions to encountering a formal complaint, we are in a better position to address those reactions constructively and realistically.

GET THE HELP AND SUPPORT YOU NEED

As you monitor your reactions to the complaint process, realistically assess what help, if any, you need in dealing with these reactions. Some clinicians return to therapy or seek therapy for the first time. Some reach out to friends, colleagues, and family. An attorney's guidance can be invaluable in ensuring that what you say to others does not unintentionally become part of the case against you. Ethics experts in your state may be able to provide you and your attorney with additional consultation.

WHAT CAN YOU LEARN?

As the process unfolds, it is worth asking what, if anything, is to be learned from this. It is probably fair to say—in fact, it is probably an understatement—that no one ever wishes a formal complaint. But this unwelcome process nevertheless brings with it opportunity.

We may discover flaws and weaknesses in our policies, procedures, and ways of approaching clinical work. We may learn to recognize and attend more carefully to red flags in our practice. We may learn about their colleagues—about who can be counted on for support and who avoids us. We may learn about how both our own work and the allegations against us are evaluated during adversarial procedures. And in our reactions and decisions, we may learn about ourselves.

CHAPTER NINE

Steps in Ethical Decision Making

This chapter provides some steps helpful in thinking through how to respond to an ethical dilemma, taking action, and assuming personal responsibility for our response. These steps may help us to identify important aspects of a situation, consider positive and negative consequences of the ways in which we might respond, and discover better approaches.

The Canadian Psychological Association (CPA) emphasized the value and importance of such steps by including seven in its original ethics code (1986) and increasing the number to ten in subsequent editions (1991, 2000). In the following list, asterisks mark steps that are versions of those that appear in the CPA code.

Although eighteen steps are listed here, not every step is relevant to every situation, and the steps may need to be adapted to fit particular situations.

Step 1

Identify the situation that requires ethical consideration and decision making.

What is the clearest possible statement of the ethical question, issue, or dilemma? Are there other valid ways to define the situation? Do the definition's scope, perspective, assumptions, or wording make it needlessly hard for you to understand the situation and decide what to do? Do they hide or distort important aspects?

Step 2

*Anticipate who will be affected by your decision.

No one lives in a vacuum. It is rare that our ethical decisions affect only a single client or a single colleague and no one else. A client may show up for a session drunk. How you define your responsibility may influence whether the client drives home drunk and kills a pedestrian. A colleague may begin to show signs of Alzheimer's. The choices you make may affect the safety and well-being of the colleague and the colleague's patients. A therapy client may tell you about embezzling pension funds. Therapist-patient confidentiality laws may direct you to tell no one else, and the client may refuse to discuss the issue. How you decide to respond may affect whether hundreds of families retain the pensions they earned or are thrown into poverty. An insurance claims manager may refuse to authorize additional sessions for a client you believe is at risk for killing his wife and children and then committing suicide. Your supervisor may agree with the manager that no more sessions are needed. How you determine the most ethical path may help decide whether the family lives or dies.

Step 3

Figure out who, if anyone, is the client.

Is there any ambiguity, confusion, or conflict about who the client is (if it is a situation that involves a therapist-client relationship)? If one person is the client and someone else is paying your fee, is there any divided loyalty, any conflict that would influence your judgment?

Step 4

Assess your relevant areas of competence—and of missing knowledge, skills, experience, or expertise—in regard to the relevant aspects of this situation.

Are you well prepared to handle this situation? What steps, if any, could you take to make yourself more effective? In the light of all relevant factors, is there anyone else who is available that you believe could step in and do a better job?

Step 5

Review relevant formal ethical standards.

Do the ethical standards speak directly or indirectly to this situation? Are the ethical standards ambiguous when applied to this situation? Does this situation involve conflicts within the ethical standards or between the ethical standards and other (for example, legal) requirements or values? In what ways, if at all, do the ethical standards seem helpful, irrelevant, or misdirected when applied to this situation?

Step 6

Review relevant legal standards.

Do legislation and case law speak directly or indirectly to this situation? Do the legal standards speak to this situation in a way that is clear? Are there conflicts within the legal standards or between the law and other requirements or values? Do the relevant laws seem to support—or at least allow—the most ethical response to the situation, or do they seem to work against or block the most ethical response? Would it be helpful to consult an attorney?

Step 7

Review the relevant research and theory.

Is there new research or theory that helps you to conceptualize, understand, or respond to the situation? One occupational hazard of a field with such diverse approaches—cognitive, psychodynamic, behavioral, feminist, psychobiosocial, family, multicultural, and existential, to name but a few—is that we often lose touch with the research and theory emerging outside our own theoretical orientation.

Step 8

*Consider how, if at all, your personal feelings, biases, or self-interest might affect your ethical judgment and reasoning.

Does the situation make you angry, sad, or afraid? Do you find yourself eager to please someone (or an organization)? Do you desperately want to avoid conflict? Do you find yourself concerned that doing what you believe is most ethical will get you into trouble, will make someone mad at you, will be second-guessed by colleagues who disagree with you, or would be hard to square with the law or the ethics code? Will doing what seems ethically right to you cost you time, money, referrals, prestige, a promotion, your job, or your license?

Step 9

Consider what effects, if any, that social, cultural, religious, or similar factors may have on the situation and on identifying ethical responses.

The same act may take on sharply different meanings in different societies, cultures, or religions. What seems ethical in one context may violate fundamental values in another society, culture, or spiritual tradition. Are you overlooking any relevant contexts? Does the situation include social, cultural, religious, or similar conflicts?

Step 10

Consider consultation.

Is there anyone who would likely provide useful consultation for this specific situation? Is there an acknowledged expert in the relevant areas? Is there someone who has faced a similar situation and handled it well—or who might tell you what does not work and what pitfalls to avoid? Is there someone whose perspective might be helpful? Is there someone whose judgment you trust?

Step 11

*Develop alternative courses of action.

What possible ways of responding to this situation can you imagine? What alternative approaches can you create? The initial possibilities that occur to you may strike you as "not bad" or "good enough," but much better responses may occur to you if you keep searching.

Step 12

*Evaluate the alternative courses of action.

What impact is each action likely to have—and what impact could each have under the best possible and worst possible outcome that you can imagine—for each person who will be affected by your decision? What are the immediate and longer-term consequences and implications for each individual, including yourself, and for any relevant organization, discipline, or society? What are the risks and benefits? Almost any significant action has unintended consequences. What might they be for each possible course of action?

Step 13

Try to adopt the perspective of each person who will be affected.

Putting yourself in the shoes of those who will be affected by your decisions can change your understanding and help you discover what you believe will be the most ethical response to a difficult situation. Ask yourself: What would each person consider the most ethical response? In this way you can try to compensate for some of the distortion that may occur from seeing things only from your own perspective. One example is what Jones (1979; see also Gawronski, 2003; Gilbert & Malone, 1995; Weary, Vaughn, Stewart, & Edwards, 2006) called "correspondence bias." Although we often explain our own behavior in specific situations as due to external factors, we tend to attribute the behavior of others to their dispositions. Another example is what Meehl (1977) called a "double-standard of morals" (p. 232): we tend to hold explanations provided by other people to much more scientifically and logically rigorous standards than we use for our own explanations.

Step 14

*Decide what to do, and then review or reconsider it.

Once you have decided on a course of action, you can—if time permits—rethink it. Sometimes simply making a decision to choose one option and exclude all others makes you suddenly aware of flaws in that option that had gone unnoticed up to that point.

Step 15

*Act on and assume personal responsibility for your decision.

In some cases, trying to weigh ethical options, reconcile ethical conflicts, and discover the most ethical response—the steps leading up to taking action—are the hard part. Once the decision is made, acting is relatively easier. In other cases, thinking through the situation may seem relatively easy, but the acting is hard. The most ethical response may seem to come at overwhelming personal risk or cost. When risks or costs overwhelm us, it is a natural temptation to blur or evade personal responsibility.

Step 16

*Evaluate the results.

What happened when you acted? To what extent, if at all, did your action bring about the expected consequences? To what extent, if at all, were there unforeseen consequences? Knowing what you know now, would you have acted in the same way or chosen a different response to the situation?

Step 17

*Assume personal responsibility for the consequences of your action.

If your response to the situation now seems—with the benefit of hindsight—to have been wrong or has caused negative consequences, what steps, if any, do you need to take to address the consequences of your decision and action? If it seems to have been incomplete, what else needs to be done to address the situation? Have your actions and their consequences brought about new ethical challenges?

Step 18

*Consider implications for preparation, planning, and prevention.

Did this situation and the effects of your response to it suggest any useful possibilities in the areas of preparation, planning, and prevention? Are there practical steps that would head off future problems or enable you and others to address them more effectively? Would changes in policies, procedures, or practices help?

CHAPTER TEN

Beginnings and Endings, Absences and Accessibility

Therapists have a fundamental responsibility to clarify the boundaries of the relationship with their clients. Two of the most important boundaries are the beginning and ending of the therapy. The individual seeking help needs to know whether he or she is a client and whether he or she can expect that a particular clinician will act to fulfill the responsibilities of the role of therapist.

Information about the beginning and ending of therapy, as well as about the availability of services during therapy, is important if the client's decisions about whether to consent to treatment are to be truly informed. Chapter Eleven provides a more detailed discussion of the ethical requirement to obtain informed consent from the client to participate in psychotherapy and related procedures.

ACCESSIBILITY FOR PEOPLE WITH DISABILITIES

Our decisions about how accessible we make our structures and services to people with disabilities reflect our ethical values (Pope, 2005). They also affect many people. Psychologist Martha Banks (2003) wrote:

> Approximately one-fifth of U.S. citizens have disabilities. The percentage is slightly higher among woman and girls (21.3%) than among men and boys (19.8%). Among women, Native American women and African American women have the highest percentages of disabilities. . . . As a result of limited access to funds, more than one-third of women with work disabilities and more than 40% of those with severe work disabilities are living in poverty [p. xxiii].

What barriers, if any, do people who use wheelchairs encounter when they come to the building in which you do therapy and enter your office (Pope & Vasquez, 2005)? Would a person who is deaf face any needless difficulties contacting you for an initial session? Would a person who is blind have any unnecessary problems in navigating your building? If you have a professional Web site, is it accessible to those who are disabled and use assistive technologies? (For articles and other resources to address these issues, go to *Accessibility and Disability Information and Resources in Psychology Training and Practice* at http://kpope.com.)

CLARIFICATION

Therapists must be alert to possible complications and confusions. An individual may call for an initial appointment. The therapist may assume that the session is one of initial evaluation regarding possible courses of action (for example, if therapy makes sense for the individual, or what modality of therapy under what conditions implemented by what clinician seems most promising). The individual, however, may assume that the clinician, by virtue of accepting that request for an initial appointment, has become his or her therapist. Similarly, several months into treatment, a client may become enraged at the therapist but be unable to express that anger directly. The client may leave suddenly halfway through a session and miss the regular appointment time for the next five weeks, during which time the client fails to return any of the therapist's telephone calls. Is that client still a client, or has a de facto termination occurred?

Acting to prevent unnecessary misunderstandings regarding the beginning and ending of therapy is part of a clinician's more general ethical responsibility to clarify the availability of and access to therapeutic resources. One of the more immediate aspects of this responsibility is for both therapist and client to understand clearly when and under what circumstances the therapist will be available for sessions or for telephone communication and what resources will be available for the client when the therapist is not available. Clarification is important for several reasons. First, it forces the therapist to consider carefully this client's needs for telephone access during the course of therapy. For example, is this an impulsive, depressed client with few friends who might need telephone contact with the therapist or some other professional in the middle of the night to avert a suicide? Clarification enables the therapist to plan for such contingencies.

Second, by leading the therapist to specify backup availability—for example, what the client can do if he or she is unable to reach the therapist by telephone in an emergency—the efforts to clarify availability enable the therapist to prepare for therapeutic needs that are difficult or impossible to anticipate. For example, a client with moderate coping resources may attend appointments regularly over the course of a year or two, never contacting the therapist between sessions. However, during a period when the therapist is seriously ill and unavailable, the client may receive numerous shocks, such as the loss of a job or the death of a child. The client may become acutely suicidal and need prompt access to therapeutic resources. Careful planning by the therapist may meet such needs that are virtually impossible to anticipate with a specific client.

Third, explicit clarification of the client's access to the therapist or to other therapeutic resources encourages the therapist to think carefully about the effects that the therapist's availability and unavailability are likely to have on the client and the course of treatment. For example, some clients are likely to experience overwhelming feelings of sadness, anger, or abandonment when the therapist goes on vacation. Other clients may find the clear boundaries that the therapist has established so uncomfortable and infuriating that they are constantly testing both the therapist and the boundaries. Such clients may frequently show up at the therapist's office at the wrong time for their appointment, may leave urgently cryptic messages ("Am quitting therapy; no hope; life too painful; can't go on") on the therapist's answering machine without leaving a number where they can be reached, and may persistently try to discover the therapist's home address and home telephone number (if the therapist customarily keeps these private).

Fourth, when therapist and client work together to develop a plan for emergencies during which the therapist might not be immediately available, the process can help the patient to assess realistically his or her dependence and needs for help and to assume—to the extent that he or she is able—realistic responsibility for self-care during crises. For example, the therapist may ask the client to locate the nearest hospital providing twenty-four-hour services and develop ways of reaching the hospital in an emergency. As the client assumes responsibility for this phase of crisis planning, he or she increases the sense of self-efficacy and self-reliance (within a realistic context), becomes less inclined to view therapy as a passive process (in which the therapist does all the "work"), and may feel less panicky and helpless when facing an impending crisis or the therapist's future absences. In this sense, planning becomes an empowering process for the patient.

Fifth, the process of clarification encourages the therapist to consider carefully his or her own needs for time off, away from the immediate responsibilities of work. Such planning helps ensure that the therapist does not become overwhelmed by the demands of work and does not experience burnout. The drawing of such boundaries also encourages the therapist to attend explicitly to other sources of meaning, joy, fulfillment, and support so that he or she does not begin looking to clients to fill personal needs (see Chapter Five). This is a crucial aspect of the therapist's maintaining emotional competence (see Chapter Four).

All therapists need to clarify major areas of accessibility in a manner consistent with their own needs and style of practice and with the clinical needs of each client. Some clinicians hold to exact time boundaries. With virtually no exceptions, they begin and end the session on the dot. Even if the client has just experienced a painful breakthrough and is in obvious distress, they do not extend the therapy session. In some situations, ending promptly is a practical necessity: the therapist may have another client scheduled to begin a session immediately. In other situations, observing strict time boundaries is required by the theoretical orientation: running over the time boundary might be considered by the therapist to constitute a breaking of the frame of therapy or represent the therapist and client colluding in acting out.

Therapists must consider carefully the approach to time boundaries of the session that best fits their own theoretical orientation and personal needs. The effects of the policy on individual clients need to be considered, and the client should understand the policy.

THERAPIST AVAILABILITY BETWEEN SESSIONS

When and under what conditions can the client normally speak with the therapist between sessions? Some therapists receive nonemergency calls from clients during reasonable hours (for example, 9:00 A.M. to 9:00 P.M.) of weekdays when they are not otherwise engaged. A very few therapists take nonemergency calls when they are conducting psychotherapy. We recommend against this practice, which seems disrespectful of the client who is in session and seems to have numerous potentially harmful effects on the course of therapy of the client whose session is interrupted by nonemergency calls (or is aware that any session might be interrupted at any time by such calls to the therapist).

The therapist needs to be clear about the times between sessions when he or she can be contacted on a nonemergency basis. For example, are weekend calls or calls on holidays such as Labor Day, Memorial Day, or Martin Luther King Day acceptable?

An extremely important point to clarify is whether the therapist will speak with the client more than briefly by telephone when there is no emergency. Some clients may wish to use telephone calls to address the unresolved issues from the previous therapy session, share a dream while it is still fresh in their mind, or talk over how to handle a situation at work. Some therapists may see such telephone sessions as therapeutically useful for some clients. The sessions may, for example, help particularly fragile and needy clients, who might otherwise require day treatment or periodic hospitalizations, to function under the constraints of once- or twice-weekly outpatient therapy. They may help some clients learn how to use and generalize the adaptive skills they are acquiring in office sessions; the telephone sessions serve as a bridge between office therapy sessions and independent functioning by the client.

Other therapists believe that such telephone sessions during which therapy is conducted are—except under rare emergency conditions—countertherapeutic. For example, they might view extended telephone contacts between sessions as similar in nature and effect to going beyond the temporal boundary at the end of a session. Other therapists may, as part of their own self-care (see Chapter Five), limit out-of-office telephone contacts to emergencies.

Again, whether the therapist uses an approach that includes therapy sessions conducted by telephone on an ad hoc basis or prohibits them is less important than that (1) the therapist thinks through the issues carefully in terms of consistency with his or her theoretical orientation and personal approach, (2) the therapist considers carefully the implications of the policy for the individual client, and (3) both therapist and client clearly understand the ground rules.

It can also be important to clarify under what circumstances, if any, the therapist will be available for e-mail communication and how privacy issues will be addressed; for example, do any third parties have access to the therapist's or the client's e-mail accounts? Some therapists have been surprised to receive unexpected e-mail from a client who has searched the Internet and discovered the therapist's supposedly "personal" e-mail address. Both therapist and client must clearly understand whether e-mail can be used to schedule and cancel sessions, check in between regularly schedule office sessions, or provide therapy or counseling over the Internet.

Many standards, guidelines, and codes listed in Appendix G include sections addressing communication with clients using telephone, e-mail, or other electronic means. A few (for example, the National Board for Certified Counselors' "The Practice of Internet Counseling" and the American Psychological Association's "Statement on Services by Telephone, Teleconferencing, & Internet") focus exclusively on electronic communications.

An excellent resource is a recently published survey of ethical dilemmas that psychologists encountered in telephone counseling (Dalen, 2006). Dilemmas involving "confidentiality and professional secrecy" were the most frequently reported (p. 240). Dilemmas involving integrity were also frequently reported, although dilemmas involving competence were rarely mentioned.

VACATIONS AND OTHER ANTICIPATED ABSENCES

Extended and sometimes even brief interruptions in the schedule of appointments can evoke deep and sometimes puzzling or even overwhelming reactions in a client. What is important is that the therapist give the client adequate notice of the anticipated absence. If the therapist tends to take a two-week vacation at the same time each year, there may be no reason for the therapist to omit this information from the customary orientation provided to a new client. A therapist who finds that he or she will be taking a six-week sea cruise during the coming year should consider carefully if there is any compelling clinical or practical reason to withhold this information from the client as soon as reservations are made. Prompt notification of anticipated therapist absences minimizes the likelihood that the client will experience a psychologically paralyzing traumatic shock, gives the client maximal time to mobilize the resources to cope with the therapist's absence in a way that promotes independence and growth, and enables the client to become aware of reactions and work with them during the sessions before and after the absence.

SERIOUS ILLNESS AND OTHER UNANTICIPATED ABSENCES

Both therapists and clients tend to find comforting the myth that the therapist is immortal and invulnerable (Pope, Sonne, & Greene, 2006). Therapists may enjoy the feeling of strength and of being a perfect caregiver that such a fantasy, which sometimes occurs on an unconscious level, provides. Clients may soothe themselves (and avoid confronting some personal issues) with the fantasy that they are being cared for by an omnipotent, immortal parental figure.

Although we have not completed our careful study of every therapist who has ever lived, our preliminary results suggests that there has yet to appear a therapist who is immortal and invulnerable. For all of us who are mortal and vulnerable, it is important to prepare for those unexpected times when we are suddenly unavailable to our clients (see Chapter Six).

STEPS FOR FOSTERING AVAILABILITY OF HELP IN A CRISIS

Once the client clearly understands how to contact the therapist by telephone between regularly scheduled appointments, the therapist and client can discuss appropriate arrangements for situations in which this system is inadequate. The client, for example, may experience an unanticipated crisis and be unable to reach the therapist promptly by telephone because the therapist's line is busy for an extended time, the therapist's answering service mishandles the client's call, the therapist is in session with another client who is in crisis, or any number of other typical or once-in-a-lifetime delays, glitches, or human errors. For the five reasons cited at the beginning of this chapter, planning for such "unanticipated" breakdowns in communication can enable access to prompt clinical services in time of crisis and can foster more careful therapeutic planning.

If the client's need for help is urgent and the therapist is unavailable, is there a colleague who is providing coverage for the therapist? Some organization settings, such as health maintenance organizations and community mental health centers, as a matter of policy and procedure assign clinicians to serve on-call rotations so that there is always someone available to provide coverage in a crisis when a patient's therapist is unavailable. However, many therapists, particularly those in solo independent practice, may need to create and implement their own plans to ensure coverage in an emergency should they be unavailable.

The decision of whether to arrange for coverage for a specific client is complex. Perhaps the first question is what sorts of information the covering clinician will be provided about the client. Will the coverage provider receive a complete review and periodic update of the client's clinical status, treatment plan, and therapeutic progress? Will the coverage provider have access to the client's chart? Will the coverage provider keep a separate set of notes regarding information supplied by the primary therapist? To what extent will the coverage provider need to secure independent informed consent for treatment by the client? The more foreseeable or the greater the risk is that the client will experience a serious crisis demanding prompt intervention, the more compelling the reason is for the primary therapist to brief the coverage provider in a careful, thorough manner.

Once the therapist has determined what degree of coverage seems appropriate for a specific client, a second question is how to introduce the possibility of or actually implement such coverage affecting the client's status or treatment. Some clients might feel greatly reassured to know that the therapist is taking his or her responsibilities seriously and is carefully thinking through possible, even if unlikely, treatment needs. Other clients may become alarmed and feel as if the therapist is predicting that a crisis will occur. Still other clients may stall in their progress; the strict privacy and confidentiality of therapy is essential for them, and the knowledge that the therapist will be sharing the contents of sessions with the coverage provider inhibit the client's ability to explore certain issues or feelings. In many cases, discussion between the therapist and client of the question of whether specific coverage will be provided is useful therapeutically.

If it is decided that specific coverage will be provided, a third question for the therapist is what will best ensure the client's right to adequate informed consent for sharing information with the coverage provider and otherwise making arrangements for the coverage.

A fourth question addresses the selection of a clinician to provide the coverage. The primary therapist may incur legal (that is, malpractice) liability for negligence in selecting the coverage. If, for example, the clinician providing the coverage mishandles a crisis situation or otherwise harms the client through inappropriate acts or failures to act, the primary therapist may be held accountable for failure to screen and select an appropriate clinician. However, the ethical and clinical issues are much more subtle. It is important to select a clinician who is well trained to provide the type of care that the client may need. The primary therapist may be tempted to select a clinician solely (and perhaps inappropriately) on grounds of expedience. The primary therapist may know that the clinician is not a very good one and is perhaps less than scrupulous in his or her professional attitudes and actions. Furthermore, the primary therapist may be aware that the clinician does not tend to work effectively with the general client population that the therapist treats. Nevertheless, the therapist may push such uncomfortable knowledge out of awareness because this particular clinician is handy, and it might take considerable effort to locate an appropriate and trustworthy coverage provider. As in so many other situations discussed in this book, the Golden Rule seems salient. If we were the patient, or if it were our parent, spouse, or child who desperately needed help in a crisis when the primary therapist is unavailable, if the careful handling of the crisis were potentially a matter of life and death, what level of care would we believe adequate in selecting a clinician to provide the coverage? If, for example, our parent became suddenly despondent, received a totally inadequate response from the clinician providing the coverage, and committed suicide, would convenience seem sufficient rationale for the primary therapist's selection of that clinician to provide the coverage?

If no clinician has been identified to provide coverage or if the identified clinician is for some reason unavailable, to whom does the client in crisis turn when the primary therapist is unavailable? It may be useful for the client to locate a psychiatric hospital, a general hospital with psychiatric services, or other facility providing emergency psychiatric services. There are at least five crucial questions. First, is the facility nearby? Second, are the services available on a twenty-four-hour basis? (If the crisis occurs in the middle of the night, on a weekend, or on a holiday, will the client find help available?) Third, can the client afford to use the facility? Some facilities charge exceptionally high prices and may offer services only to those who can provide proof of ability to pay—for example, an insurance policy currently in effect. Fourth, does the client know where the facility is located and what its telephone number is? Especially during a crisis, even basic information (such as the name of a hospital) may be hard to remember. In some instances—for example, both the therapist and client believe that there is a high risk for a crisis—it may be useful for the client to write down the name of the hospital, the address, and the telephone number to carry with him or her and to leave by the telephone at home. Sometimes close friends or family play a vital role in supporting a client in times of crisis. If the circumstances are appropriate, the client may also wish to give this information to a close friend or relative. Fifth, both the therapist and client must have justifiable confidence that the facility provides adequate care. Substandard care may make a crisis worse; in certain instances, no care from certain facilities may be better than an inappropriate response.

If the primary therapist, secondary coverage, and designated facility are all unavailable—for whatever reason—in time of crisis, is there an appropriate hot line or other twenty-four-hour telephone service that can provide at least an immediate first-aid response to the crisis and attempt to help the client locate a currently available source of professional help? Some locales have twenty-four-hour suicide hot lines. There may be a twenty-four-hour crisis line providing help for individuals with certain kinds of problems. At a minimum, such a telephone service may help a client survive a crisis. For some clients (for example, those who cannot afford a telephone at their residence), identifying locations of telephones that will be accessible in times of crisis will be an important part of the planning.

If all of the resources noted are inaccessible to the client, the client may nevertheless be able to dial 911, the operator, or a similar general call for emergency response. The client may then be guided to sources of help, or, if appropriate, an ambulance or other emergency response may be dispatched.

Whenever a therapist is assessing a client's resources for coping with a crisis that threatens to endanger or overwhelm the client, it is important to assess not only the professional resources but also the client's social resources. Individual friends and family members may play key roles in helping a client to avert or survive a crisis (though a friend or family member can also initiate, intensify, or prolong a crisis). In some instances, nonprofessional groups, such as Alcoholics Anonymous, may provide virtually twenty-four-hour access to support. The presence of such social supports gains in relative importance when the client's access to professional help tends to be difficult. For example, some clients (especially those who cannot afford a telephone) cannot gain easy access to a telephone, particularly if they are experiencing a crisis in the middle of the night. For many clients, the awareness of such social supports helps them to feel less isolated and thus less vulnerable to becoming overwhelmed by a crisis.

It is worth noting that sometimes therapy begins with the patient in crisis and that the patient's access to a team of clinicians or caregivers may be useful. The *American Psychologist* presented the following case study illustrating a situation in which the immediate creation of crisis team proved helpful when a person without funds or coverage needed help:

> In an instance in which a woman required daily sessions during a critical time in her life, colleagues accepted [the therapist's] request that they serve pro bono as an interdisciplinary team, offering detailed daily consultation to him and providing periodic psychological assessment and clinical interviews for the woman. Her meetings with diverse professionals let her know that many people cared about her. These colleagues mobilized to help a battered woman, a victim of multiple sexual assault, now penniless and homeless, living in her car and hiding from a stalker. She and [the therapist] began meeting daily (later gradually reduced to weekly) for crisis intervention. They agreed that the first priority was her safety. [The therapist] gave her the number of an old college friend in another state. The friend immediately wired her $500 for food and housing and an airline ticket with an open date for use any time she felt in danger from the stalker. The friend asked her not to repay this loan directly to him but rather to give the money to someone else for whom it would make a difference as it did for her now. Within a year, the woman had taken legal action against the stalker and recovered enough to support herself ["Biography," 1995, p. 242].

ENDINGS

An easily overlooked responsibility in regard to ending the therapeutic relationship is the therapist's responsibility to terminate the relationship under certain conditions. The APA Ethics Code (APA, 2002) Standard 10.10a clarifies responsibilities to end the therapeutic relationship when appropriate by indicating that "psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service" (p. 1073). The CPA Code of Ethics (CPA, 2000) Standard II.37 requires that psychologists "terminate an activity when it is clear that the activity carries more than minimal risk of harm and is found to be more harmful than beneficial, or when the activity is no longer needed" (p. 24).

Ideally, therapists provide continuing service as long as it is needed and beneficial. Some insurance coverage or managed care plans can create stark challenges. For example, an insurance company may refuse to approve continuing services for a patient, despite the therapist's professional judgment that terminating services would be harmful for the patient, perhaps even resulting in the patient's suicide. A managed care company may provide only four to six sessions annually for any patient, with exceptions provided only for "medical necessity," which might be defined as imminent risk of suicide or homicide. Some patients who do not meet the relevant criteria of medical necessity may suffer from conditions or crises that cannot be adequately addressed in four to six sessions. For some such patients, interruption of their treatment, even though in accordance with a managed care company's policies and procedures, may constitute abandonment.

How do therapists and patients know when to terminate therapy? A key psychotherapeutic strategy is to review the presenting concerns, goals, and progress from time to time. This helps clarify how much has been accomplished, as well as what still needs to be addressed, and whether the patient and therapist collaboratively wish to continue. Some clients are able to easily announce that they are ready to stop coming, or that their employer has switched insurance providers, and that they would like your help to choose their next therapist from their new provider list. Others may be panicked at the notion of stopping without appropriate preparation.

The issue becomes complex if the psychotherapist perceives that the treatment is progressing well, and the client or patient either is not clear about how long to continue or no longer wishes to continue, but has difficulty raising the issue. Often these clients just stop coming. They either indicate that they will call to schedule the next appointment or cancel and do not reschedule. In addition, many people use psychotherapy in short installments and "drop out" for a while, later returning to the same clinician or starting with a new therapist. When clients who seemed successfully engaged in psychotherapy stop coming, a note or call to provide them with options can be helpful and provide useful information. Examples of options may include to come in for a review and termination session, terminate by telephone or note, or return to psychotherapy.

When approaching termination, therapists must—if they are able—adequately address the questions that tend to be an inherent part of termination. The American Psychological Association's Ethical Principles and Code of Conduct (2002, p. 1073) Standard 10.10c states the responsibilities of a therapist to engage in a termination process: "Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate." A new APA Ethics Code standard indicates that we have the right to terminate psychotherapy when we are threatened by the client or patient or another person with whom the client or patient has a relationship (Standard 10.10b). This is an attempt to balance the importance of therapist self-care with the responsibilities to the patient. It is probably not appropriate to terminate when a client is in crisis.

CONCLUSION

Constant awareness—particularly a careful, imaginative awareness—and a sense of personal responsibility play a fundamental role in ensuring that clients have adequate access to the help they need, particularly in times of crisis when the therapist is not immediately available. In hospital and similar organizational settings, the apparent abundance of staff may lead to a diffusion of responsibility in which no one is available to help a patient in crisis. Levenson and Pope (1981), for example, present a case study in which a psychology intern was assigned responsibility to contact promptly a suicidal individual who had been referred to the outpatient unit by the crisis service and arrange for conducting an intake assessment. The intern, however, was absent from the staff meeting at which the assignment was made. His supervisor, also absent from the meeting, had sent him to attend a two-day training session at another institution. During the next few days, the individual committed suicide.

The hospital's thanatology committee concluded that the crisis service had handled the situation appropriately in referring to the outpatient unit. The outpatient unit itself was not involved in the postmortem investigation because, according to the hospital's procedures, outpatient cases are not opened until the potential patient is contacted by the outpatient unit for an intake screening. The intern himself struggled with his reactions to these events. Among his conclusions was that he had "at some level internalized the organizational view that no one is really responsible" (p. 485).

Imagination is useful in creating an awareness of the types of crises a client might experience and what difficulties he or she might experience in trying to gain timely access to needed resources. The scenarios for discussion presented at the end of this chapter provide examples.

Thinking things through on a worst-possible-case basis can help the therapist to anticipate the ways in which Murphy's law can make itself felt in human endeavors. If we look back from that imaginative perspective, we can ask ourselves: If any of the worst possible case outcomes had happened, what, if anything, do we wish we would have done to prevent them, lessen their impact, or prepare for addressing these events?

No therapist is infallible. The most careful and confident assessment of a patient's potential for crisis can go awry for any number of reasons. But the therapist should take into account his or her own fallibility and plan for the unexpected.

Similarly, imaginative approaches can create accessibility to needed resources. For example, a therapist was treating an extremely isolated, anxious, and troubled young woman pro bono because of the client's lack of money. From time to time, the client became overwhelmed by anxiety and was acutely suicidal. However, she had no practical access to hospitalization because of her financial status and the absence in the community of sufficient beds for those who lacked adequate funds or insurance coverage. In similar cases, the therapist had encouraged clients to make arrangements to have a trusted friend come by to stay with the client during periods of extreme dysfunction and suicidal risk. However, this client was so socially isolated that she had no friends, and the therapist was unable to locate an individual—from local church and synagogue groups or from hospital volunteer organizations—who could stay with the client in times of crisis. Determined to come up with some arrangement that would help ensure the client's safety and welfare should the client experience a crisis and the therapist be unavailable, the therapist and client finally hit on the possibility of the client's going to the local hospital's waiting room. (The waiting room adjacent to the emergency room was open around the clock.) The therapist contacted hospital personnel to make sure that they would have no objection to her patient showing up at odd hours to sit for indefinite periods of time in the waiting room.

The arrangement worked well during the remaining course of therapy. According to the client, simply knowing that there was someplace for her to go frequently helped her to avoid becoming completely overwhelmed by external events or by her own feelings. On those occasions when she did feel that she was in crisis and at risk for taking her own life, she found that going to the hospital waiting room seemed helpful; it made her feel more active and aware that she was doing something for herself. Being out of her rather depressing and claustrophobic apartment, sitting in a "clean, well-lighted place," and being around other people (who, because they were strangers, would be unlikely to make, in her words, "demands" on her) were all factors that helped her feel better. Knowing that there were health care professionals nearby (even though she had no contact with them) who could intervene should her impulses to take her own life become too much for her, and aware that she was carrying out a "treatment plan" that she and her therapist had developed together, helped her to feel calmer, less isolated, and comforted in crisis. The waiting room strategy enabled this highly suicidal client to be treated safely, although hospitalization was not feasible, during the initial period of therapy when outpatient treatment alone seemed, in the judgment of both the therapist and an independent consultant, inadequate and when the client could not afford additional resources. It made imaginative use of resources that were readily available in the community and were accessible to the client.

Understanding the degree to which individual clinicians and mental health organizations will be accessible and will make help available is a crucial aspect of the patient's informed consent, the focus of the following chapter.

SCENARIOS FOR DISCUSSION

Chapters Ten through Eighteen in this book end with scenarios, each accompanied with a set of questions for discussion. This approach had been used in *Sexual Feelings in Psychotherapy: Explorations for Therapists and Therapists-in-Training* (Pope, Sonne, & Holroyd, 1993). Although we have created original vignettes for the other chapters in this book, the following scenarios and questions come from *Sexual Feelings in Psychotherapy* and *What Therapists Don't Talk About and Why: Understanding Taboos That Hurt Us and Our Clients* (Pope, Sonne, & Greene, 2006).

You notice that it is exactly 2:00 P.M., the time you are scheduled to meet a new client, and no one is in the waiting room. The telephone rings. It is your new client. She asks if you would mind coming out to the front steps. You're puzzled but say, "I'll be right there." When you go to the front steps, you see your new client in her wheelchair at the bottom of the steps.

1. How do you feel?
2. What thoughts go through you mind?
3. What do you think is the first thing you would say?
4. What would you like to do?
5. What do you think you would do?

You are late getting to the airport, in danger of missing your plane (during a holiday season, so it would be very hard to get space on a later flight), when you receive an emergency call from a local hospital. One of your therapy patients has tried to commit suicide and has been hospitalized. The client is desperate to talk with you in person—refusing to talk over the telephone—immediately about having just discovered a horrifying secret. You have no idea what the "secret" is.

1. How do you feel?
2. Are there any feelings about the patient, the emergency room staff person who called you, or the situation that are particularly difficult to acknowledge?
3. What are your immediate options?

4. What do you think you would do?
5. To what extent, if at all, do any concerns about a malpractice suit influence your judgment?

A new client begins the first session by saying, “I need therapy because I lost my job, and my partner, whom I lived with for three years, left me for someone else. I don’t know whether to kill myself, kill my boss, kill everyone else, or just try to hang on since now I’m all my little baby has left.”

1. How do you feel?
2. Assuming that you cannot rule out that the person’s threats are serious, what steps do you take in clarifying access to you and others before the client leaves this first appointment?
3. What concerns, if any, do you have about this person’s adequate access to prompt and adequate help?
4. Is there anything you wish you would have told the person about your availability or anything else before the person made these statements?

You work for a large managed care company, providing individual and family therapy full time. You meet with your manager late Friday afternoon and are told that the company has been taken over by a new owner, who is merging several companies. There are now too many therapists, and it is with the greatest regret that your manager tells you that reorganization has led to your no longer being retained by the company. This is your last day. Your clients are being reassigned. You will be allowed to return to your office only with a security guard, you will be able to stay only thirty minutes to clean out your desk, and you will not be allowed to copy any telephone numbers or other information or to take any charts with you.

1. How do you feel?
2. What are your options?
3. What steps do you think you would take?
4. Would you make any effort to contact the clients you had been seeing? If so, how and what would you tell them?

A former client, whom you had seen in therapy for three years, called in crisis. She said that she had started psychotherapy with someone else, given a change of jobs and a new insurance plan. You were not listed on the managed care provider list. However, she cannot reach that new therapist during her crisis. Besides, she feels more comfortable with you.

1. What do you feel?
2. Do you have any legal or ethical obligations to this former client, and, if so, what are they?
3. If you agree to talk with this client on the telephone for a while or meet with her for one or more crisis sessions, what legal, ethical, or clinical responsibilities, if any, do you have in regard to coordinating your work with her current managed care therapist?
4. Do you chart this telephone call?
5. Do you have a clear policy regarding contacts with former clients? If so, are clients made aware of this policy prior to termination?

CHAPTER ELEVEN

Informed Consent and Informed Refusal

The right to informed consent reflects respect for individual freedom, autonomy, and dignity. It is fundamental to the ethics of therapy and counseling. The APA ethics code (see Appendix A) sets forth specifics standards for informed consent (sections 3.10, 10.01, 10.02, 10.03, and 10.04). Truscott and Crook (2004) note that "informed consent is the most represented value in the Canadian Code of Ethics for Psychologists" (p. 55; see Appendix B).

This fundamental concept can trip us up if we are not careful. Nothing blocks a patient's access to help with such cruel efficiency as a bungled attempt at informed consent. We may have struggled successfully with the challenges outlined in the previous chapter. The doors to our offices and clinics are open wide. The resources are all in place. But not even the most persistent patients can make their way past intimidating forms (which clerks may shove at patients when they first arrive), our set speeches full of noninformative information, and our nervous attempts to meet externally imposed legalistic requirements such as the Health Insurance Portability and Accountability Act. A first step in remedying the situation is to recognize that informed consent is not a static ritual but a useful process.

THE PROCESS OF INFORMED CONSENT

The CPA ethics code notes that psychologists "recognize that informed consent is the result of a process of reaching an agreement to work collaboratively, rather than of simply having a consent form signed" (see Appendix B). The process of informed consent provides both the patient and therapist an opportunity to make sure that they adequately understand their shared venture. It is a process of communication and clarification. Does the therapist possess at least a sufficient initial understanding of why the patient is seeking help? Does the therapist know what the patient expects, or hopes, or fears from the assessment and therapy? Does the patient adequately understand the approach the clinician will be using to assess and address the problem? Does the patient know the common effects of using such an approach and alternative approaches to his or her problem?

Informed consent also involves making decisions. The patient must decide whether to undertake this course of assessment and treatment, whether to start now or delay, and whether to try an alternative approach or an alternative therapist. The therapist must decide whether the patient is competent to exercise informed consent. For example, very young children, adults who have been declared legally incompetent, and those who have significant intellectual impairment may not be capable of providing fully informed consent. If informed consent is not possible, the therapist must decide whether the situation justifies an intervention in the absence of fully informed consent. The therapist must also consider whether a fully competent patient has been provided the relevant information with which to make a decision and sufficiently understands that information and whether the patient is providing consent on an adequately voluntary basis.

Patrick O'Neill, a former president of the Canadian Psychological Association, suggests that the process of informed consent take the form of negotiation: "While most therapists recognize that negotiation can clear up clients' misconceptions, fewer recognize that negotiation is also a vehicle for clearing up the *therapist's* misconceptions. An open dialogue can make the therapist aware of features of the case that depart from both the therapist's model and his or her previous experience, and thus it serves as a corrective to the representativeness and availability biases" (1998, p. 176).

Finally, informed consent tends to be a recurrent process. The patient may consent to an initial psychological, neuropsychological, and medical assessment as well as to a course of individual psychotherapy based on an initial, very provisional treatment plan. Several months into treatment, the treatment plan may be significantly altered on the basis of the results of the assessments, the patient's diverse reactions to various components of the treatment plan, and the patient's changing needs. As the treatment plan undergoes significant evolution, the patient must adequately understand these changes and voluntarily agree to them.

THE BASIS OF INFORMED CONSENT

Informed consent is an effort to ensure that the trust required of the patient is truly justified, the power of the therapist is not abused intentionally or accidentally, and the caring of the therapist is expressed in ways that the patient clearly understands and agrees to. Case law has provided a clear analysis of the basis and workings of informed consent. Much of this case law has concerned medical practice, but the relevance (not always complete) of the principles to clinical assessment and psychotherapy can be inferred.

Historically, the health care professions took a fairly arrogant and authoritarian position in regard to what the patient needed. The Hippocratic Oath lacked the principle of informed consent. The patient obviously did not have sufficient training and knowledge, let alone objectivity, to determine what procedures were indicated.

One landmark in the shift away from this authoritarian approach appeared in a New York case. In 1914, Judge Benjamin Cardozo, who later became a justice of the U.S. Supreme Court, wrote that "every human being of adult years and sound mind has a right to determine what shall be done with his own body" (*Schloendorf* v. *Society of New York Hospital,* 1914, p. 93). It was not so much that this case changed the customary procedures by which doctors went about their work; it was more that Judge Cardozo articulated clearly the principle that it was the patient, rather than the doctor, who had the right to decide whether to undertake a specific treatment approach. The implications of this principle lay dormant for decades.

The Nuremberg trials and subsequent Nuremberg Code on Medical Intervention and Experimentation focused professional and public attention on the issue of informed consent. The trials revealed the horrific and inhumane practices of many health care professionals during World War II under the guise of "treatment" and "research"

(Cocks, 1985; Gallagher, 1990; Koenig, 2000; Lifton, 1986; Muller-Hill, 1988; Pope, 1991; Proctor, 1988; Spitz, 2005). The Nuremberg trials and code emphasized the individual's fundamental right to informed consent to or informed refusal of participation in treatment or research. O'Neill (1998) wrote, "The two main ways of protecting the public from the healer are oversight and consent. Throughout most of the history of healing, the emphasis was on oversight: monitoring of professional activity by professional associations, regulatory bodies, or the courts. The Nuremberg Declaration gave a new, privileged position to consent, putting control into the hands of the client" (pp. 13–14).

Shuster noted how easy it could be, when the right to consent or refusal is ignored, to allow purportedly good ends to justify inflicting terrible—sometimes fatal—"treatments" on human beings without their knowledge or consent:

> This was the case of ionising radiation research motivated by the cold war and sponsored by the US government for national security. Patients in hospital, children, mentally ill and impaired persons, pregnant women, workers, soldiers, and others were used as experimental subjects often without their knowledge, or that of their families; many believed they were being treated for their medical conditions [Shuster, 1998, p. 976; see also Advisory Committee on Human Radiation Experiments, 1995].

Another landmark appeared in 1960, in the Kansas case of *Natanson* v. *Kline.* The court reaffirmed the Cardozo principle: "Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man is considered to be master of his own body" (p. 1104). The court stated that to make this determination, the patient obviously needed the relevant information. But what information was relevant was left entirely to the community of doctors to decide:

> The duty . . . to disclose . . . is limited to those disclosures which a reasonable . . . practitioner would make under the same or similar circumstances. . . . So long as the disclosure is sufficient to assure an informed consent, the physician's choice of plausible courses should not be called into question if it appears, all circumstances considered, that the physician was motivated only by the patient's best therapeutic interests and he proceeded as competent medical men would have done in a similar situation [p. 1106].

This case exemplifies the "community standard" rule: Informed consent procedures must adhere only to what the general community of doctors customarily do. It also reflects the strong value of autonomy and self-determination that underlies Western law, policy, and ethical decision making.

In 1972, with decisions handed down by the Federal District Court in Washington, D.C., and the California Supreme Court, the full implications of Judge Cardozo's principle were realized. The reasoning began with the reaffirmation of *Schloendorf* v. *Society of New York Hospital* and an emphasis that the patient must have relevant information that only the doctor can provide:

> The root premise is the concept, fundamental in American jurisprudence, that "every human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ." True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision. From these almost axiomatic considerations springs the need, and in turn the requirement, of a reasonable divulgence by physician to patient to make such a decision possible [*Canterbury* v. *Spence,* 1972, p. 780].

It is the patient, and not the doctor, who must make the final decision, and this decision, to be meaningful, must be based on an adequate range of information provided by the doctor: "It is the prerogative of the patient, not the physician, to determine for himself the direction in which he believes his interests lie. To enable the patient to chart his course knowledgeably, reasonable familiarity with the therapeutic alternatives and their hazards becomes essential" (*Cobbs* v. *Grant,* 1972, p. 514).

This line of reasoning emphasized the exceptional trust and dependence inherent in health care, differentiating them from the milder versions of trust and dependence, often dealt with using a caveat emptor principle, characteristic of less intense, less intimate transactions in the marketplace:

> A reasonable revelation in these aspects is not only a necessity but, as we see it, is as much a matter of the physician's duty. It is a duty to

> warn of the dangers lurking in the proposed treatment, and that is surely a facet of due care. It is, too, a duty to impart information which the patient has every right to expect. The patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms-length transactions. His dependence upon the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject [*Canterbury* v. *Spence,* 1972, p. 782].

This landmark case law specifically rejected the idea that doctors, through their "community standards," could determine what degree of information the patient should or should not have. It was not up to doctors, individually or collectively, to decide what rights a patient should have with regard to informed consent or to determine those rights indirectly by establishing customary standards regarding what information was and was not to be provided. Patients were held to have a right to make an informed decision, and the courts were to guarantee that they had the relevant information for making the decision. The court observed in *Canterbury* v. *Spence*, "We do not agree that the patient's cause of action is dependent upon the existence and nonperformance of a relevant professional tradition. . . . Respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves" (1972, pp. 783–784).

The case law clearly states the need for doctors to provide adequate relevant information regardless of whether the patient actively asked the "right" questions in each area. Thus, doctors were prevented from withholding or neglecting to provide relevant information because a patient did not inquire. The doctors were seen as having an affirmative duty to make an adequately full disclosure:

> We discard the thought that the patient should ask for information before the physician is required to disclose. Caveat emptor is not the norm for the consumer of medical services. Duty to disclose is more than a call to speak merely on the patient's request, or merely to answer the patient's questions: it is a duty to volunteer, if necessary, the information the patient needs for intelligent decision. The patient may be ignorant, confused, overawed by the physician or frightened by the hospital, or even ashamed to inquire. . . . Perhaps relatively few patients could in any event identify the relevant questions in the absence of prior explanation by the physician. Physicians and hospitals have pa-

> tients of widely divergent socio-economic backgrounds, and a rule which presumes a degree of sophistication which many members of society lack is likely to breed gross inequalities [*Canterbury v. Spence,* 1972, p. 783].

Realizing that some patients would certainly choose not to undertake specific assessment or treatment procedures, the courts emphasized that understanding what might happen as a result of not getting adequate assessment or treatment was as relevant to making an informed decision as understanding the assessment and treatment procedures themselves. Thus, the California Supreme Court in 1980 not only reaffirmed the principles previously set forth in *Canterbury* v. *Spence* and *Cobbs* v. *Grant* but also affirmed that patients have a right to informed refusal of treatment as well as a right to informed consent to treatment: "The rule applies whether the procedure involves treatment or a diagnostic test. . . . If a patient indicates that he or she is going to *decline* a risk-free test or treatment, then the doctor has the additional duty of advising of all the material risks of which a reasonable person would want to be informed before deciding not to undergo the procedure. On the other hand, if the recommended test or treatment is itself risky, then the physician should always explain the potential consequences of declining to follow the recommended course of action" (*Truman* v. *Thomas,* 1980, p. 312).

Recognizing that some doctors might be intimidated by the daunting thought of presenting to patients essentially all they had learned during their training and that patients might be ill-suited recipients of jargon-filled lectures, the court emphasized that the patient needed only the relevant information to make an informed decision but needed it in clear, straightforward language: "The patient's interest in information does not extend to a lengthy polysyllabic discourse on all possible complications. A mini-course in medical science is not required" (*Cobbs* v. *Grant,* 1972, p. 515).

In summary, the courts in the 1970s tended to shift the locus of decision making clearly to the patient and the responsibility for ensuring that the decision was based on adequate, relevant information clearly to the doctor. The California Supreme Court attempted to articulate the basis of this concept of informed consent:

> We employ several postulates. The first is that patients are generally persons unlearned in the medical sciences and therefore, except in rare cases, courts may safely assume the knowledge of patient and

> physician are not in parity. The second is that a person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment. The third is that the patient's consent to treatment, to be effective, must be an informed consent. And the fourth is that the patient, being unlearned in medical sciences, has an abject dependence upon and trust in his physician for the information upon which he relies during the decisional process, thus raising an obligation in the physician that transcends arm-length transactions. From the foregoing axiomatic ingredients emerges a necessity, and a resultant requirement, for divulgence by the physician to his patient of all information relevant to a meaningful decisional process [*Cobbs* v. *Grant,* 1972, p. 513].

These principles began to pass from case law into legislation. Indiana's House Enrolled Act of 1984, for example, stated, "All patients or clients are entitled to be informed of the nature of treatment or habilitation program proposed, the known effects of receiving and of not receiving such treatment or habilitation, and alternative treatment or habilitation programs, if any. An adult voluntary patient or client, if not adjudicated incompetent, is entitled to refuse to submit to treatment or to a habilitation program and is entitled to be informed of this right" (Section F).

The increasing emphasis on the importance of informed consent is reflected in the latest revision of the APA ethics code. Celia Fisher, director of the Fordham University Center for Ethics Education and Marie Doty University Chair in Psychology, wrote:

> Informed consent is seen by many as the primary means of protecting the self-governing and privacy rights of those with whom psychologists work. In the 1992 Ethics Code, the obligation to obtain informed consent was limited to research and therapy. In the 2002 Ethics Code, the broader informed consent requirement for most psychological activities reflects the societal sea change from a paternalistic to an autonomy-based view of professional and scientific ethics [2003, p. 77].

ADEQUATE INFORMATION

The information provided during the consent process will differ according to the professional service (for example, assessment, therapy) and other factors. However, any consent process can be evaluated in terms of whether it adequately addresses the following questions. This list may be useful in planning and in concurrent review of consent procedures in any setting:

- Does the client understand who is providing the service and the clinician's qualifications (for example, license status)? If more than one person is involved (for example, a therapist and clinical supervisor; see Chapter Eighteen), does the client understand the nature and implications of this arrangement?
- Does the client understand the reason for the initial session? Although in many instances clients will have scheduled an initial appointment on their own initiative and for relatively clear reasons, in other instances they may have been referred by others (perhaps an internist or a court) and not clearly understand the reason for the session.
- Does the client understand the nature, extent, and possible consequences of the services the clinician is offering? Does the client understand the degree to which there may be alternatives to the services provided by the clinician?
- Does the client understand actual or potential limitations to the services (for example, a managed care plan's limitation of eight therapy sessions; an insurance policy's limitation of coverage to a specific dollar amount) or to the clinician (for example, the therapist is an intern whose rotation will conclude in three months, after which he or she will no longer be available to the client)? Does the client understand the ways in which the services may be terminated?
- Does the client understand fee policies and procedures, including information about missed or canceled appointments?
- Does the client understand policies and procedures concerning access to the clinician, to those providing coverage for the clinician, or to emergency services? For example, under what conditions, if any, will a therapist (or someone else providing coverage) be available by telephone between sessions during business hours, at night, or on weekends? (Chapter Ten discusses these issues.)
- Does the client understand exceptions to confidentiality, privilege, or privacy? For example, does the client understand the conditions, if any, under which the clinician might disclose information about the client to an insurance company, the police, or the courts? Does the person understand under what conditions other people in the setting (such as clerical workers, clinical supervisors or consultants, administrative supervisors or other administrative staff,

quality control personnel, utilization review committees, auditors, researchers) may learn about the client and the services provided to the client, whether through discussion (case conferences, supervision, consultation) or writings (clinical chart notes, treatment summaries, administrative records). Chapter Sixteen provides a discussion of these issues and exceptions.

CONSIDERATIONS IN PROVIDING INFORMED CONSENT

No unvarying and inflexible method exists for legitimately ensuring a client's informed consent. No method can relieve us of a thoughtful response to the particulars before us. All of us have developed unique and personal styles as therapists or counselors. Each of our clients is unique.

Informed consent is a recurrent process, not a static set of pro forma gestures, that develops out of the relationship between clinician and client. It must fit the situation and the setting. It must respond not only to the explicit standards of the clinician's professional associations, such as the American Psychological Association or the Canadian Psychological Association, but also to the relevant state and federal laws and evolving case law. It must be sensitive to the client's ability to understand the relevant information (Is the client a young child, developmentally disabled, suffering from severe thought disorder?) and the client's situation (Is the client in the midst of a crisis, referred for mandatory treatment by the courts, being held against his or her will in a mental hospital?). Human sensitivity and professional judgment are required.

As we attempt to create and sustain the process of informed consent, several considerations, noted in the remainder of this chapter, are useful.

Failing to Provide Informed Consent

In considering how to ensure the client's right to informed consent, we must remain aware that the right is violated, perhaps often. We can take those instances to justify our own decisions not to accord clients informed consent, or we can use those instances as an opportunity to consider the matter from the client's perspective. How would we feel if we were the clients who had been kept in the dark and had not been given the chance to make a decision on an informed basis?

An example of the withholding of informed consent involved the provision of free medical care to hundreds of U.S. citizens (J. H. Jones, 1981; see also Rivers, Schuman, Simpson & Olansky, 1953; U.S. Public Health Service, 1973). The program began in 1932 and continued to 1972. If all we were told was that the government, through what eventually became the U.S. Public Health Service, was giving us comprehensive medical care, how would we likely feel? Grateful? Relieved that we would be spared financial burdens? Excited that we would have access to state-of-the-science medical interventions provided by the federal government? Who among us would turn down this rare opportunity?

What the participants were not told is that they were being used to research the effects of syphilis when it goes untreated. Treatment for syphilis was in fact withheld from all the individuals. Research procedures were presented as treatment; for example, painful spinal taps were described to the subjects as a special medical treatment. Although Public Health Service officials denied that there were any racist aspects to this research, admission to the program was limited to male African Americans.

More recent examples are numerous. Hospitals, for example, perform AIDS tests on virtually all patients without patients' knowledge or permission, sometimes in direct violation of state law (Pope & Morin, 1990). As another example, Stevens (1990) described a testing center that administered the Stanford-Binet Intelligence Scale so that students could be placed in the appropriate classes at school. The information schools received contradicted that given to the child's parents. In one case, for example, the report sent to the school "recommended that David be placed in a class for average students"; the report sent to the parents recommended that "David should be placed in a class for superior students" (p. 15). Here is how the testing center explained the policy: "The [report] we send to the school is accurate. The report for the parents is more soothing and positive" (p. 15).

How would we feel if we relied on the government and health care professions to provide us with free medical care when in fact they were observing the untreated consequences of a painful, virulent, usually fatal disease? How would we feel if we went to a hospital for help and were given an AIDS test without our knowledge or permission? How would we feel if we were given completely inaccurate information about the results of an intelligence assessment because someone else thought it would be "more soothing"?

Benefits of Informed Consent

Approaching the issue of informed consent, we may, as clinicians, fear that providing adequate information to clients and explicitly obtaining their consent will somehow derail therapy and may in fact have detrimental consequences for our clients. The research has not supported these fears. The process of informed consent tends to be beneficial. A variety of studies have indicated that the use of informed consent procedures makes it more likely that clients will become less anxious, follow the treatment plan, recover more quickly, and be more alert to unintended negative consequences of the treatment (Handler, 1990).

Limits of Consent

Informed consent is not a strategy to insulate a clinician from responsibility when performing unethical or illegal acts:

> At least one case has suggested that there are limits to what a patient can validly consent to. In that case, several adults were treated with a form of psychotherapy that involved physically beating them. The defendants argued they could not be sued because the plaintiffs had consented to the treatment; however, the Court of Appeals refused to accept the consents as a defense. This decision implies that a patient's consent will not be deemed valid if acts consented to would otherwise be illegal or contrary to public policy (such as a sexual relationship between therapist and patient). An earlier case held that whether touching is therapeutic or nontherapeutic goes to the essence of the act and may vitiate a consent [Caudill & Pope, 1995, pp. 553–554].

Consent for Families and Other Multiple Clients

Individual psychotherapy is only one model for providing services. Sometimes clinicians provide therapy to couples, families, or groups. Therapists must ensure that adequate informed consent and informed refusal is provided for each person and that the consent addresses issues specific to therapy when more than one client is involved. For example, what are the limits of confidentiality and privilege for material disclosed by one of the clients? Will the therapist hold confidential from one family member material disclosed by another family member? If one client receiving couple therapy waives privilege, does the privilege still apply to the other member of the couple?

These issues are best clarified at the outset of the treatment, and on a continuing basis to clarify conflicts or potential conflicts that might arise during the therapy process. The APA Ethics Code (APA, 2002) includes a new standard, 10.03 Group Therapy, that requires that "when psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality" (p. 1073). Thus, psychologists must describe at the outset of group therapy the unique roles and responsibilities of both therapist and clients in the group therapy, including the fact that while group members are advised to maintain confidentiality about other group members, they are not held to legal liability or ethical codes of conduct. It may be helpful, although not required, to have group members sign an informed consent document, including the group rules and guidelines.

Unequal Opportunity for Informed Consent

It is crucial that we do not accord unequal opportunities to our clients for informed consent based on prejudice and stereotypes (see Chapter Fifteen). Research suggests that this unfortunately happens, at least occasionally, thus depriving some clients of their right to informed consent. For example, in an examination of informed consent practices, Benson (1984) found that whether important information was disclosed by a sample of physicians was systematically related to such factors as the patient's race and socioeconomic status.

Cognitive Processes

Clinicians must maintain up-to-date knowledge of the evolving research and theory regarding the cognitive processes by which people arrive at decisions (see, for example, Arbuthnott, Arbuthnott, & Thompson, 2006; Bell, Raiffa, & Tversky, 1989; Bursztyajn, Feinbloom, Hamm, & Brodsky, 2000; Evans, 1989; Goleman, 1985; Janis, 1982; Janis & Mann, 1977; Kahneman, Slovic, & Tversky, 1982; Kahneman & Tversky, 2000; Langer, 1989; Plous, 1993; Pope, Butcher, & Seelen, 2006; Rachlin, 1989). This research and theory can help clinicians understand the factors that influence clients who are choosing whether to participate in assessment or treatment procedures.

At a Harvard University hospital, McNeil, Pauker, Sox, and Tversky (1982) presented individuals with two options based on actuarial data concerning patients suffering from lung cancer. The data indicated whether patients had chosen a surgical or a radiological treatment for their cancer and what the outcome had been. Of those who chose surgery, 10 percent died during the operation itself, an additional 22 percent died within the first year after the surgery, and another 34 percent died within five years. Of those who chose radiation therapy, none died during the radiation treatments, 23 percent died within the first year, and an additional 55 percent died by the end of five years.

If you were given those actuarial data, which intervention would you choose? When these data were presented, 42 percent of the participants in the study indicated that they would choose radiation. Note that the data were presented in terms of mortality—the percentages of patients who died. When the same actuarial information was presented in terms of percentages of patients who survived at each stage—for radiation, 100 percent survived the treatment, 73 percent survived the first year, and 22 percent survived five years—only 25 percent chose radiation. The change from a mortality to a survivability presentation caused a change in the way individuals cognitively processed the information and arrived at a decision.

Because our interventions may have profound effects for our clients and the decisions they may make regarding whether to begin therapy and what sort of therapeutic approaches to try are significant, we have an important ethical responsibility to attend carefully to the form in which we present information relevant to those decisions.

Problems with Forms

Many of us may be so eager to start doing therapy that we try to avoid talking with our clients about consent issues. We try to push all the responsibility off onto a set form, and let the form do the work. Those of us who work within clinics or hospitals may not even handle such forms. The client who shows up for an initial appointment may be handed an imposing-looking form by the receptionist, asked to read it, sign it, and return it before seeing the therapist. The form itself may have been crafted by the clinic or hospital's attorney and may not even have been reviewed by a clinician. The wording may be in intimidating legalese and bureaucratic jargon. Such forms may be intended more to protect the organization against successful lawsuits than to help the client understand the options and make reasonable decisions.

Providing information in written form can be vital in ensuring that clients have the information they need. But the form cannot serve as a substitute for an adequate process of informed consent. At a minimum, the clinician must discuss the information with the client and arrive at a professional judgment that the client has adequate understanding of the relevant information.

Clinicians using consent forms must ensure that their clients have the requisite reading skills. Illiteracy is a major problem in the United States; clinicians cannot simply assume that all of their clients can read. Moreover, some clients may not be well versed in English, perhaps having only rudimentary skills in spoken English as a second or third language.

Not only must the client be able to read, but the form itself must be readable. Grundner (1980, p. 900) noted that great effort has been made to ensure that "consent forms have valid content, but little effort has been made to ensure that the average person can read and understand them." He analyzed five forms with two standardized readability tests and found that "the readability of all five was approximately equivalent to that of material intended for upper division undergraduates or graduate students. Four of the five forms were written at the level of a scientific journal, and the fifth at the level of a specialized academic magazine" (p. 900).

Reading a form does not ensure that the client understands the material or can remember it even a short time later. Robinson and Merav (1976) reinterviewed twenty patients four to six months after they had read and signed a form for informed consent and had undergone treatment. They found that all patients showed poor recall regarding all aspects of the information covered by the form, including the diagnosis, potential complications, and alternate methods of management. Cassileth, Zupkis, Sutton-Smith, and March (1980) found that only one day after reading and signing a form for informed consent, only 60 percent of the patients understood the purpose and nature of the procedures. A perfunctory indication from clients that they understand can be unreliable (Irwin et al., 1985). The clinician bears the responsibility for ensuring that the client understands the information

It would be comforting to believe that the identification of problems in these early studies led to effective solutions. Unfortunately, the problems continue to emerge in contemporary research. For example, research by Akkad, Jackson, Kenyon, Dixon-Woods, Taub, and Habiba (2006; see also Commons et al., 2006; Dixon-Woods et al., 2006) found that "even when the consent process satisfies administrative and legal requirements, patients' needs may not be met, and some patients may even consent to [unwanted procedures]. . . . Though patients did identify several important advantages of the consent process, there was substantial uncertainty about the implications of signing or not signing the consent form. . . . Many patients did not see written consent as functioning primarily in their interests nor as a way of making their wishes known. As suggested in previous work, . . . many thought the primary function of the form was to protect the hospital. . . . These findings are disconcerting for healthcare professionals and patients alike and raise questions about how far current consent processes genuinely fulfil their aim of safeguarding autonomy and protecting patients' rights" (p. 529).

ADDITIONAL RESOURCES

A Web page (*Informed Consent in Psychotherapy & Counseling: Forms, Standards & Guidelines, & References*) at http://kspope.com/consent/index.php provides resources that may be helpful in thinking through the process of informed consent. The Web page's resources fall into three categories:

1. Links to examples of informed consent forms from the American Psychological Association Insurance Trust; the University of Rochester Counseling Center; the West Virginia University Carruth Center for Counseling and Psychological Services; Laura Brown Ph.D., ABPP; and the Center for Ethical Practice
2. Excerpts setting forth informed-consent requirements from the standards and guidelines of professional associations (with links to the original documents), including the American Association for Marriage and Family Therapy; American Association of Christian Counselors; American Association of Spinal Cord Injury Psychologists and Social Workers; American Group Psychotherapy Association; American Mental Health Counselors Association; American Psychoanalytic Association; American Psychological Association; Association for Specialists in Group Work; British Association for Counselling and Psychotherapy; British Columbia Association of Clinical Counsellors; California Board of Behavioral Sciences; Canadian Counselling Association; Canadian Psychiatric Association; Canadian Psychological Association; European Federation of Psychologists' Associations; Irish Association for Counseling and Therapy; National Associa-

tion of Social Workers; National Board for Certified Counselors; and Psychological Society of Ireland

3. Quotes and information about informed consent from articles, books, and research studies

SCENARIOS FOR DISCUSSION

You work full time for an HMO that requires the clinician to obtain written informed consent from all patients before providing psychotherapy. One of the HMO physicians refers a patient to you for psychotherapy. When the patient shows up for the initial session, you discover that the patient has recently been permanently blinded by an explosion and wants help in making the transition to living without reliance on this particular sense.

1. How do you feel?
2. What are the initial consent issues that you consider?
3. In what ways, if at all, should the consent process explicitly address therapeutic approaches specifically developed for those without sight?
4. If you were not fluent in Braille, the HMO provided no consent forms in Braille, and no HMO employee could write in Braille, how would you approach the HMO's requirement that written consent be obtained before clinical services were provided?
5. If the patient asked if any of the interventions you planned to use had been validated as effective for those without sight, how would you respond?
6. If the patient asked if your graduate training and supervised experience included adequate work with sightless patients so that you were competent to provide services to this population, how would you respond?

You work for a managed care facility that allows no more than eight sessions of outpatient psychotherapy in any given year. A new client tells you during the first session that surprising and intrusive memories have started to occur about experiences of incest as a child. The client thinks that the parent who perpetrated the incest may now be sexually abusing several grandchildren.

1. How do you feel?
2. What are the informed consent and informed refusal issues, if any, that you consider during this initial session regarding a formal assessment of this client?
3. What are the informed consent and informed refusal issues, if any, that you consider during this initial session regarding potential clinical interventions for this person?

You have just begun working as a counselor at a university counseling center. At your first meeting with the counseling center director, you ask if the center has consent forms. The director replies, "I'm so glad you brought that up. We've been leaving that up to individual counselors, but we need one that everyone can use. I've been looking at your curriculum vitae, and I think you're the perfect person to design the form. Please have it on my desk by next Thursday."

1. How do you feel?
2. Assuming that there is no way you can get out of this task, what process would you use for designing the form?
3. What issues or elements are you sure the informed consent form should address?

You have agreed to provide psychotherapy to an adolescent who had gotten in trouble for drinking. The parents have agreed to allow the sessions to be confidential, given your ethical responsibilities. However, they now request to see the records because they have reason to believe that their adolescent is smoking pot.

1. How do you feel?
2. What are the legal and ethical factors you consider?
3. What do you think you might say to the parents?
4. What do you think you might say to your client?
5. To what extent does your form for informed consent adequately address the issues that this scenario raises?

You are a provider of services for a managed care company. Utilization reviews are required before additional sessions are provided. You realize, during the review, that although you believe sexual orientation is a critical issue and focus for your gay client, you did not inform your client that the information would be revealed to the reviewer.

1. How do you feel?
2. What consent issues does this situation involve?
3. What possible approaches do you consider in deciding how to handle this situation?
4. What information concerning utilization review, peer review, and similar review processes should an adequate form for informed consent and informed refusal contain?

CHAPTER TWELVE

Assessment, Testing, and Diagnosis

Assessment, testing, and diagnosis can change the course of clients' lives. They can have a decisive impact on employment, custody, reputation, involuntary hospitalization, and the prospect of prison.

Those of us who practice within institutional settings may face externally imposed limitations on the time and other resources we can devote to assessment. Those of us in solo practice may face challenges in consistently performing evaluations that are ethical, accurate, useful, and consistent with the latest advances in research and theory. We tend to lack the ready-made professional support, educational resources, and peer review that many clinics and hospitals provide through in-service training programs, grand rounds, case conferences, and program evaluation. We may need to be more active in updating, improving, and monitoring our evaluation services.

The following considerations are useful in identifying ethical pitfalls and helping to ensure that diagnosis, testing, and assessment are as valid and useful as possible for both clinician and client.

AWARENESS OF STANDARDS AND GUIDELINES

The American Psychological Association (APA) and the Canadian Psychological Association (CPA) publish several documents relevant to testing, assessment, and diagnosis. Reviewing them on a periodic basis can help ensure that work in this area meets the highest standards. For example, APA's Ethical Principles and Code of Conduct includes sections relevant to assessment, including "Evaluation, Diagnosis, and Interventions in Professional Context," "Competence and Appropriate Use of Assessments and Interventions," "Test Construction," "Use of Assessment in General and with Special Populations," "Interpreting Assessment Results," "Unqualified Persons," "Obsolete Tests and Outdated Test Results," "Test Scoring and Interpretation Services," "Explaining Assessment Results," "Maintaining Test Security," "Forensic Assessments," and "Describing the Nature and Results of Psychological Services." The Canadian Code of Ethics for Psychologists includes relevant statements such as that psychologists "provide suitable information about the results of assessments, evaluations, or research findings to the persons involved, if appropriate and if asked. This information would be communicated in understandable language" (Section III.15) and that psychologists "protect the skills, knowledge, and interpretations of psychology from being misused, used incompetently, or made useless (e.g., loss of security of assessment techniques by others)" (Section IV.11).

Other documents published by APA and CPA that may be helpful in this area include "Guidelines for Psychological Practice with Older Adults" (APA, 2004); "Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists" (APA, 2003b); "Guidelines for Psychological Evaluations in Child Protection Matters" (APA, 1999); "Guidelines for the Evaluation of Dementia and Age-Related Cognitive Decline" (APA, 1998a); "Guidelines for Child Custody Evaluations in Divorce Proceedings" (APA, 1994); "Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations" (APA, 1993); "General Guidelines for Providers of Psychological Services" (APA, 1987b); *Practice Guidelines for Providers of Psychological Services* (CPA, 2001a); *Rights and Responsibilities of Test Takers: Guidelines and Expectations* (APA, 1998b); and *Standards for Educational and Psychological Testing*

(American Educational and Research Association, American Psychological Association, and National Council on Measurement in Education, 1999). (There are links to the full text of these documents at http://kspope.com/ethcodes/index.php.)

STAYING WITHIN AREAS OF COMPETENCE

A psychology degree, internship, and license do not by themselves qualify a professional to administer, score, interpret, or otherwise use psychological tests.

Hall and Hare-Mustin (1983, p. 718) reported an APA ethics case in which "one psychologist charged another with incompetence, especially in testing. . . . CSPEC (Committee on Scientific and Professional Ethics and Conduct [CSPEC was the former name of the APA Ethics Committee]) reviewed the report of the state committee, which had carried out the investigation, and found that the person had no training or education in principles of psychological testing but was routinely engaged in evaluations of children in child custody battles. The committee found violation of Principle 2a, competence in testing, and stipulated that the member should work under the supervision of a clinical psychologist for one year." Psychological testing requires competence. This competence cannot merely be asserted, but must be shown to have developed through formal education, training, and experience. This point is relevant to the process of diagnosis, evaluation, or assessment more generally, even if testing were not involved. For example, when the diagnosis is based on interview and observation, training and supervised experience in those assessment methods are necessary.

UNDERSTANDING MEASUREMENT, VALIDATION, AND RESEARCH

Being able to document substantial course work, supervised training, and extensive experience in a given area of testing such as neuropsychological assessment of geriatric populations, intelligence testing of young children, or personality testing of adults helps a professional establish competence in that area of testing in an ethics committee hearing, licensing hearing, or malpractice suit. But beyond this evidence of competence, whether there is basic understanding of measurement, validation, and research is an important issue.

Sanders and Keith-Spiegel (1980) described an APA ethics case in which a psychologist evaluated a person using a Minnesota Multiphasic Personality Inventory (MMPI), among other resources. The person who was evaluated felt that the test report, particularly the part based on the MMPI results, was not accurate. All materials, including the test report and raw data, were eventually submitted to the APA Ethics Committee, which in turn submitted the materials for evaluation to two independent diplomates with expertise in testing.

The committee concluded that the psychologist did not demonstrate an adequate understanding of measurement, validation, and inference in his report: "The only test used by the complainee that has any established validity in identifying personality disorders is the MMPI, and none of the conclusions allegedly based on the MMPI are accurate. We suspect that the complainee's conclusions are based upon knowledge of a previous psychotic episode and information from the psychiatric consultant, whose conclusions seem to have been accepted uncritically. The complainee's report is a thoroughly unprofessional performance, in our opinion. Most graduate students would do much better" (Sanders & Keith-Spiegel, 1980, p. 1098).

ENSURING THAT THE CLIENT UNDERSTANDS AND CONSENTS TO TESTING

Ensuring that a client fully understands the nature, purposes, and techniques of a given instrument helps to fulfill the client's right to give or withhold informed consent to any phase of assessment or treatment. Determining that the client understands the testing is different from just providing information aloud or in written form. Some clients may be anxious, distracted, preoccupied, or so eager to please the clinician that they nod their heads as if to acknowledge that they understand an explanation when, in fact, they have understood none or little of the information. Some clients are unfamiliar with technical terms and concepts that the clinician tends to take for granted. Often this lack of communication combines with the clinician's eagerness to proceed with the testing and the client's fear of appearing ignorant.

It is the clinician's responsibility to make the necessary effort to provide a fully understandable explanation and to form a professional opinion regarding whether a client understands and consents. For a client to be adequately informed, the consent must be given or withheld in the light of adequate knowledge about who will or may receive the results, which in turn may be influenced by the Health Insurance Portability and Accountability Act (HIPAA) and other legislation. Although these issues concern the variety of people who may eventually receive copies of the report and the associated raw data once the assessment has been completed, they must be addressed with the client before starting the assessment, so that the client's decision to give or withhold consent is adequately informed. The following section discusses clarifying these issues.

CLARIFYING ACCESS TO THE TEST REPORT AND RAW DATA

Therapists function within a complex framework of legal and ethical standards regarding the discretionary and mandatory release of test information. The U.S. Privacy Act of 1974, the California "truth-in-testing" statute, *Detroit Edison* v. *National Labor Relations Board,* the 1996 HIPAA, and the Canadian 2000 Personal Information Protection and Electronic Documents Act (PIPEDA) are examples of legislation and case law that affect access to assessment documents. The APA Ethics Code (APA, 2002) provides a definition of *test data* and guidance about the release of test data:

> (a) The term *test data* refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of *test data.* Pursuant to a client/patient release, psychologists provide test data to the client/patient or other persons identified in the release. Psychologists may refrain from releasing test data to protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law. (See also Standard 9.11, Maintaining Test Security.)
>
> (b) In the absence of a client/patient release, psychologists provide test data only as required by law or court order [pp. 1071–1072].

The following fictional vignette illustrates the complex judgments therapists may have to make regarding responsibilities to withhold or disclose assessment information:

> A seventeen-year-old boy comes to your office and asks for a comprehensive psychological evaluation. He has been experiencing some headaches, anxiety, and depression. A high school dropout, he has been married for a year and has a one-year-old baby, but has left his wife and child and returned to live with his parents. He works full time as an auto mechanic and has insurance that covers the testing procedures. You complete the testing. During the following year, you receive requests for information about the testing from a number of people:
>
> - The boy's physician, an internist
> - The boy's parents, who are concerned about his depression
> - The boy's employer, in connection with a worker's compensation claim filed by the boy
> - The attorney for the insurance company that is contesting the worker's compensation claim
> - The attorney for the boy's wife, who is suing for divorce and for custody of the baby
> - The boy's attorney, who is considering suing you for malpractice because he does not like the results of the tests
>
> Each of the requests asks for the full formal report, the original test data, and copies of each of the tests you administered (for example, instructions and all items for the MMPI-2).

To which of these people are you ethically or legally obligated to supply all information requested, partial information, a summary of the report, or no information at all? For which requests is having the boy's written informed consent for release of information relevant?

There is no set of answers to these complex questions that would be generally applicable for all or even most readers. Each state, province, and other jurisdiction has its own evolving legislation and case law that address, sometimes in an incomplete or confusing manner, clinician responsibilities. Such questions can, however, provide a basis for discussion in ethics courses, clinical supervision and consultation, staff meetings, or workshops; answers can be sought that are relevant for a specific jurisdiction. Practitioners may want to consider working through their local professional associations to develop clear guidelines to the current legal requirements. If the legal requirements in this or any other area of practice seem unethical, unreasonable, unclear, or potentially damaging to clients, practitioners may want to propose and support remedial legislation.

FOLLOWING STANDARD PROCEDURES FOR ADMINISTERING TESTS

When we are reciting the instructions to the Wechsler Intelligence Scale for Children-Revised (WISC-R) or the Halstead Category Test for the five hundredth time, we may experience the urge to break the monotony, liven things up, and let our originality show through. And particularly when we are in a hurry, we may want to abbreviate the instructions. After all, we assume, the client will catch on as we go along.

The assumption underlying standardized tests is that the test-taking situation and procedures are as similar as possible for everyone. When one departs from the procedures on which the norms are based, the standardized norms lose their direct applicability and the "standard" inferences drawn from those norms become questionable. Reasonable accommodations for assessing people with disabilities may sometimes include changing the method of test administration. Lee, Reynolds, and Willson (2003) wrote:

> The 1999 Standards for Educational and Psychological Testing adopted by AERA, APA, and NCME requires examiners to make reasonable accommodations for individuals with disabilities when administering psychological tests to such persons. Changes in test administration may be required, but the Standards also require the examiner to provide evidence associated with the validity of test score interpretation in the face of such changes in administration. Departures from standard procedures during test administration may change the meaning of test scores, because scores based on norms derived from standardized procedures may not be appropriate; error terms and rates may also be affected [p. 55].

The Committee on Professional Standards of the APA (1984) published a finding that allowing a client to take home a test such as the MMPI departs from the "standard procedure." The "Casebook for Providers of Psychological Services" (Committee on Professional Standards, 1984) describes a case in which a psychologist permitted his client to take the MMPI home to complete. When the complaint was filed with APA, the Committee on Professional Standards stated that whenever a psychologist "does not have direct, first-hand information as to the condition under which the test is taken, he or she is forced (in the above instance, unnecessarily) to assume that the test responses were not distorted by the general situation in which the test was taken (e.g., whether the client consulted others about test responses). Indeed the psychologist could have no assurance that this test was in fact completed by the client. In the instance where the test might be introduced as data in a court proceeding it would be summarily dismissed as hearsay evidence" (p. 664).

Unless the assessment is carefully monitored, there is no way to know the conditions under which the person filled out response sheets and completed other aspects of the testing. Psychologist Jack Graham, an expert in the MMPI, described an interesting MMPI administration in an inpatient setting (Pope, Butcher, & Seelen, 2006). He observed a large gathering of patients. Several times a minute, some of the patients would raise their hands. Graham became intrigued and asked one of the patients to tell him what was going on. The patient explained that a psychologist had given an MMPI to one of the patients, asking him to complete it and then return it to the psychologist's office. The patient had asked for help from the other patients. The patient was reading each MMPI item aloud, and the patients raised their hands to vote on whether that item should be answered true or false. Psychologist Jim Butcher, another expert in the MMPI, observed a patient sitting with his spouse outside a psychologist's office while filling out an MMPI. From time to time as the patient marked an answer, his wife, reading along, would tell him he was wrong and should change his answer, which the patient dutifully did (Pope, Butcher, & Seelen, 2006).

KNOWING THE LITERATURE ON RECORDINGS AND THIRD-PARTY OBSERVERS

If a third party is to be present during the assessment, or if there is going to be an audiotape, videotape, or similar recording, clinicians should be familiar with the research on how this factor may affect the assessment. For example, Constantinou, Ashendorf, and McCaffrey (2002) found that "in the presence of an audio-recorder the performance of the participants on memory tests declined. Performance on motor tests, on the other hand, was not affected by the presence of an audio-recorder" (p. 407). Gavett, Lynch, and McCaffrey (2005) found that "third party observers have been found to significantly impair neuropsychological test performance on measures of attention, verbal memory, verbal fluency, and cognitive symptom validity" (p. 49; see also Constantinou, Ashendorf, & McCaffrey, 2005; Lynch, 2005; Yantz & McCaffrey, 2005).

Clinicians must also be aware of the relevant policy statements and similar articles. If neuropsychological functioning is at issue in the assessment, for example, clinicians should be familiar with the American Academy of Clinical Neuropsychology's "Policy Statement on the Presence of Third Party Observers in Neuropsychological Assessment" (2001); Axelrod and colleagues' "Presence of Third Party Observers During Neuropsychological Testing: Official Statement of the National Academy of Neuropsychology" (2000); Duff and Fisher's "Ethical Dilemmas with Third Party Observers" (2005); Lynch and McCaffrey's "Neuropsychological Assessments in the Presence of Third Parties: Ethical Issues and Literature Review" (2004); and McSweeny and colleagues' "Ethical Issues Related to the Presence of Third Party Observers in Clinical Neuropsychological Evaluations" (1998).

AWARENESS OF BASIC ASSUMPTIONS

Fundamental assumptions and theoretical frameworks can significantly affect our assessments. Langer and Abelson's classic study (1974), "A Patient by Any Other Name . . . ," for example, illustrates one way in which behavior therapists and psychoanalytically oriented therapists can differ when viewing the same individual:

> Clinicians representing two different schools of thought, behavioral and analytic, viewed a single videotaped interview between a man who had recently applied for a new job and one of the authors. Half of each group was told that the interviewee was a "job applicant," while the remaining half was told that he was a "patient." At the end of the videotape, all clinicians were asked to complete a questionnaire evaluating the interviewee. The interviewee was described as fairly well adjusted by the behavioral therapists regardless of the label supplied. This was

> not the case, however, for the more traditional therapists. When the interviewee was labeled “patient,” he was described as significantly more disturbed than he was when he was labeled “job applicant” [p. 4].

The point here is not whether either of these two orientations is more valid, reliable, respectable, empirically based, or useful, but rather to illustrate the obvious: differing basic theoretical orientations can lead to very different assessments. Clinicians conducting assessments and assigning diagnoses need to be continually aware of their own theoretical orientation and the ways in which this orientation is likely to affect the evaluation. Langer and Abelson (1974, p. 9) state clearly, “Despite the questionable light in which the analytic therapist group was cast in the present study, one strongly suspects that conditions might be arranged wherein the behavior therapists would fall into some kind of error, as much as the traditionalists. No single type of orientation toward clinical training is likely to avoid all types of biases or blind spots.”

AWARENESS OF PERSONAL FACTORS LEADING TO MISUSING DIAGNOSIS

In addition to a lack of awareness of our basic assumptions and our assumptions in specific areas, insufficient attention to our own personal reactions and dynamics may tend to make us vulnerable to faulty evaluations. Reiser and Levenson’s excellent article, “Abuses of the Borderline Diagnosis” (1984), focuses on six ways in which the diagnosis of borderline personality disorder is commonly abused “to express countertransference hate, mask imprecise thinking, excuse treatment failures, justify the therapist’s acting out, defend against sexual clinical material, and avoid pharmacologic and medical treatment interventions” (p. 1528). Openness to such issues within ourselves and frequent consultations with colleagues can help prevent abuses of this kind and help ensure that our assessments meet the highest ethical standards.

AWARENESS OF FINANCIAL FACTORS LEADING TO MISUSING DIAGNOSIS

Third-party reimbursement has become so prevalent that most therapists have become acutely aware of which diagnostic categories are “covered” and which are not. Insurance companies, HMOs, and a wide variety of managed care organizations may authorize services for only a very restricted range of diagnoses. For example, the personality or character disorders are rarely covered. Unfortunately, the temptation to substitute a fraudulent but covered diagnosis for an honest but unreimbursable one can influence even senior and well-respected practitioners, as shown in a national study (Pope & Bajt, 1988). Kovacs (1987), in his strongly worded article on insurance billing, issues a stern warning that those "who are naive about insurance billing or who play a little fast and loose with carriers are beginning to play Russian Roulette. The carriers are now prepared to spend the necessary funds for investigators and for lawyers which will be required to sue in civil court and/or to bring criminal charges against colleagues who do not understand their ethical and legal responsibility in completing claim forms on behalf of their patients" (p. 24).

"Advice on Ethics of Billing Clients" (1987), an article in the *APA Monitor,* lists among "billing practices that should be avoided": "Changing the diagnosis to fit reimbursement criteria" (p. 42). The APA's Ethical Principles of Psychologists and Code of Conduct (2002), Standard 6.06, Accuracy in Reports to Payors and Funding Sources, states: "In their reports to payors for services or sources of research funding, psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided or research conducted, the fees, charges, or payments, and where applicable, the identity of the provider, the findings, and the diagnosis. (See also Standards 4.01, Maintaining Confidentiality; 4.04, minimizing Intrusions on Privacy; and 4.05, Disclosures.)" (p. 1068).

Unfortunately, many organized systems of care such as managed care have reduced reimbursement for assessment to one hour. Often a full evaluation to determine accurate diagnoses requires several hours of testing and report preparation. Either the provider of services must provide rationale for further reimbursement or provide pro bono services.

The problem of financial factors leading to false diagnosis appears to be significant. Gross (2004) wrote that "the abuse of insurance is one of the most common ethical and legal violations committed by practicing therapists, resulting in imposed sanctions by licensing agencies and criminal convictions. . . . Unfortunately for the profession, abuse of insurance has become so commonplace that many practitioners have deceived themselves into believing it is normal or acceptable behavior" (p. 36).

ACKNOWLEDGING LOW BASE RATES[1]

When an assessment involves a condition, ability, aptitude, quality, or something else that is rarely found in the population, overlooking the low base rate leads to problems. Even when the psychological tests themselves are accurate, the statistical properties of low base rates can cause big mistakes. Imagine you have been commissioned to develop an assessment procedure that will identify crooked judges so that candidates for judicial appointment can be screened. It is a difficult challenge, in part because only one out of five hundred judges is (hypothetically speaking) dishonest.

You pull together all the actuarial data you can locate and find that you are able to develop a screening test for crookedness based on a variety of characteristics, personal history, and test results. Your method is 90 percent accurate.

When your method is used to screen the next five thousand judicial candidates, there might be ten candidates who are crooked (because about one out of five hundred is crooked). A 90 percent accurate screening method will identify nine of these ten crooked candidates as crooked and one as honest.

So far, so good. The problem is the 4,990 honest candidates. Because the screening is wrong 10 percent of the time and the only way for the screening to be wrong about honest candidates is to identify them as crooked, it will falsely classify 10 percent of the honest candidates as crooked. Therefore, this screening method will incorrectly classify 499 of these 4,990 honest candidates as crooked.

So out of the 5,000 candidates who were screened, the 90 percent accurate test has classified 508 of them as crooked: 9 who actually were crooked and 499 who were honest. Every 508 times the screening method indicates crookedness, it tends to be right only 9 times. And it has falsely branded 499 honest people as crooked.

ACKNOWLEDGING DUAL HIGH BASE RATES[2]

The following example shows why it is crucial to recognize dual high base rates:

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[1] *Source:* "Fallacies and Pitfalls in Psychological Assessment." Copyright © 2003 by K. S. Pope. Used with permission.

[2] *Source:* "Fallacies and Pitfalls in Psychological Assessment." Copyright © 2003 by K. S. Pope. Used with permission.

As part of a disaster response team, you are flown in to work at a community mental health center in a city that has experienced a severe earthquake. Taking a quick look at the records the center has compiled, you note that of the 200 people who have come for services since the earthquake, there are 162 who are of a particular religious faith and are diagnosed with posttraumatic stress disorder (PTSD) related to the earthquake and 18 of that faith who came for services unrelated to the earthquake. Of those who are not of that faith, 18 have been diagnosed with PTSD related to the earthquake, and 2 have come for services unrelated to the earthquake.

It seems almost self-evident that there is a strong association between that particular religious faith and developing PTSD related to the earthquake: 81 percent of the people who came for services were of that religious faith and had developed PTSD. Perhaps this faith makes people vulnerable to PTSD. Or perhaps it is a more subtle association: this faith might make it easier for people with PTSD to seek mental heath services.

But the inference of an association is a fallacy: religious faith and the development of PTSD in this community are independent factors. Ninety percent of all people who seek services at this center happen to be of that specific religious faith (90 percent of those who had developed PTSD and 90 percent who had come for other reasons) and 90 percent of all people who seek services after the earthquake (90 percent of those with that particular religious faith and 90 percent of those who are not of that faith) have developed PTSD. The two factors appear to be associated because both have high base rates, but they are statistically unrelated.

AVOIDING CONFUSION BETWEEN RETROSPECTIVE AND PREDICTIVE ACCURACY

The predictive accuracy of an assessment instrument focuses first on the test results and asks, What are the chances, expressed as a conditional probability, that a person with these results has a particular condition, ability, aptitude, or quality? The retrospective accuracy of an assessment instrument focuses first on the particular condition, ability, aptitude, or quality and asks, What are the chances, expressed as a conditional probability, that a person who has this particular condition or ability will show these test results? Many problems spring from this common mistake of confusing the directionality of the inference.

This mistake of confusing retrospective with predictive accuracy often resembles the affirming the consequent logical fallacy (see Chapter Two):

> People with condition X are overwhelmingly likely to have these specific test results.

Person Y has these specific test results.

Therefore, Person Y is overwhelmingly likely to have condition X.

AWARENESS OF FORENSIC ISSUES

Our society has become more litigious, and we tend to find ourselves as therapists appearing in court more frequently than in the past or preparing documents that will become part of legal proceedings. Forensic settings set forth specific demands, and practitioners need to become aware of them. For example, financial factors can, under certain circumstances, create a bias—or at least the appearance of bias—in carrying out and reporting assessments. For this reason, forensic texts mandate that no psychologist accept a contingency fee. Blau (1984, p. 336) wrote: "The psychologist should never accept a fee contingent upon the outcome of a case." Shapiro (1990, p. 230) stated: "The expert witness should never, under any circumstances, accept a referral on a contingent fee basis." Only about 15 percent of the respondents in a national survey reported engaging in this practice (Pope, Tabachnick, & Keith-Spiegel, 1987), and about the same percentage (14 percent) believe it to be good practice or good under most circumstances (Pope, Tabachnick, & Keith-Spiegel, 1988).

Another potentially troublesome area in forensic practice involves conducting child custody assessments. Shapiro (1990, p. 99), for example, states that "under no circumstances should a report on child custody be rendered to the court, based on the evaluation of only one party to the conflict." "Guidelines for Child Custody Evaluations in Divorce Proceedings" (APA, 1994) provides guidance for psychologists in this area. According to this document, the best interest of the child is the primary purpose of the evaluation and is considered paramount.

ATTENTION TO POTENTIAL MEDICAL CAUSES

Particularly when a constellation of symptoms fits a well-known psychological diagnosis, it is tempting to ignore possible medical causes for a distress or disability (such as pain, weight loss, or bleeding from bodily orifices). A comprehensive evaluation, however, needs to rule out (or identify) possible medical causes. Rick Imbert, when he was president of the American Professional Agency, stressed that "if there is any indication of a physical problem, then have a full medical screening; for example, symptoms which appear to be part of a schizophrenic process can actually be caused by a brain tumor" (personal communication, April 18, 1988).

AWARENESS OF PRIOR RECORDS AND HISTORY

Prior records of assessment and treatment can be an invaluable resource as part of a comprehensive psychological evaluation. The courts have held that neglecting to make any effort to recognize, obtain, and use this resource violates, in some instances, the standard of care. In the federal case of *Jablonski* v. *United States* (1983), for example, the U.S. Ninth Circuit Court of Appeals upheld a "district court judge's findings of malpractice . . . for failure to obtain the past medical records."

Regardless of whether prior records exist or are obtainable, obtaining an adequate history can be crucial to an adequate assessment. Psychologist Laura Brown (1994b), for instance, discussed the pioneering work of independent practitioner Lynne Rosewater and George Washington University professor Mary Anne Dutton in demonstrating how overlooked history could lead to misdiagnosis when relying on standardized tests:

> Their work has involved collecting data on large numbers of battered women and identifying common patterns of response on the testing. In effect, they have noted that the standard mainstream texts and computerized scoring systems for the MMPI do not take into account the possibility that the person taking the test is a woman who currently is, or recently has been, beaten by her spouse or partner. . . .
>
> As Rosewater first pointed out, without the context, specifically the identification of the presence of violence, battered women look like schizophrenics or borderline personalities on the MMPI. With the context of violence explicitly framing the interpretation of the test findings, however, it is possible to note that the sort of distress indicated on the testing is a reasonable response to events in the test-taker's life. That is to say, when a woman's partner is beating her, it makes sense that she is depressed, confused, scattered, and feeling overwhelmed. It is not necessarily the case that this state of response to life-threatening violence is either usual for the woman in question or a sign of psychopathology [Brown, 1994, p. 187].

INDICATING ALL RESERVATIONS ABOUT RELIABILITY AND VALIDITY

If any circumstances might have affected the results of psychological testing, such as dim lighting, frequent interruptions, a noisy environment, or medication, or if there is doubt that the person being tested shares all relevant characteristics with the reference groups on which the norms are based, these factors must be taken into account when interpreting test data and must be included in the formal report.

One implication of this responsibility is that psychologists must remain alert to the diverse array of factors that may affect validity and reliability. For example, psychologists who test individuals whose first language is not English face a challenge to determine whether the testing in English is appropriate. Often, referral of the client to a mental health professional who is competent in the client's language may be important. If translation is necessary, psychologists do not retain the services of translators or paraprofessionals who may have a dual role with the client to avoid jeopardizing the validity of evaluation or the effectiveness of intervention.

PROVIDING ADEQUATE FEEDBACK

Feedback is a dynamic, interactive process in which the results and implications of testing or other forms of assessment are shared with the person who is being assessed (Pope, 1992). Many factors can block this process. First, HMOs and other managed care organizations can inflict harsh, sometimes unrealistic demands on clinicians' time. The rationing of time may allow too little opportunity to sit with a client to discuss an assessment and attend carefully to the client's questions and concerns. Similarly, federal, state, and private mental health insurance may disallow coverage for all but the most minimal feedback session. For example, there may be a standard fixed payment for administrating a specific psychological test; the payment may barely (sometimes inadequately) cover the time necessary to administer the test and prepare a brief write-up of the results. The clinician may have to donate pro bono the time required to provide adequate feedback.

Second, advertisements and marketing literature may promote individual tests, versions of tests, or test batteries by stressing how little time they take. One continually reads of quick, brief, short, and abbreviated tests. Such promotion may unintentionally nurture the notion that a complex assessment can be carried out in just a few minutes with no real demands on the clinician's time, skills, judgment, or even attention. This rush to judgment may encourage clinicians to match their quick, brief, short, and abbreviated testing with quick, brief, short, and abbreviated feedback.

Third, on a personal level, therapists and counselors may be uncomfortable discussing assessment results with a client. Some may be reluctant to be the bearer of what they fear the client will receive as bad news. Others may be uncomfortable trying to translate for the client the technical jargon that clogs so many test interpretation texts, computer interpretation printouts, volumes on diagnosis, and so forth. Still others may be uneasy facing a client's expectations of clear results with test results that may necessarily leave many important questions unanswered.

These and other factors may encourage clinicians to forget that feedback is a dynamic, interactive process that is an aspect of the larger process of assessment and that the assessment often continues during what is called the feedback session or phase. Consequently, feedback may come to be viewed as simply a pro forma, static method of closure or an obligatory technicality in which the "results" are dumped in the client's lap (or referral source or someone else). This view of feedback seems so aversive and unproductive that some clinicians may decide—wrongly—to withhold feedback altogether. No rote, by-the-numbers approach to feedback can legitimately replace a thoughtful discussion with the client of what the results are, what they mean, and what they do not mean.

SCENARIOS FOR DISCUSSION

You are attending your first rounds at the community mental health center where you began working last week. Your supervisor discusses a recent intake who will be assigned to you for therapy. The supervisor, who assessed the new client using the MMPI-2 and a clinical interview, says that the assessment shows that the client's claims about being raped are clearly false. The treatment plan, which you will be implementing, will be to help the new client realize that this confabulation is not real.

1. How do you feel?
2. What options do you have?

3. What would you like to say to the supervisor?
4. What do you think that you would say to the supervisor?

You work for an HMO. A new client shows up at your office for an initial session. The person says: "I have felt so incredibly edgy all week. I don't know what's wrong with me. But I feel like I want to smash someone in the mouth, like I want to get my gun and blow someone's brains out. I don't even know who, but it's like something's building up and it just won't be stopped."

1. How do you feel?
2. When the person stopped talking, what would be the first things you'd say?
3. How do you go about creating an assessment plan in this situation? What phases of the assessment would you make sure to complete before the person left your office, and how would you go about completing them? What phases of the assessment would you schedule for later? Who else, if anyone, would you involve in the assessment?

You are responsible for all intakes on Mondays, Wednesdays, and Fridays. After discussing recent intakes with you, your supervisor tells you: "From now on, I want to obtain standardized testing data on all intakes. I want you to administer the [names a test] to all intakes. I think we need to base our decisions on test data." You believe that this test lacks adequate validity and reliability for clinical work and is therefore not useful. You diplomatically say that you aren't sure about giving the test, but your supervisor says, "I can understand that. No method is endorsed by everyone. But I'm responsible for intakes, and I'll take responsibility for this. All you need to do is administer, score, and interpret them."

1. How do you feel?
2. What would you like to say to the supervisor?
3. What do you think you'd end up saying to the supervisor?
4. What are your options?
5. What would you do?

A parent schedules an appointment with you. The parent shows up with a child, and says, "The people at school say that my Jesse here cheats at school. Can you talk with Jesse and give some tests to find out if that's true?"

1. How do you feel?
2. What are your options?
3. What ethical concerns do you have? How would you address them?

A former client, whom you liked very much, calls and reports that she and her spouse are getting divorced. The client asks to return for an evaluation, as requested by her attorney, regarding a child custody dispute. She expresses her assumption that you will testify in court on her behalf.

1. How do you feel?
2. What are your options?
3. What issues do you consider?
4. How do you think you would respond?

An attorney calls to ask you to provide a basic evaluation for a client who will be deported unless proof can be provided that the attorney's client is under severe duress as a refugee. The hearing is in one week, and the attorney says that no other resources for obtaining an evaluation are available and that there are waiting lists at the clinics providing such evaluations. The hearing judge has refused to grant an extension. The client does not speak English but has a family member who can interpret. You do not speak the client's language. You have attended multicultural diversity workshops and classes.

1. How do you feel?
2. What issues do you consider in deciding whether to schedule the assessment?
3. What assessment approaches, including any standardized tests, would you consider in planning such an evaluation?
4. Assume you agreed to conduct the assessment and when you began, you found that the family member had minimal skills in speaking English. What would you do?

CHAPTER THIRTEEN

Sexual Relationships with Clients

The prohibition against sexual involvement with a patient is one of the oldest ethical mandates in the health care professions. Annette Brodsky (1989) noted that this rule is older than the twenty-five-hundred-year-old Hippocratic Oath. It was mentioned in the even more ancient code of the Nigerian healing arts.

Modern codes of clinical ethics contained no explicit mention of this topic until research began revealing that substantial numbers of therapists were violating the prohibition. Although the codes had not highlighted this particular form of patient exploitation by name, therapist-patient sex was in violation of various sections of the codes prior to the 1970s. Rachel Hare-Mustin (1974), former chair of the American Psychological Association's Ethics Committee, noted that the 1963 *Ethical Standards of Psychologists* of the American Psychological Association contained standards that would prohibit therapist-patient sexual involvement. She wrote that in the light of "a review of principles relating to competency, community standards and the client relationship that genital contact with patients is ethically unacceptable" (p. 310). Similarly, UCLA professor Jean Holroyd, senior author of the first national study of therapist-patient sex, explained that the

1977 code did not represent a change in the standards regarding sexual activities with patients:

> ADMINISTRATIVE LAW JUDGE: Was it [the 1977 ethics code] a codification of what was already the standard of practice?
>
> HOLROYD: Yes, it was making it very explicit in the ethics code.
>
> ADMINISTRATIVE LAW JUDGE: What I am asking is whether or not the standard of practice prior to the inclusion of that specific section in the [1977] ethics code, whether or not that changed the standard of practice.
>
> HOLROYD: No, it did not change the standard of practice. The standard of practice always precluded a sexual relationship between therapist and patient.
>
> ADMINISTRATIVE LAW JUDGE: Even though it was not expressed in the ethics codes?
>
> HOLROYD: From the beginning of the term psychotherapy with Sigmund Freud, he was very clear to prohibit it in his early publications [*In the Matter of the Accusation Against: Myron E. Howland,* 1980, pp. 49–50].

The courts recognized the long history of prohibition against therapist-patient sexual involvement. In the mid-1970s, New York Supreme Court Presiding Justice Markowitz recognized evidence that from the time of Freud to the present, the health care professions had agreed that therapist-patient sex harms patients: “Thus from [Freud] to the modern practitioner we have common agreement of the harmful effects of sensual intimacies between patient and therapist” (*Roy* v. *Hartogs,* 1976, p. 590).

That this prohibition has remained constant over so long a time and throughout so many diverse cultures reflects to some extent the recognition that sex involvement places the patient at undue risk for serious harm.

Until relatively recently, our understanding of therapist-client sexual involvement was based mainly on theory, common sense, and individual case studies. Only in the past quarter-century has a considerable body of diverse systematic investigations informed our understanding with empirical data. Some of the findings are summarized in this chapter. (For more detailed presentations of this research, see Gabbard, 1989, and Pope, 1993, 1994, 2001.)

HOW CLIENTS CAN BE INJURED

Beginning with Masters and Johnson (1966, 1970, 1975), investigators have examined how therapist-client sexual involvement affects clients (Bouhoutsos, Holroyd, Lerman, Forer, & Greenberg, 1983; Brown, 1988; Butler & Zelen, 1977; Feldman-Summers & Jones, 1984; Herman, Gartrell, Olarte, Feldstein, & Localio, 1987; Pope & Vetter, 1991; Sonne, Meyer, Borys, & Marshall, 1985; Vinson, 1987). Approaches to learning about effects have included studies of clients who have returned to therapy with a subsequent therapist as well as those who undertook no further therapy after their sexual involvement with a therapist.

The consequences for clients who have been sexually involved with a psychotherapist have been compared to those for matched groups of therapy clients who have not been sexually involved with a therapist and of patients who have been sexually involved with a (nontherapist) physician. Subsequent treating therapists (of those clients who undertook a subsequent therapy), independent clinicians, and the clients themselves have evaluated the effects. Standardized psychological assessment instruments have supplemented clinical interview and behavioral observation. These diverse approaches to systematic study have supplemented individual patients' firsthand accounts (Bates & Brodsky, 1989; Freeman & Roy, 1976; Noel & Waterson, 1992; Plaisil, 1985; Walker & Young, 1986).

The consequences for the clients seem to cluster into ten very general categories: (1) ambivalence, (2) guilt, (3) emptiness and isolation, (4) sexual confusion, (5) impaired ability to trust, (6) confused roles and boundaries, (7) emotional liability, (8) suppressed rage, (9) increased suicidal risk, and (10) cognitive dysfunction, frequently in the areas of concentration and memory and often involving flashbacks, intrusive thoughts, unbidden images, and nightmares (Pope, 1988b, 1994, 2001).

PATTERNS OF PERPETRATORS AND VICTIMS

Despite the prohibition and the harm that can occur to sexually abused clients, a significant number of therapists report on anonymous surveys that they have become sexually involved with at least one client. When the data from the first eight national self-report surveys published in peer-reviewed journals are pooled, there are 5,148 participants providing anonymous self-reports (Akamatsu, 1988;

Bernsen, Tabachnick, & Pope, 1994; Borys & Pope, 1989; Holroyd & Brodsky, 1977; Pope, Keith-Spiegel, & Tabachnick, 1986; Pope, Levenson, & Schover, 1979; Pope, Tabachnick, & Keith-Spiegel, 1987). Each of the three professions (psychiatry, psychology, and social work) is represented by at least two studies conducted in different years.

According to these pooled data, about 4.4 percent of the therapists reported becoming sexually involved with a client. The gender differences are significant: 6.8 percent of the male therapists and 1.6 percent of the female therapists reported engaging in sex with a client.

Data from these studies as well as others (for example, reports by therapists working with patients who have been sexually involved with a prior therapist) suggest that therapist-patient sex resembles other forms of abuse such as rape and incest in that the perpetrators are overwhelmingly (though not exclusively) male and the victims are overwhelmingly (thought not exclusively) female (Pope, 1989b). For example, Bouhoutsos et al. (1983) reported a study in which 92 percent of the cases of therapist-patient sex involved a male therapist and female patient. Gartell, Herman, Olarte, Feldstein, and Localio (1986), who reported the first national self-report study of sexual involvement between psychiatrists and their patients, found that 88 percent of the "contacts for which both the psychiatrist's and the patient's gender were specified occurred between male psychiatrists and female patients" (p. 1128).

Data based on therapists' reports of engaging in sex with patients or on therapists' work with patients who have been sexually exploited by a prior therapist have been supplemented with national survey data from patients who have been sexually involved with a therapist. In one study, about 2.19 percent of the men and about 4.58 percent of the women reported having become sexually involved with their own therapists (Pope & Feldman-Summers, 1992).

Yet another source of data (supplementing those provided through reports by subsequent therapists, therapists' anonymous self-reports, and patients' anonymous self-reports) is consistent with the significant gender differences. Data obtained from licensing disciplinary actions suggested that about 86 percent of the therapist-patient cases are those in which the therapist is male and the patient is female (Pope, 1993).

This significant gender difference has long been a focus of scholarship in the area of therapist-patient sex but is still not well understood. Holroyd and Brodsky's report (1977) of the first national study of therapist-patient sex concluded with a statement of major issues that had yet to be resolved: "Three professional issues remain to be addressed: (a) that male therapists are most often involved, (b) that female patients are most often the objects, and (c) that therapists who disregard the sexual boundary once are likely to repeat" (p. 849). Holroyd suggested that the significant gender differences reflected sex role stereotyping and bias: "Sexual contact between therapist and patient is perhaps the quintessence of sex-biased therapeutic practice" (Holroyd, 1983, p. 285).

Holroyd and Brodsky's landmark research (1977) was followed by a second national study focusing on not only therapist-patient but also professor-student sexual relationships (Pope et al., 1979):

> When sexual contact occurs in the context of psychology training or psychotherapy, the predominant pattern is quite clear and simple: An older higher status man becomes sexually active with a younger, subordinate woman. In each of the higher status professional roles (teacher, supervisor, administrator, therapist), a much higher percentage of men than women engage in sex with those students or clients for whom they have assumed professional responsibility. In the lower status role of student, a far greater proportion of women than men are sexually active with their teachers, administrators, and clinical supervisors [p. 687; see also Pope, 1989a, 1994].

Although statistical analyses of the first eight national self-report studies published in peer-reviewed journals reveal significant gender effects and also significant effects related to the year of the study (the pooled data suggest that each year, there are about 10 percent fewer self-reports of therapist-patient sex than the year before), there is no significant effect due to profession. According to these data, psychologists, psychiatrists, and social workers report engaging in sex with their patients at about the same rates. Apparent differences are actually due to differing years in which the studies were conducted (there was a confounding correlation between the professions and the years they were studied). The statistical analysis tested the predictive power of each variable (profession and year) once the variance accounted for by the other variable had been subtracted. Year had significantly more predictive power once effects due to profession had been accounted for than the predictive power of profession once effects due to year had been accounted for. Once year of study is taken into account, significant differences between professions disappear.

Bates and Brodsky (1989) examined the various risk factors that have been hypothesized at one time or another to make certain clients more vulnerable to sexual exploitation by a therapist. Their analysis led them not to the personal history or characteristics of the client but rather to prior behavior of the therapist: the most effective predictor of whether a client will become sexually involved with a therapist is whether that therapist has previously engaged in sex with a client.

With access to a considerable set of historical and actuarial data, the APA Insurance Trust (1990, p. 3) revealed that "the recidivism rate for sexual misconduct is substantial." Holroyd and Brodsky's landmark survey (1977) found that 80 percent of the therapists who reported engaging in therapist-patient sexual intimacies indicated that they became involved with more than one patient. The California Department of Consumer Affairs (1997) published its findings in a document that was sent to all licensed therapists and counselors in California and that must, according to California law, be provided by a therapist to any patient who reports having been sexually involved with a prior therapist. This document notes that "80 percent of the sexually exploiting therapists have exploited more than one client. In other words, if a therapist is sexually exploiting a client, chances are he or she has done so before" (p. 14).

Table 13.1 presents additional information, based on a national survey, of 958 patients who had been sexually involved with a therapist. In this study, 80 percent of the patients who had become sexually involved with a therapist only after termination of the therapy were found to have been harmed.

Five percent of the patients described in Table 13.1 were minors at the time that they were sexually involved with a therapist. This finding underscores an important aspect of therapist-patient sex: although much of the literature on this topic seems to assume that the patient is an adult, this is not always the case. In a national study focusing exclusively on minor patients who were sexually involved with a therapist, most (56 percent) were female (Bajt & Pope, 1989). The average age of these girls who were sexually involved with a therapist was thirteen, and the range was from age seventeen down to age three. The average age of the male minor patients was twelve, ranging from sixteen down to seven.

COMMON SCENARIOS

It is useful for therapists to be aware of the common scenarios in which therapists sexually exploit their patients. Pope and Bouhoutsos (1986, p. 4) presented ten of the most common scenarios:

Characteristics	Number	Percentage
Patient was a minor at the time of the involvement	47	5
Patient married the therapist	37	3
Patient had experienced incest or other child sex abuse	309	32
Patient had experienced rape prior to sexual involvement with therapist	92	10
Patient required hospitalization considered to be at least partially a result of the sexual involvement	105	11
Patient attempted suicide	134	14
Patient committed suicide	7	1
Patient achieved complete recovery from any harmful effects of sexual involvement	143	17[a]
Patient seen pro bono or for reduced fee	187	20
Patient filed formal (for example, licensing, malpractice) complaint	112	12

Table 13.1. Characteristics of 958 Patients Who Had Been Sexually Involved with a Therapist.

[a] Refers to 17 percent of the 866 patients who experienced harm.

Source: Adapted from Pope, K. S., & Vetter, V. A. (1991). Prior therapist-patient sexual involvement among patients seen by psychologists. *Psychotherapy*, *28*, 429–438. Available at http://kspope.com. Copyright 1991 Division of Psychotherapy (22) of the American Psychological Association. Reprinted with permission.

- *Role Trading:* Therapist becomes the "patient" and the wants and needs of the therapist become the focus.
- *Sex Therapy:* Therapist fraudulently presents therapist-patient sex as valid treatment for sexual or related difficulties.
- *As If . . . :* Therapist treats positive transference as if it were not the result of the therapeutic situation.
- *Svengali:* Therapist creates and exploits an exaggerated dependence on the part of the patient.
- *Drugs:* Therapist uses cocaine, alcohol, or other drugs as part of the seduction.
- *Rape:* Therapist uses physical force, threats, and/or intimidation.
- *True Love:* Therapist uses rationalizations that attempt to discount the clinical/professional nature of the professional relationship and its duties.

- *It Just Got Out of Hand:* Therapist fails to treat the emotional closeness that develops in therapy with sufficient attention, care, and respect.
- *Time Out:* Therapist fails to acknowledge and take account of the fact that the therapeutic relationship does not cease to exist between scheduled sessions or outside the therapist's office.
- *Hold Me:* Therapist exploits patient's desire for nonerotic physical contact and possible confusion between erotic and nonerotic contact.

It is important to emphasize, however, that these are only general descriptions of some of the most common patterns, and many instances of therapist-patient sexual involvement will not fall into these ten.

WHY DO THERAPISTS REFRAIN?

Although our apparent insights into our own motives as therapists may be questionable at best, it is worth asking: Why do the overwhelming majority of therapists avoid sexually exploiting patients? Table 13.2 presents the answers to this question as provided by therapists in two national studies: one of psychologists and the other of social workers.

CONFRONTING DAILY ISSUES

The issue of therapist-client sexual intimacies focuses many of the major themes of this book. The great vulnerability of the client highlights the power of the therapist and the trust that must characterize the client's relationship with the therapist. The therapist's caring may be crucial in protecting against the temptation to exploit the client.

The issue of therapist-client sexual involvement illustrates another fundamental theme of this book: ethics is not mindlessly following a list of do's and don'ts but always involves active awareness, thinking, and questioning. There is, of course, a clear prohibition: avoid any sexual involvement with clients. No cause, situation, or condition could ever legitimize such intimacies with any client (see, for example, Gabbard & Pope, 1989). The prohibition stands as a fundamental ethical mandate no matter what the rationalizations. Taking this prohibition seriously, however, marks the initial rather than the final steps in meeting our ethical responsibilities in this area. Several associated issues that we must confront and struggle with follow.

Reasons	Social Workers	Psychologists
Unethical	210	289
Countertherapeutic/exploitative	130	251
Unprofessional practice	80	134
Against therapist's personal values	119	133
Therapist already in a committed relationship	33	67
Feared censure/loss of reputation	7	48
Damaging to therapist	39	43
Disrupts handling transference/countertransference	10	28
Fear of retaliation by client	2	19
Attraction too weak/short-lived	16	18
Illegal	14	13
Self-control	8	8
Common sense	7	8
Miscellaneous	13	3

Table 13.2. Reasons Therapists Offer for Refraining from Sexual Involvement with Clients.

Sources: Adapted from Pope, K. S., & Vetter, V. A. (1991). Prior therapist-patient sexual involvement among patients seen by psychologists. *Psychotherapy*, *28*, 429–438. Available at http://kspope.com. Copyright 1991 Division of Psychotherapy (22) of the American Psychological Association. Reprinted with permission.

Physical Contact with Clients

The very topic of therapist-client sexual involvement as well as concern that we may be subject to an ethics complaint or malpractice suit may make many of us very nervous. We may go to great lengths to ensure that we maintain physical distance from our clients and under no circumstances touch them for fear that this might be misconstrued. A similar phenomenon seems to be occurring in regard to increasing public acknowledgment of child sexual abuse: adults may be reluctant to hold children and engage in nonsexual touch that is a normal part of life.

Is there any evidence that nonsexual touching of patients is actually associated with therapist-client sexual involvement? Holroyd and Brodsky (1980) examined this question and found no indications that physical contact with patients made sexual contact more likely. They did find evidence that differential touching of male and female clients (that is, touching clients of one gender significantly more than clients of the other gender) was associated with sexual intimacies: "Erotic contact not leading to intercourse is associated with older, more experienced therapists who do not otherwise typically touch their patients at a rate different from other therapists (except when mutually initiated). Sexual intercourse with patients is associated with the touching of opposite-sex patients but not same-sex patients. It is the differential application of touching—rather than touching per se—that is related to intercourse" (p. 810).

If the therapist is personally comfortable engaging in physical contact with a patient, maintains a theoretical orientation for which therapist-client contact is not antithetical, and has competence (education, training, and supervised experience) in the use of touch, then the decision of whether to make physical contact with a particular client must be based on a careful evaluation of the clinical needs of the client at that moment in the context of any relevant cultural and other contextual factors. When solidly based on clinical needs and a clinical rationale, touch can be exceptionally caring, comforting, reassuring, or healing. When not justified by clinical need and therapeutic rationale, nonsexual touch can also be experienced as intrusive, frightening, or demeaning. The decision must always be made carefully and in full awareness of the power of the therapist and the trust (and vulnerability) of the client.

Our responsibility to be sensitive to the issues of nonsexual touch and explore them carefully extends to other therapeutic issues conceptually related to the issue of therapist-client sexual involvement. Our unresolved concerns with therapist-client sexual intimacies may prompt us to respond to the prospect of nonsexual touching either phobically—avoiding in an exaggerated manner any contact or even physical closeness with a client—or counterphobically—engaging in apparently nonsexual touching such as handshakes and hugs as if to demonstrate that we are very comfortable with physical intimacy and experience no sexual impulses. These unresolved concerns can also elicit phobic or counterphobic behavior in other areas, such as the clinician's initiating or focusing on sexual issues to an extent that is not based on the client's clinical needs. To respond ethically, authentically, and therapeutically to such issues, we must come to terms with our own unresolved feelings of sexual attraction to our clients.

Sexual Attraction to Patients

Sexual attraction to patients seems to be a prevalent experience that evokes negative reactions. National survey research suggests that over four out of five psychologists (87 percent) and social workers (81 percent) report experiencing sexual attraction to at least one client (Pope et al., 1986; Bernsen et al., 1994). As Table 13.3 illustrates, therapists identify many aspects of patients that, according to the therapists, are the source or focus of the attraction. Yet simply experiencing the attraction (without necessarily even feeling tempted to act on it) causes most of the therapists who report such attraction (63 percent of the psychologists and 51 percent of the social workers) to feel guilty, anxious, or confused about the attraction.

That sexual attraction causes such discomfort among so many psychologists and social workers and psychologists may be a significant

Characteristics	Social Workers	Psychologists
Physical attractiveness	175	296
Positive mental/cognitive traits or abilities	84	124
Sexual	40	88
Vulnerabilities	52	85
Positive overall character/personality	58	84
Kindness	6	66
Fills therapist's needs	8	46
Successful	6	33
"Good patient"	21	31
Client's attraction	3	30
Independence	5	23
Other specific personality characteristics	27	14
Resemblance to someone in therapist's life	14	12
Availability (client unattached)	0	9
Pathological characteristics	13	8
Long-term client	7	7
Sociability (sociable, extroverted)	0	6
Miscellaneous	23	15
Same interests/philosophy/background as therapist	10	0

Table 13.3. Characteristics of Clients to Whom Psychotherapists Are Attracted.

Sources: Social work data are from Bernsen, A., Tabachnick, B. G., & Pope, K. S. (1994). National survey of social workers' sexual attraction to their clients: Results, implications, and comparison to psychologist. *Ethics and Behavior, 4*, 369–388. Available at http://kspope.com. Copyright 1994 Lawrence Erlbaum Associates, Inc. Adapted with permission. Psychology data are from Pope, K. S., Keith-Spiegel, P., & Tabachnick, B. G. (1986). Sexual attraction to patients: The human therapist and the (sometimes) inhuman training system. *American Psychologist, 41*, 147–158. Available at http://kspope.com. Copyright 1986, American Psychological Association. Adapted with permission.

reason that graduate training programs and internships tend to neglect training in this area. Only 9 percent of psychologists and 10 percent of social workers surveyed in these national studies reported that their formal training on the topic in graduate school and internships had been adequate. A majority of psychologists and social workers reported receiving no training about attraction.

This discomfort may also be a significant reason that scientific and professional books seem to neglect this topic:

> In light of the multitude of books in the areas of human sexuality, sexual dynamics, sex therapies, unethical therapist-patient sexual contact, management of the therapist's or patient's sexual behaviors, and so on, it is curious that sexual attraction to patients per se has not served as the primary focus of a wide range of texts. The professor, supervisor, or librarian seeking books that turn their *primary* attention to exploring the therapist's *feelings* in this regard would be hard pressed to assemble a selection from which to choose an appropriate course text. If someone unfamiliar with psychotherapy were to judge the prevalence and significance of therapists' sexual feelings on the basis of the books that focus exclusively on that topic, he or she might conclude that the phenomenon is neither wide-spread nor important [Pope, Sonne, & Holroyd, 1993, p. 23].

These and similar factors may form a vicious circle: discomfort with sexual attraction may have fostered an absence of relevant textbooks and graduate training; in turn, an absence of relevant textbooks and programs providing training in this area may sustain or intensify discomfort with the topic (Pope et al., 1993). The avoidance of the topic may produce a real impact. Koocher wrote, "How can the extant population of psychotherapists be expected to adequately address [these issues] if we pay so little attention to training in these matters?" (1994, p. viii).

These studies reveal significant gender effects in reported rates of experiencing sexual attraction to a patient. About 95 percent of the male psychologists and 92 percent of the male social workers compared with 76 percent of the female psychologists and 70 percent of the female social workers reported experiencing sexual attraction to a patient. The research suggests that just as male therapists are significantly more likely to become sexually involved with their patients, male therapists are also more likely to experience sexual attraction to their patients.

These national surveys suggest that a sizable minority of therapists carry with them—in the physical absence of the client—sexualized images of the client and that a significantly greater percentage of male than of female therapists experience such cognitions. About 27 percent of male psychologists and 30 percent of male social workers, compared with 14 percent of female psychologists and 13 percent of female social workers, reported engaging in sexual fantasies about a patient while engaging in sexual activity with another person (not the patient). National survey research has found that 46 percent of psychologists reported engaging in sexual fantasizing (regardless of the occasion) about a patient on a rare basis and that an addition 26 percent reported more frequent fantasies of this kind (Pope et al., 1987), and 6 percent have reported telling sexual fantasies to their patients (Pope & Tabachnick, 1993). Such data may be helpful in understanding not only how therapists experience and respond to sexual feelings but also how therapists and patients represent (for example, remember, anticipate, think about, fantasize about) each other when they are apart and how this affects the therapeutic process and outcome (see Geller, Cooley, & Hartley, 1981; Orlinsky & Geller, 1993; Pope & Brown, 1996; Pope & Singer, 1978b; Pope, Sonne, & Greene, 2006).

For any of us who experience sexual attraction to a client, it is important to recognize that the research suggests that this is a common experience. To feel attraction to a client is not unethical; to acknowledge and address the attraction promptly, carefully, and adequately is an important ethical responsibility. For some of us, consultation with respected colleagues will be useful. For others, obtaining formal supervision for our work with that client may be necessary. For still others, entering or reentering psychotherapy can be helpful.

WHEN THE THERAPIST IS UNSURE WHAT TO DO

What can the therapist do when he or she doesn't know what to do? The book *Sexual Feelings in Psychotherapy* (Pope et al., 1993) suggests a ten-step approach to such daunting situations, which are summarized here. A repeated theme of that book is that therapists lack easy, one-size-fits-all answers to what sexual feelings about patients mean or their implications for the therapy. Different theoretical orientations provide different, sometimes opposing ways of approaching such questions. Each person and situation is unique. Therapists must explore and achieve a working understanding of their own unfolding, evolving feelings and the ways in which these feelings may play a helpful role in deciding what to say or do next. Cookbook approaches can block rather than foster this process.

The approach outlined here places fundamental trust in the individual therapist, adequately trained and consulting with others, to draw his or her own conclusions. Almost without exception, therapists learn at the outset the fundamental resources for helping themselves explore problematic situations. Depending on the situation, they may introspect, study the available research and clinical literature, consult, seek supervision, or begin or resume personal therapy. But sometimes, even after the most sustained exploration, the course is not clear. The therapist's best understanding of the situation suggests a course of action that seems productive yet questionable and perhaps potentially harmful. To refrain from a contemplated action may cut the therapist off from legitimately helpful spontaneity, creativity, intuition, and ability to respond effectively to the patient's needs. But engaging in the contemplated action may lead to disaster. When reaching such an impasse, therapists may find it useful to consider the potential intervention in the light of the following ten considerations.

The Fundamental Prohibition

Is the contemplated action consistent with the fundamental prohibition against therapist-patient sexual intimacy? Therapists must never violate this special trust. If the considered course of action includes any form of sexual involvement with a patient, it must be rejected.

The Slippery Slope

The second consideration may demand deeper self-knowledge and self-exploration. Is the contemplated course of action likely to lead to or create a risk for sexual involvement with the patient? The contemplated action may seem unrelated to any question of sexual exploitation of a patient. Yet depending on the personality, strengths, and weaknesses of the therapist, the considered action may constitute a subtle first step on a slippery slope. In most cases, the therapist alone can honestly address this consideration.

Consistency of Communication

The third consideration invites the clinician to review the course of therapy from the start to the present: Has the therapist consistently and unambiguously communicated to the patient that sexual intimacies cannot and will not occur, and is the contemplated action consistent with that communication? Does the contemplated action needlessly cloud the clarity of that communication? The human therapist may be intensely tempted to act in ways that stir the patient's sexual interest or respond in a self-gratifying way to the patient's sexuality. Does the contemplated action represent, however subtly, a turning away from the legitimate goals of therapy?

Clarification

The fourth consideration invites therapists to ask if the contemplated action would be better postponed until sexual and related issues have been clarified. Assume, for example, that a therapist's theoretical orientation does not preclude physical contact with patients and that a patient has asked that each session conclude with a reassuring hug between therapist and patient. Such ritualized hugs could raise complex questions about their meaning for the patient, their impact on the relationship, and how they might influence the course and effectiveness of therapy. It may be important to clarify such issues with the patient before making a decision to conclude each session with a hug.

The Patient's Welfare

The fifth consideration is one of the most fundamental touchstones of all therapy: Is the contemplated action consistent with the patient's welfare? The therapist's feelings may become so intensely powerful that they may create a context in which the patient's clinical needs may blur or fade out altogether. The patient may express wants or feelings with great force. The legal context—with the litigiousness that seems so prevalent in current society—may threaten the therapist in a way that makes it difficult to keep a clear focus on the patient's welfare. Despite such competing factors and complexities, it is crucial to assess the degree to which any contemplated action supports, is consistent with, is irrelevant to, or is contrary to the patient's welfare.

Consent

The sixth consideration is yet another fundamental touchstone of therapy: Is the contemplated action consistent with the basic informed consent of the patient?

Adopting the Patient's View

The seventh consideration urges the therapist to empathize imaginatively with the patient: How is the patient likely to understand and respond to the contemplated action?

> Therapy is one of many endeavors in which exclusive attention to theory, intention, and technique may distract from other sources of information, ideas, and guidance. Therapists-in-training may cling to theory, intention, and technique as a way of coping with the anxieties and overwhelming responsibilities of the therapeutic venture. Seasoned therapists may rely almost exclusively on theory, intention, and technique out of learned reflex, habit, and the sheer weariness that approaches burn-out. There is always risk that the therapist will fall back on repetitive and reflexive responses that verge on stereotype. Without much thought or feeling, the anxious or tired therapist may, if analytically minded, answer a patient's question by asking why the patient asked the question; if holding a client-centered orientation, may simply reflect or restate what the client has just said; if gestalt-trained, may ask the client to say something to an empty chair; and so on.
>
> One way to help avoid responses that are driven more by anxiety, fatigue, or other similar factors is to consider carefully how the therapist would think, feel, and react if he or she were the patient. Regardless of the theoretical soundness, intended outcome, or technical sophistication of a contemplated intervention, how will it likely be experienced and understood by the patient? Can the therapist anticipate at all what the patient might feel and think? The therapist's attempts to try out, in his or her imagination, the contemplated action and to view it from the perspective of the patient may help prevent, correct, or at least identify possible sources of misunderstanding, miscommunication, and failures of empathy [Pope et al., 1993, pp. 185–186].

Competence

The eighth consideration is one of competence: Is the therapist competent to carry out the contemplated intervention? Ensuring that a therapist's education, training, and supervised experiences are adequate and appropriate for his or her work is a fundamental responsibility.

Uncharacteristic Behaviors

The ninth consideration involves becoming alert to unusual actions: Does the contemplated action fall substantially outside the range of the therapist's usual behaviors? That an action is unusual does not, of course, mean that something is necessarily wrong with it. Creative therapists occasionally try creative interventions, and it is unlikely that even the most conservative and tradition-bound therapist conducts therapy the same way all the time. However, possible actions that are considerably outside the therapist's general approaches likely warrant special consideration.

Consultation

The tenth consideration concerns secrecy: Is there a compelling reason for not discussing the contemplated action with a colleague, consultant, or supervisor? Therapists' reluctance to disclose an action to others is a red flag to possibly inappropriate action. Therapists may consider any possible action in the light of the following question: If they took this action, would they have any reluctance for all of their professional colleagues to know that they had taken it? If the response is yes, the reasons for the reluctance warrant examination. If the response is no, it is worth considering if one has adequately taken advantage of the opportunities to discuss the matter with a trusted colleague. If discussion with a colleague has not helped to clarify the issues, consultation with additional professionals, each of whom may provide different perspectives and suggestions, may be useful.

WORKING WITH PATIENTS WHO HAVE BEEN SEXUALLY INVOLVED WITH A THERAPIST

It is not unlikely that any therapist, counselor, or trainee reading this book will encounter clients who have been sexually victimized by a prior therapist. A national study of 1,320 psychologists found that 50 percent reported working with at least one client who, in the therapist's professional opinion, had been a victim of therapist-client sexual intimacies (Pope & Vetter, 1991). About 4 percent reported working with at least one client who, in the therapist's opinion, had made false allegations about sex with a prior therapist.

It is crucial that clinicians working with such clients be genuinely knowledgeable about this area. Clients who have been sexually exploited tend to be exceptionally vulnerable to revictimization when their clinical needs are not recognized. Special methods and considerations for providing therapeutic services to victims of therapist-patient sexual intimacies have been developed and continue to evolve (Pope, 1994). One of the first steps toward gaining competence in this area is recognition of the diverse and sometimes extremely intense reactions that encountering a patient who reports sexual involvement with a former therapist can evoke in the subsequent therapist. Table 13.4 identifies some of the most common reactions.

Awareness of these reactions can prevent them from blocking the therapist from rendering effective services to the patient. The therapist can be alert for such reactions and sort through them should they occur. In some instances, the therapist may seek consultation to help gain perspective and understanding.

ETHICAL ASPECTS OF REHABILITATION

Unfortunately, therapists and counselors may act in ways that discount the harm done by perpetrators of therapist-patient sex, obscure the responsibilities of perpetrators, and enable perpetrators to continue—sometimes after a period of suspension—victimizing clients (Bates & Brodsky, 1989; Gabbard, 1989). The rehabilitation methods by which perpetrators are returned to practice focus many of this book's themes and pose difficult ethical dilemmas. Pope (1990c, 1990d, 1994) reviewed some of the crucial but difficult ethical questions facing therapists and counselors considering rehabilitation efforts; they are summarized below.

Competence

Does the clinician who is implementing the rehabilitation plan possess demonstrable competence in the areas of rehabilitation and therapist-patient sexual intimacies?

Has the rehabilitation method the clinician uses been adequately validated through independent studies? Obviously, a clinician who was claiming an effective "cure" for pedophilia, kleptomania, dyslexia,

1. **Disbelief and denial:** The tendency to reject reflexively—without adequate data gathering—allegations about therapist-patient sex (because, for example, the activities described seem outlandish and improbable)
2. **Minimization of harm:** The tendency to assume reflexively—without adequate data gathering—that harm did not occur or that, if it did, the consequences were minimally, if at all, harmful
3. **Making the patient fit the textbook:** The tendency to assume reflexively—without adequate data gathering and examination—that the patient must inevitably fit a particular schema
4. **Blaming the victim:** The tendency to attempt to make the patient responsible for enforcing the therapist's professional responsibility to refrain from engaging in sex with a patient and holding the patient responsible for the therapist's offense
5. S**exual reaction to the victim:** The clinician's sexual attraction to or feelings about the patient; such feelings are normal but must not become a source of distortion in the assessment process
6. **Discomfort at the lack of privacy:** The clinician's (and sometimes patient's) emotional response to the possibility that under certain conditions (for example, malpractice, licensing, or similar formal actions against the offending therapist; a formal review of assessment and other services by the insurance company providing coverage for the services) the raw data and the results of the assessment may not remain private
7. **Difficulty "keeping the secret":** The clinician's possible discomfort (and other emotional reactions) when he or she has knowledge that an offender continues to practice and to victimize other patients but cannot, in the light of confidentiality or other constraints, take steps to intervene
8. **Intrusive advocacy:** The tendency to want to guide, direct, or determine a patient's decisions about what steps to take or what steps not to take in regard to a perpetrator
9. **Vicarious helplessness:** The clinician's discomfort when a patient who has filed a formal complaint seems to encounter unjustifiable obstacles, indifference, lack of a fair hearing, and other responses that seem to ignore or trivialize the complaint and fail to protect the public from offenders
10. **Discomfort with strong feelings:** The clinician's discomfort when experiencing strong feelings (for example, rage, neediness, or ambivalence) expressed by the patient and focused on the clinician

Table 13.4. Common Therapists' Reactions to Victims of Therapist-Patient Sexual Involvement.

Source: Pope, K. S., Sonne, J. L., & Holroyd, J. (1993). *Sexual feelings in psychotherapy: Explorations for therapists and therapists-in-training.* Pp. 241–261. Washington, DC: American Psychological Association. Copyright 1993 American Psychological Association. Adapted with permission.

panic attacks, or a related disorder would need to present the scientific evidence for the intervention's effectiveness. Ethical standards for claims based on evidence in this area—particularly given the risks for abuse to which future patients may be exposed—should not be waived. Such evidence must meet the customary requirement of publication in peer-reviewed scientific or professional journals. As Pope (1990d, p. 482) noted, "Research results that survive and benefit from this painstaking process of systematic review created to help ensure the scientific integrity, merit, and trustworthiness of new findings may be less likely (than data communicated *solely* through press conferences, popular lectures, books, workshops, and television appearances) to contribute to what Tavris (1987) terms 'social-science fiction.'" We have been unable to locate any independently conducted, replicated research published in peer-reviewed scientific or professional journals that supports the effectiveness of rehabilitation efforts in this area.

Informed Consent

Whether the rehabilitation technique is viewed as an intervention of proven effectiveness (through independently conducted research trials) or an experimental research trial for a promising approach, have those who are put at risk for harm been adequately informed and been given the option of not assuming the risk, should the rehabilitation fail to be 100 percent effective?

Assessment

Do the research trials investigating the potential effectiveness of the rehabilitation method meet at least minimal professional standards? For example, is the research conducted independently? (We are rarely disinterested judges of the profundity, effectiveness, and near-perfection of our own work.)

A more complex requirement concerns whether the base rate of discovery of abuse is adequately taken into account in conducting and reporting the results of experimental trials of rehabilitation efforts. Perpetrators may continue to engage in sexual intimacies with clients during (or after) rehabilitation efforts, even when they are supervised (see, for example, Bates & Brodsky, 1989). The abuse may come to the light only if the client reports it. Yet the base rate of such reports by clients is quite low. Surveys of victims suggest that only about 5 percent report the behavior to a licensing board (see Pope & Vetter, 1991). The percentage appears to be significantly lower when the number of instances of abuse estimated from anonymous surveys of clinicians (who report instances in which they have engaged in abuse) is compared with complaints filed with licensing boards, ethics committees, and the civil and criminal courts. Using the higher 5 percent reporting estimate, assume that you conduct research in which a licensing board refers ten offenders to you for rehabilitation. You work with the offenders for several years and are convinced that you have completely rehabilitated all ten. You assure the licensing board of your complete confidence that none of the ten will pose any risk to future clients. But also assume that your rehabilitation effort fails miserably: all ten offenders will engage in sex with a future client. What are the probabilities that any of the ten future abuse victims will file a complaint? If each client has only a 5 percent probability of reporting the abuse, there is a 59.9 percent probability that none of the ten will file a complaint. Thus, there is close to a 60 percent chance that these research trials, even if independently evaluated, will appear to validate your approach as 100 percent effective when in fact it was 100 percent ineffective. If ignored in conducting and reporting research, the low base rate can make a worthless intervention appear completely reliable.

Power and Trust

The ethics of psychotherapy and counseling are inherently related to power and trust. How are these factors relevant to the dilemmas of rehabilitation?

If a judge were convicted of abusing the power and trust inherent in the position of judgeship by allowing bribes to determine the outcome of cases, numerous sanctions, both criminal and civil, might follow. However, even after the judge paid the debt due to society by the abuse of power and trust, the judge would not be allowed to resume the bench, regardless of any "rehabilitation."

Similarly, if a preschool director were discovered to have sexually abused students, he or she would likely face both civil and criminal penalties. The director might undergo extensive rehabilitation efforts to help reduce the risk that he or she would engage in further abuse of children. However, regardless of the effectiveness of the rehabilitation efforts, the state would not issue the individual a new license to found and direct another preschool.

Neither of these two offenders would necessarily be precluded from practicing their professions. The former judge and preschool director, once rehabilitated, might conduct research, consult, publish, lecture, or pursue other careers within the legal and educational fields. However, serving as judge or as preschool director are positions that involve such trust by both society and the individuals subject to their immediate power that the violation of such an important and clearly understood prohibition against abuse of trust (and power) precludes the opportunity to hold such special positions within the fields of law and education.

The helping professions must consider the ethical, practical, and policy implications of allowing and enabling offenders to resume the positions of special trust that they abused. Do psychotherapy and counseling involve or require a comparable degree of inviolable trust, from individual clients and from the society more generally, and ethical integrity as the positions of judge and preschool director within the legal and educational fields?

Hiring, Screening, and Supervising

Those who work within health maintenance organizations, hospitals, and other structures hiring clinicians have a responsibility to attend carefully to the risks that staff may sexually exploit clients. Carefully structured and adequately comprehensive forms and procedures (verifying education, supervision, licensure, employment, history of licensing or ethics complaints, and others) for screening potential personnel, establishing and monitoring policies prohibiting sex with clients, and so on have long been advocated as important in minimizing the risk that organizational personnel will sexually exploit clients (see Pope & Bouhoutsos, 1986; Pope, 1994). More recently, however, the usefulness of such forms and procedures that operationally define screening procedures and policy implementation has been recognized as an important component of malpractice risk management not only in hospitals but also in clinics, group practices, and similar settings. As defense attorney Brandt Caudill (1993) stated, "Given the current state of the law, it seems clear that psychologists must assume that they may be sued if a partner, employee, or supervisee engages in a sexual relationship with a patient, because it appears that the courts are moving to the position that a sexual relationship between a therapist and a patient is a recognizable risk of employment which would be within the scope of the employer-employee relationship" (pp. 4–5). It may be very difficult for employers and those with administrative or clinical supervisory responsibilities to argue successfully that the sexual relationship involving a supervisee or employee was not within the scope of employment. As one court held, "We believe that the nature of the work performed by a psychotherapist is substantially different than that of a day-care teacher as in *Randi F.* or a security guard as in *Webb* or a medical doctor as in *Hoover* so that a psychotherapist who engages in sexual relations with a patient could not be said, as a matter of law, to have acted outside the scope of his employment" (*St. Paul Fire & Marine Insurance Company* v. *Downs,* 1993, p. 344).

Illinois is an example of a state that enacted legislation making an employer liable when it knows or should reasonably know that a psychotherapist-employee engaged in sexual contact with a patient (Ill. Rev. Stat. 1991, chap. 70, para. 803).

Here are some steps that have previously been suggested as useful in addressing these issues when screening job applicants (Pope & Bouhoutsos, 1986; Pope, 1994):

- Discuss with the applicant any formal or informal training experiences in such areas as identifying and addressing both the clinician's and the client's sexual feelings. Are there classroom teachers, practicum supervisors, or previous employers who have provided such training and could be contacted to obtain information?
- Use an employment application form that traces back in sufficient detail from the present to college graduation. Ensure that there are no gaps in education or employment that are not clearly explained in writing.
- Provide a form for release of information that will enable the prospective employer to check with each setting of previous training, employment, or experience.
- Check with supervisors at any institutions at which the applicant obtained graduate training.
- Verify that the applicant was awarded all degrees claimed on the application form.
- Verify that any internships, practica, or postdocs were successfully completed. Check with a supervisor at each site.

- Check for information with each state that has issued the applicant a clinical license. Verify that no license has been revoked or subject to disciplinary procedures in which the applicant was found to have engaged in prohibited activities.
- Obtain a copy of all significant certifications.
- Obtain a copy of the applicant's résumé or curriculum vitae. Ensure that it is consistent with the responses to the application form described in the second item above.
- Ensure that the applicant fully understands the explicit policies of the organization in regard to prohibited activities with clients and that he or she signs an agreement to that effect.

If entering into a sexual relationship with a client must be avoided, what about entering into a nonsexual relationship? The next chapter focuses on these nonsexual dual and multiple relationships.

SCENARIOS FOR DISCUSSION

It has been an extremely demanding week, and you're looking forward to going to the new movie with your life partner. The theater is packed, but you find two seats on the aisle not too close to the screen. You feel great to have left work behind you at the office and to be with your lover for an evening on the town. As the lights go down, you lean over to give your partner a passionate kiss. For some reason, while kissing, you open your eyes and notice that, sitting in the seat on the other side of your partner and watching you, is a therapy client who just that afternoon had revealed an intense sexual attraction to you.

1. What feelings does this scenario evoke in you?
2. If you were the therapist, what, if anything, would you say to the client at the time of this event? What would you say during the next therapy session?
3. How would the client's presence affect your subsequent behavior at the theater?
4. How might this event affect the therapy and your relationship with the client?
5. What, if anything, would you say to your partner—either at the theater or later—about what had happened? Are there any cir-

cumstances under which you would call the client before the next scheduled appointment to discuss the matter?

9. Imagine that during a subsequent therapy session, the client begins asking about whom you were with at the theater. How would you feel? What would you say?
10. What if the client were a business client of your partner (or knew your partner in another context) and they begin talking before the movie? What feelings would this discovery evoke in you? What would you consider in deciding how to handle this matter?
11. To what extent do you believe that therapists should be free to be themselves? To what extent should they behave in public as if a client might be observing them?

During your first session with a new client, he tells you that he has always been concerned that his penis was too small. Suddenly he pulls down his pants and asks you if you think it is too small. [Consider the same scenario with a new patient who is concerned about the size of her breasts.]

1. What are you feelings? What are you thinking? What are your fantasies about this scenario?
2. What would you, as therapist, want to say first? Why? What do you think you would say first? Why?
3. What difference would it make if this were a client you had been treating for a year rather than a new client?
4. How, if at all, would your feelings and actions be different according to whether treatment were conducted on an inpatient or an outpatient basis?
5. How, if at all, would your feelings and actions differ according to the gender of the client?
6. Imagine that the client in the scenario is fifteen years old. What feelings does the scenario evoke in you? What do you do? What fantasies occur to you about what might happen after the event described in the scenario?

Your client describes to you her troubled marriage. Her husband used to get mad and hit her—"not too hard," she says—but he's pretty much gotten over that. Their sex life is not good. Her husband enjoys anal intercourse, but she finds it frightening and painful. She tells you that she'd like to explore her resistance to this form of sexual behavior in her therapy. Her goal is to become comfortable engaging in the behavior so that she can please her husband, enjoy sex with him, and have a happy marriage.

1. What are you feeling when the client says that her husband used to "get mad and hit her"? What are you thinking?
2. What are you feeling when she says that she finds anal intercourse frightening and painful? What are you thinking?
3. What do you feel when she describes her goals in therapy? What are you thinking?
4. In what ways do you believe that your feelings may influence how you proceed with this client?

The therapy group you are leading is into its eighth month of weekly meetings. One of the members of the group begins sobbing, describes terrible feelings of depression, and ends by pleading, "I need someone to hold me!"

Bob, another member of the group, spontaneously jumps up and goes over to the other member, who stands up. As they embrace, it becomes obvious that Bob is getting an erection. He continues the hugging, which the other group member seems to find comforting, and seems to be stimulating himself by rubbing up against the other person.

1. When you imagine this scenario, what do you feel?
2. Would you, as therapist, call attention to what is happening? If so, how?
3. If you were the therapist, could you imagine that such an event might make you feel aroused? frightened? upset? angry? confused?
4. Do any of the following considerations change the feelings that this scenario evokes in you:
    - Whether your supervisor is watching this scene through a one-way mirror

- Whether Bob and the client are the same gender
- Whether Bob is suffering from schizophrenia
- Whether Bob is a pedophile
- Whether the client receiving the hug seems to be aroused
- Whether Bob had been sexually abused during childhood
- Whether this is an inpatient group
- Whether all members of this group are suffering from terminal illnesses
- Whether the client receiving the hug had been sexually abused during childhood
- Whether the client receiving the hug has sued a prior therapist for malpractice in regard to sexual issues

You are working in a busy mental health center in which the doors to the consulting rooms, while offering some privacy, are not completely soundproof. As long as therapist and client are talking at a normal level, nothing can be heard from outside the door. But words spoken loudly can be heard and understood in the reception area.

A client, Sal, sits in silence during the first five minutes of the session, finally saying, "It's been hard to concentrate today. I keep hearing these sounds, like they're ringing in my ear, and they're frightening to me. I want to tell you what they're like, but I'm afraid to."

After offering considerable reassurance that describing the sounds would be okay and that you and Sal can work together to try to understand what is causing the sounds, what they mean, and what you might do about them, you notice that Sal seems to be gathering the courage to reveal them to you.

Finally, Sal leans back in the chair and imitates the sounds. They build quickly to a very high pitch and loud volume. They sound exactly like someone becoming more and more sexually aroused and then experiencing an intense orgasm.

You are reasonably certain that these sounds have been heard by the receptionist, some of your colleagues, the patients sitting in the waiting room, and a site visitor from the Joint Commission for the Accreditation of Hospitals who is deciding whether the hospital in which your clinic is based should have its accreditation renewed.

1. What feelings does this scenario evoke in you?
2. As you imagined the scene, was the client male (Salvador) or female (Sally)? Does the client's gender make any difference in the way you feel?
3. If Sal began to make the sounds again, would you make any effort to interrupt or ask the client to be a little quieter? Why?
4. If none of the people who might have heard the sounds mentioned this event to you, would you make any effort to explain what had happened?
5. Imagine that just as Sal finishes making these sounds, someone knocks loudly on the door and asks, "What's going on in there?" What do you say or do?
6. Would your feelings or behavior be any different if the sounds were of a person being beaten rather than having an orgasm?
7. How would you describe this session in your chart notes?
8. If you were being supervised, would you feel at all apprehensive about discussing this session with your supervisor?
9. What approach do you usually take toward your clients' making loud noises that might be heard outside the consulting room?

CHAPTER FOURTEEN

Nonsexual Multiple Relationships and Other Boundary Issues

Anyone laboring under the mistaken impression that dual relationships, multiple relationships, and other boundary issues are simple need only look at the literature running throughout the 1980s and into the 1990s, a tumultuous period of intense questioning and healthy controversy. Thoughtful articles, books, and chapters explored boundaries from virtually every possible point of view. Old ideas were challenged; new ideas were argued. Authors called attention to important factors that had been relatively neglected. Every suggested standard, guideline, and approach was examined carefully for possible benefits, drawbacks, and unintended consequences.

In 1981 Samuel Roll and Leverett Millen, for example, presented "A Guide to Violating an Injunction in Psychotherapy: On Seeing Acquaintances as Patients." Patricia Keith-Spiegel and Gerald Koocher's 1985 edition of their widely used textbook, *Ethics in Psychology: Professional Standards and Cases,* examined ways in which boundary crossings in ethical therapy and counseling may be unavoidable. They provided an approach to examining the ethical aspects of various dual relationships and other boundary issues. Karen Kitchener's influential 1988 article, "Dual Role Relationships," helped readers sort out "counselor-client relationships that are likely to lead to harm and those that are not likely to be harmful" (p. 217). Kitchener suggested that dual relationships are more likely to cause problems if they involve "(1) incompatibility of expectations between roles; (2) diverging obligations associated with different roles, which increases the potential for loss of objectivity; and (3) increased power and prestige between professionals and consumers, which increases the potential for exploitation" (p. 217).

Robert Ryder and Jeri Hepworth (1990) argued thoughtfully that the AAMFT should not prohibit dual relationships in its ethics code. Janet Sonne (1994) examined the ways in which the then-current APA ethics code addressed multiple relationships and argued that some segments represented "steps backward" (p. 343). Vincent Rinella and Alvin Gerstein wrote that "the underlying moral and ethical rationale for prohibiting dual relationships (DRs) is no longer tenable" (1994, p. 225). Tom Gutheil and Glen Gabbard (1993) maintained that "boundary crossings may be benign or harmful" (p. 195) and explored factors that influence the impact.

Elisabeth Horst (1989), Amy Stockman (1990), and Floyd Jennings (1992) helped foster awareness and appreciation of the special challenges that rural settings present for dual relationships and other boundary issues. Laura Brown (1989; see also 1994b) was among those who thoughtfully argued against a simple prohibition when considering dual relationships and other boundary issues in the lesbian therapy community in "Beyond Thou Shalt Not: Thinking About Ethics in the Lesbian Therapy Community." Melanie Geyer (1994) proposed adopting some of the special guidelines for considering multiple relationships and other boundary issues in rural settings and adapting them for difficult dilemmas faced by Christian counselors (and counselors for whom other religious faiths are a primary foundation and concern of practice). Bruce Sharkin and Ian Birky (1992) focused attention on the unplanned, unexpected encounters between therapists and clients and on the difficulties of maintaining boundaries during incidental encounters.

Jeanne Adleman and Susan Barrett (1990) were among those who pioneered considering multiple relationships and other boundary issues afresh using feminist principles. Patruska Clarkson's "In Recognition of Dual Relationships" explored the implications of believing in a "mythical, single relationship" and cautioned therapists and counselors against "an unrealistic attempt to avoid all dual relationships"

(1994, p. 32). Ellen Bader (1994) maintained that we should stop focusing on whether there are dual roles and consider instead whether each instance represents exploitation.

In 1994, the journal *Ethics and Behavior* invited some of the major voices in the area to debate the topic of boundaries in therapy (Borys, 1994; Bennett, Bricklin, & VandeCreek, 1994; Brown, 1994a; Gabbard, 1994; Gottlieb, 1994; Gutheil, 1994; Lazarus, 1994a, 1994b).

The care with which this and other work from the 1980s and 1990s called attention to the many factors (for example, setting, culture, expectations, theoretical orientation) to be taken into account when considering whether a specific multiple relationship or other boundary crossing with a specific client in a specific situation is likely to be helpful or hurtful has encouraged therapists and counselors to appreciate the complexity of these decisions and engage in careful questioning rather than unthinking rule following. It is a process that also often involves the therapist's or counselor's feelings, as Jeffrey Kottler's frank exploration discloses:

> Sorting out dual relationships has become the most prevalent ethical issue of our time. . . . Our family members and friends constantly ask us for advice. Although we may do our best to beg off, the truth of the matter is that we may well enjoy being needed. I love it when people ask me what to do. . . . I feel so self-important that someone else thinks I know something that they do not. I pretend I am a little annoyed by those who ask me how to handle their children, confront their bosses, or straighten out their lives, but I appreciate the fact that they thought enough of me to ask [2003, p. 4].

WHAT MAKES THIS AREA SO HARD FOR US?

Why is this area so difficult for virtually all of us as individuals and as a profession? Here are five potential causes that may be at work.

First, major boundary dilemmas often catch us off-guard and unprepared. They can sweep us into unfamiliar, unexpected territory where we must make a quick decision of great importance, perhaps influencing the therapy in a decisive way. In Chapter Seventeen on responding to suicidal risk, we provide an example of how a sudden decision about a boundary crossing can have a profoundly transformative and healing effect. In this example, Stone (1982) describes a young woman, hospitalized during a psychotic episode, who continuously vilified her therapist for not caring about her. Without warning, she escaped from the hospital:

> The therapist, upon hearing the news, got into her car and canvassed all the bars and social clubs in Greenwich Village which her patient was known to frequent. At about midnight, she found her patient and drove her back to the hospital. From that day forward, the patient grew calmer, less impulsive, and made great progress in treatment. Later, after making substantial recovery, she told her therapist that all the interpretations during the first few weeks in the hospital meant very little to her. But after the "midnight rescue mission" it was clear, even to her, how concerned and sincere her therapist had been from the beginning [p. 271].

Interestingly, from the time that this example and related accounts of the positive and healing potential of what are now called boundary crossings appeared in the first edition of this book over fifteen years ago, they have been one of the most frequent topics of reader comments.

Second, opportunities to cross boundaries can—as Jeffrey Kottler's courageously honest statement acknowledges—tap into some of our most basic needs and strongest desires. It is possible to fall vulnerable to fallacies in reasoning and judgment (see Chapter Two) and mistake our own self-interest as if it were the client's needs. Our own needs and desires prompt us to see crossing the boundaries that *we* want to cross in the way that *we* want to cross them as the only meaningful clinical intervention, the only humane approach, the only prospect for helping the client. We become convinced that what we want to do is an ethical imperative. Glen Gabbard wrote:

> Harry Stack Sullivan (1954) once observed that psychotherapy is a unique profession in that it requires therapists to set aside their own needs in the service of addressing the patient's needs. He further noted that this demand is an extraordinary challenge for most people, and he concluded that few persons are really suited for the psychotherapeutic role. Because the needs of the psychotherapist often get in the way of the therapy, the mental health professions have established guidelines, often referred to as boundaries, that are designed to minimize the opportunity for therapists to use their patients for their own gratification [1994, p. 283].

Third, the need for clarity about boundaries can be misunderstood as the need for inflexible boundaries reflexively applied. Clarity in thinking through boundary issues for each client is essential. Reflexively applying a rigid set of rules about inflexible boundaries can never be an acceptable substitute for thinking through boundary issues for an individual client as clearly and carefully as possible. Decisions about boundaries must be made with the greatest possible clarity about the potential benefits and harm, the client's needs and well-being, informed consent and informed refusal, the therapist's motives, and the therapist's knowledge and competence. A subsequent section in this chapter lists resources that can help therapists as they make clear and thoughtful decisions in this area.

Fourth, boundary decisions can evoke anxiety and even fear. For example, clinical and forensic psychologist Martin Williams points out that some may try to avoid the area entirely to minimize the risk of being sued. He describes how the fear of lawsuits and ethics complaints can lead clinicians to avoid even justifiable boundary crossings. He uses the work of one of this book's authors as an example. This example, originally published in *American Psychologist* ("Biography," 1996), was one of a number of descriptions, published over the decades, of the author's personal experiences with boundary crossings and how they had turned out. The example involved providing psychological services to a homeless woman who had survived an assault, who was being stalked, and whose life was at risk. Williams noted how the author's work with the client included instances

> of what Gutheil and Gabbard (1993) might term boundary crossings (although not boundary violations). . . . [This] treatment carried out by Pope had included daily meetings without fee and his arranging for a personal friend of his to lend the patient money and to provide her with an airline ticket and a place to stay. In the context of the particular case, these boundary excursions appeared to be both humane and sensible. However, some practitioners might, in the interest of risk management, avoid making similar modifications [1997, p. 248].

Fifth, we find relatively little guidance in making real-world decisions about boundary crossings in our classrooms and treatment guides. Moreover, many boundary crossings are subject to misinterpretation. American Psychological Association president Gerry Koocher's account of his own boundary crossings frequently, as he writes, makes some of his students gasp:

> On occasion I tell my students and professional audiences that I once spent an entire psychotherapy session holding hands with a 26 year old woman together in a quiet darkened room. That disclosure usually elicits more than a few gasps and grimaces. When I add that I could not bring myself to end the session after 50 minutes and stayed with the young woman holding hands for another half hour, and when I add the fact that I never billed for the extra time, eyes roll.
>
> Then, I explain that the young woman had cystic fibrosis with severe pulmonary disease and panic-inducing air hunger. She had to struggle through three breaths on an oxygen line before she could speak a sentence. I had come into her room, sat down by her bedside, and asked I how I might help her. She grabbed my hand and said, "Don't let go." When the time came for another appointment, I called a nurse to take my place. By this point in my story most listeners, who had felt critical of or offended by the "hand holding," have moved from an assumption of sexualized impropriety to one of empathy and compassion. The real message of the anecdote, however, lies in the fact that I never learned this behavior in a classroom. No description of such an intervention exists in any treatment manual or tome on empirically-based psychotherapy [2006, p. xxii].

RESEARCH LEADING TO A CALL FOR A CHANGE IN THE ETHICS CODE

Chapter Seven noted that the original APA ethics code was empirically based, the result of a survey of the membership, asking them what ethical dilemmas they encountered. It also described a replication of that critical incident study a half-century later. This 1992 replication, published in *American Psychologist,* found that the second most often reported ethical dilemmas were in the area of "blurred, dual, or conflictual relationships" (Pope & Vetter, 1992).

On the basis of their findings, Pope and Vetter called for changes to the APA ethical principles in the areas of dual relationships, multiple relationships, and boundary issues so that the ethics code would, for example:

- Define dual relationships more carefully and specify clearly conditions under which they might be therapeutically indicated or acceptable

- Address clearly and realistically the situations of those who practice in small towns, rural communities, remote locales, and similar contexts (emphasizing that neither the current code in place at the time nor the draft revision under consideration at that time fully acknowledged or adequately addressed such contexts)
- Distinguish between dual relationships and accidental or incidental extratherapeutic contacts (for example, running into a patient at the grocery market or unexpectedly seeing a client at a party) and to address realistically the awkward entanglements into which even the most careful therapist can fall

The following excerpt from that article ("Ethical Dilemmas Encountered by Members of the American Psychological Association: A National Survey") presents those findings and recommendations in detail, including examples provided by the survey participants:

> ### BLURRED, DUAL, OR CONFLICTUAL RELATIONSHIPS
>
> The second most frequently described incidents involved maintaining clear, reasonable, and therapeutic boundaries around the professional relationship with a client. In some cases, respondents were troubled by such instances as serving as both "therapist and supervisor for hours for [patient/supervisee's] MFCC [marriage, family, and child counselor] license" or when "an agency hires one of its own clients." In other cases, respondents found dual relationships to be useful "to provide role modeling, nurturing and a giving quality to therapy"; one respondent, for example, believed that providing therapy to couples with whom he has social relationships and who are members of his small church makes sense because he is "able to see how these people interact in group context." In still other cases, respondents reported that it was sometimes difficult to know what constitutes a dual relationship or conflict of interest; for example, "I have employees/supervisees who were former clients and wonder if this is a dual relationship." Similarly, another respondent felt a conflict between his own romantic attraction to a patient's mother and responsibilities to the child who had developed a positive relationship with him:
>
> > I was conducting therapy with a child and soon became aware that there was a mutual attraction between myself and the child's mother. The strategies I had used and my rapport with the child had been positive. Nonetheless, I felt it necessary to refer to avoid a dual relationship (at the cost of the gains that had been made).

Taken as a whole, the incidents suggest, first, that the ethical principles need to define dual relationships more carefully and to note with clarity if and when they are ever therapeutically indicated or acceptable. For example, a statement such as "Minimal or remote relationships are unlikely to violate this standard" ("Draft," 1991, p. 32) may be too vague and ambiguous. A psychologist's relationship to a very casual acquaintance whom she or he meets for lunch a few times a year, to an accountant who only does very routine work in filling out her or his tax forms once a year (all such business being conducted by mail), to her or his employer's husband (who has no involvement in the business and with whom the psychologist never socializes), and to a travel agent (who books perhaps one or two flights a year for the psychologist) may constitute relatively minimal or remote relationships. However, will a formal code's assurance that minimal or remote relationships are unlikely to violate the standard provide a clear, practical, valid, and useful basis for ethical deliberation to the psychologist who is serves as therapist to all four individuals? Research and the professional literature focusing on nonsexual dual relationships underscores the importance and implications of decisions to enter into or refrain from such activities (e.g., Borys & Pope, 1989; Ethics Committee, 1988; Keith-Spiegel & Koocher, 1985; Pope & Vasquez, 1991; Stromberg et al., 1988).

Second, the principles must address clearly and realistically the situations of those who practice in small towns, rural communities, and other remote locales. Neither the current code nor the current draft revision explicitly acknowledges and adequately addresses such geographic contexts. Forty-one of the dual relationship incidents involved such locales. Many respondents implicitly or explicitly complained that the principles seem to ignore the special conditions in small, self-contained communities. For example,

> I live and maintain a . . . private practice in a rural area. I am also a member of a spiritual community based here. There are very few other therapists in the immediate vicinity who work with transformational, holistic, and feminist principles in the context of good clinical training that "conventional" people can also feel confidence in. Clients often come to me because they know me already, because they are not satisfied with the other services available, or because they want to work with someone who understands their spiritual practice and can incorporate its principles and practices into the process of transformation, healing, and change. The stricture against dual relationships helps me

> to maintain a high degree of sensitivity to the ethics (and potentials for abuse or confusion) of such situations, but doesn't give me any help in working with the actual circumstances of my practice. I hope revised principles will address these concerns!

Third, the principles need to distinguish between dual relationships and accidental or incidental extratherapeutic contacts (e.g., running into a patient at the grocery market or unexpectedly seeing a client at a party) and to address realistically the awkward entanglements into which even the most careful therapist can fall. For example, a therapist sought to file a formal complaint against some very noisy tenants of a neighboring house. When he did so, he was surprised to discover "that his patient was the owner-landlord." As another example, a respondent reported,

> Six months ago a patient I had been working with for 3 years became romantically involved with my best and longest friend. I could write no less than a book on the complications of this fact! I have been getting legal and therapeutic consultations all along, and continue to do so. Currently they are living together and I referred the patient (who was furious that I did this and felt abandoned). I worked with the other psychologist for several months to provide a bridge for the patient. I told my friend soon after I found out that I would have to suspend our contact. I'm currently trying to figure out if we can ever resume our friendship and under what conditions.

The latter example is one of many that demonstrate the extreme lengths to which most psychologists are willing to go to ensure the welfare of their patients. Although it is impossible to anticipate every pattern of multiple relationship or to account for all the vicissitudes and complexities of life, psychologists need and deserve formal principles that provide lucid, useful, and practical guidance as an aid to professional judgment [Pope & Vetter, 1992, pp. 400–401].

MULTIPLE RELATIONSHIPS AS DEFINED BY THE APA AND CPA ETHICS CODES

Janet Sonne has noted how concerns about multiple relationships may not be founded on an accurate understanding of multiple relationships or the ethical standards:

> You may have heard in workshops or read in books or journals that hugging a client, giving a gift to a client, or meeting a client outside of the office constitutes a multiple relationship and is prohibited by our ethics code or by the standard of care sustained by professional licensing boards. Not accurate.
>
> You may also have heard or read that telling a client something personal about yourself or unexpectedly encountering a client at a social event are examples of unprofessional multiple relationships. Again, not accurate.
>
> The inaccuracies, or errors, in our thinking about nonsexual multiple relationships, mire us in confusion and controversy [2005].

It is worth taking a look at the APA and CPA codes to see how they define this concept. The APA Ethics Code defined multiple relationships for the first time in the 2002 revision (APA, 2002). According to Standard 3.05a, "A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person" (p. 1065). Most commonly, the second role is social, financial, business, or professional.

Standard 3.05a notes that not all multiple relationships are problematic and provides guidance as to when to avoid inappropriate multiple relationships: "A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists" (p. 1065). Thus, psychologists avoid dual or multiple roles with clients unless there is no reasonable likelihood that a secondary role would interfere with one's objectivity, competence or effectiveness in therapy.

The Canadian Ethics Code (CPA, 2000) provides a similar caution. Section III.33 states, "Avoid dual or multiple relationships (e.g. with clients, research participants, employees, supervisees, students, or trainees) and other situations that might present a conflict of interest or that might reduce their ability to be objective and unbiased in their determinations of what might be in the best interests of others" (p. 31).

Standard III.34 also acknowledges that some multiple relationships are unavoidable and suggests ways to avoid risk of harm: "Manage dual or multiple relationships that are unavoidable due to cultural norms or other circumstances in such a manner that bias, lack of objectivity, and risk of exploitation are minimized. This might include obtaining ongoing supervision or consultation for the duration of the dual or multiple relationship, or involving a third party in obtaining consent (e.g. approaching a client or employee about becoming a research participant)" (p. 27).

THREE EXAMPLES OF MULTIPLE RELATIONSHIPS

In part it may be the relative simplicity and abstraction of the definition that lulls many of us into ignoring the diverse, subtle ways that therapists can enter into multiple relationships with their clients. Specific examples, more than abstract definitions, may provide us with a useful awareness of how these entanglements occur. The following three fictional scenarios illustrate nonsexual multiple relationships.

The Opportunity

Bill has just opened a private practice office and has exactly two patients. One of them, Mr. Lightfoot, is an extremely successful investment analyst who is grateful to Bill for all the benefits he is getting from psychotherapy. The worst of Mr. Lightfoot's depression seems to be in remission, and he is now focusing on his relationships with those whose financial matters he handles. Bill, who genuinely likes Mr. Lightfoot, finds himself especially attentive when his patient talks about new investment opportunities. Unexpectedly, Mr. Lightfoot says that Bill might make a great deal of money if he invests in a certain project that is now being planned. The more Bill thinks about it, the more this seems like a terrific opportunity. It will help Mr. Lightfoot's sense of self-esteem because he will be in the position of helping Bill rather than always receiving help from him. It will not cost Mr. Lightfoot anything. Finally, it may allow Bill to survive in private practice and thus enable him to continue to help others. (Bill's overhead was greater than expected, the anticipated referrals were not materializing, and he was down to his last ten thousand dollars in savings, which would not last long given his office rent and other expenses.) He decides to give his savings to Mr. Lightfoot to invest for him.

Employee Benefits

Dr. Ali is a successful psychotherapist who now owns and manages his own mental health clinic. Lately he has noticed that his normally outstanding secretary, Mr. Miller, has been making numerous mistakes, some of them resulting in considerable financial losses for the clinic. Dr. Ali's customary toleration, encouragement, and nonjudgmental pointing out of the errors have not improved his secretary's performance. He decides that a serious and frank discussion of the situation is necessary. When he begins talking with his secretary about the deteriorating performance, Mr. Miller reveals some personal and financial stresses that he has been encountering that make it difficult for him to attend to his work. Dr. Ali is aware that his secretary cannot afford therapy and that the chances of hiring a new secretary with anywhere near Mr. Miller's previous level of skills is at best a long shot. Even if a good secretary could be found in what is a cutthroat job market, there would be a long period of orientation and training during which Dr. Ali anticipates he would continue to lose revenue. He decides that the only course of action that makes sense, that creatively solves all problems, is to take on Mr. Miller as a patient for two or three hours each week until Mr. Miller has a chance to work through his problems. Mr. Miller could continue to work as secretary and would not be charged for the therapy sessions. Dr. Ali would provide them without charge as part of a creative and generous "employee benefit."

Helping as a Friend

Rosa, an attorney, is going through one of the worst times in her life. For several weeks, she had been experiencing mild abdominal discomfort and had dismissed it as a muscle strained while jogging or nervousness about the case she was preparing to argue in her first appearance before the state supreme court. The pains become worse, and she manages to drive herself to the emergency room. A rather brusk medical resident informs her that he has located a large lump on her ovary. He advises her to make an appointment to undergo extensive tests to determine the nature of the lump, which may be cancerous.

Rosa is terrified. The tests are scheduled for two days from now. She has to cope not only with the pain but also with the uncertainty of what the physicians will discover. She goes immediately to the house of her best friend, June, a psychotherapist. June suggests showing Rosa some self-hypnotic and imagery techniques that might help her cope with her pain and anxiety. As June leads her through the exercises, Rosa begins to feel relieved and comforted. However, when she tries to use the techniques by herself, she experiences no effects at all. June agrees to lead her through the hypnotic and imagery exercises two or three times a day until the medical crisis is resolved. During the fourth meeting, spontaneous images that are quite troubling begin occurring. Rosa starts talking about them and feels they are related to things that happened to her as a small child. She discusses them in detail with June, and by the end of the sixth session, June recognizes that an intense transference has developed. She encourages Rosa to consult another therapist but Rosa refuses, saying that there is no one else she could trust with these matters and that terminating the sessions would make her feel so betrayed and abandoned that she fears she would take her own life.

A REVIEW OF RESEARCH

There has been considerable research regarding sexual multiple relationships (see Chapter Thirteen). Research concerning the prevalence of nonsexual multiple relationships, however, has been rarer. Tallman (1981) conducted perhaps the earliest study on nonsexual multiple relationships. Of the thirty-eight psychotherapists participating, about 33 percent indicated that they had formed social relationships with at least some of their patients. An intriguing aspect of the findings was that although only half of the participants were male, all of the therapists who developed these social relationships with patients were male. This significant gender difference is remarkably consistent not only in terms of both sexual and nonsexual multiple relationships in psychotherapy but also in terms of multiple relationships involving teaching and supervision.

Borys and Pope summarized the research that had accumulated over the past dozen or so years:

> First, the significant difference (i.e., a greater proportion of male than of female psychologists) that characterizes sexualized multiple relationships conducted by both therapists and educators (teachers, clinical supervisors, and administrators) also characterizes nonsexual multiple relationships conducted by therapists in the areas of social/financial involvements and multiple professional roles. Male respondents tended to rate social/financial involvements and multiple professional roles as more ethical and reported engaging in these involvements with more clients than did female respondents. Second, the data suggest that male therapists tend to engage in nonsexual multiple relationships more with female clients than with male clients. . . . Third, these trends hold for psychologists, psychiatrists, and clinical social workers. Note that these statistical analyses take into account the fact that most therapists are male and most patients are female [1989, p. 290].

Pope, Tabachnick, and Keith-Spiegel (1987) included several items regarding nonsexual multiple relationships—"accepting services from a client in lieu of fee," "providing therapy to one of your friends," "going into business with a former client"—in their survey of the ethical beliefs and practices of a thousand clinical psychologists (the return rate was 46 percent). Their findings were consistent with a larger-scale multidisciplinary study focusing on multiple relationships.

This survey of sixteen hundred psychiatrists, sixteen hundred psychologists, and sixteen hundred social workers (with a 49 percent return rate) examined beliefs and behaviors regarding a range of multiple relationships (Borys & Pope, 1989). The survey's findings included these three points:

- There was no significant difference among the professions in terms of sexual intimacies with clients before or after termination (see Chapter Thirteen) or in terms of nonsexual multiple professional roles, social involvements, or financial involvements with patients.
- The percentage of therapists who rated each multiple relationship behavior as ethical under most or all conditions was invariably less than the percentage of therapists viewing it as never ethical or ethical under only some or rare conditions.
- Psychiatrists tend, as a whole, to view such relationships as less ethical than do psychologists or social workers.

The study found that various beliefs and behaviors in regard to these boundary issues tended to be significantly related to

- Therapist's gender
- Profession (psychiatrist, psychologist, social worker)
- Therapist's age
- Therapist's experience
- Therapist's marital status
- Therapist's region of residence
- Client gender
- Practice setting (such as solo or group private practice and outpatient clinics)
- Practice locale (size of the community)
- Therapist's theoretical orientation

In a separate analysis of these data, Borys (1988, p. 181) found "a clear relationship between sexual and nonsexual multiple role behaviors" (see also American Psychological Association Ethics Committee, 1988). She used a systems perspective to explore this association between nonsexual and sexual multiple relationships:

> As with familial incest, sexual involvement between therapist and client may be the culmination of a more general breakdown in roles and relationship boundaries which begin on a nonsexual level. This link was predicted by the systems perspective, which views disparate roles and behaviors within a relational system as interrelated. Changes in one arena are expected to affect those in other realms of behavior. The results of the current study suggest that the role boundaries and norms in the therapeutic relationship, just as those in the family, serve a protective function that serves to prevent exploitation [p. 182].

Baer and Murdock (1995) conducted a national survey using a slightly modified version of the Therapeutic Practices Survey reported by Borys and Pope (1989). Their findings suggested

> that overall, therapists thought that nonerotic dual-relationship behaviors were ethical in only limited circumstances at best. . . . Therapists judged social and/or financial involvements with their clients as the least ethical of the three classes of nonerotic dual relationships. . . . That psychologists appear clear about the importance of meeting their own social and financial needs (other than payment for therapy) through people who are not their clients is important and can be viewed as promising [p. 143].

Lamb and Catanzaro (1998) interviewed therapists, supervisors and instructors in an academic setting and found that those who admitted to engaging in sexual relationships with clients, supervisees, or students also reported being more likely to engage in nonsexual multiple relationships. They also rated nonsexual multiple relationships as less negative than participants who did not engage in sexual boundary violations. The authors provided helpful guidelines cited later in this chapter.

Lamb, Catanzaro, and Moorman (2004) found that “a new relationship involving social interactions and events appears to be the type of new relationship that psychologists face most often and about which the greatest clarification may be needed, but psychologists need to be aware of other new relationships as well (e.g., new collegial or professional relationships). Discussing new relationships was reported as occurring most frequently with former (as opposed to current) clients, supervisees, or students, particularly former supervisees” (p. 252).

These studies of nonsexual multiple relationships in psychotherapy provide some initial empirical data on which to develop an understanding of the phenomenon and provide some intriguing hypotheses. What is striking, however, is the scarcity of such studies. We need critical self-study, including the systematic collection of data, regarding the occurrence and effects of multiple relationships.

BARTERING

The APA allows bartering under some conditions and states that "barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative (see also Standards 3.05, Multiple Relationships, and 6.04, Fees and Financial Arrangements)" (APA, 2002, p. 1068; see also Sonne, 1994).

Different disciplines have tended to take different views of boundary issues—for example, a national survey found that psychiatrists viewed a variety of boundary-crossing behaviors as less ethical than did psychologists or social workers (Borys & Pope, 1989)—and this is true for bartering as well. A national survey of the beliefs and behaviors of psychologists who were therapists found that most participants viewed bartering with a client as either unethical or unethical under most circumstances (Pope, Tabachnick, & Keith-Spiegel, 1987; see also Baer & Murdock, 1995). A similar survey of certified counselors, however, found that 63 percent viewed bartering for a client's goods and 53 percent viewed bartering for a client's services as ethical (Gibson & Pope, 1993).

Campbell, Vasquez, Behnke, and Kinscherff (in press) describe why the APA Ethics Code allows bartering as a means of payment. Psychologists may consider bartering primarily in the light of the client's financial limitations or the values of the community or culture in which the therapist works. Pro bono services, although sometimes a good option, may not always be possible because of therapeutic issues, the discomfort or unwillingness of the patient to accept free services, or financial pressures on the therapist. However, the therapeutic impact of financial agreements may affect the quality of the relationship.

A number of factors can affect decision making about bartering:

- The client's strengths, weaknesses, needs, and expectations
- The cultural and other relevant context and history
- The nature, duration, and intensity of the psychological services

- Possible benefits and possible harm
- Informed consent and informed refusal
- The therapist's theoretical approach, competence, and motives
- The nature of possible bartering arrangements

The Canadian Ethics Code (CPA, 2000) does not directly address bartering, but many of the standards would apply in decision making; for example, Standard I.15 requires that fees be fair, and Standard IV.12 encourages psychologists to contribute to the welfare of society by providing work for little or no financial return.

A number of therapists oppose bartering. Robert Woody (1998), for example, provides a thoughtful review of the ethical and legal issues and wrote that his "foremost conclusion is that bartering is a bad idea and should be avoided" (p. 177). However, for those who choose to barter with a client, Woody suggests the following guidelines:

1. Unique financial arrangements should be minimized; that is, terms and conditions for any compensation, including the use of bartering, should be as close to established practices as possible and be consonant with the prevailing standards of the profession.
2. The rationale for any compensation decision, including the use of bartering, should be documented in the case records.
3. Discussions about any financial matters should be detailed in writing, giving equal emphasis to what is said by the psychologist and the client.
4. If bartering is used, there should be a preference for goods instead of services; this will minimize (but not eliminate) the possibility of inappropriate personal interactions.
5. The value of the goods (or services) should be verified by an objective source; this may, however, involve additional cost.
6. To guard against any semblance of undue influence, both parties should reach a written agreement for the compensation by bartering.
7. Any new, potentially relevant observations or comments about compensation by bartering should be entered into the client's records, even though a previous agreement exists.
8. The agreement should contain a provision for how valuations were determined and how any subsequent conflicts will be resolved (e.g., a mediator); this may, however, involve additional cost (and a concern

about confidentiality), which will have to be accommodated by the psychologist (i.e., the added expense should not elevate the cost to the client beyond the established service fee).

9. If a misunderstanding or disagreement begins to develop, the matter should be dealt with by the designated conflict resolution source (e.g., a mediator), not the psychologist and client; again, recall the issues of added cost and concern for confidentiality stated in the preceding guideline.
10. If monitoring by the individualized treatment plan reveals a possible negative effect potentially attributable to the compensation arrangement, it should be remedied or appropriate termination of the treatment relationship should occur [p. 177].

MULTIPLE RELATIONSHIPS AND BOUNDARY ISSUES IN SMALL COMMUNITIES

A community's size and nature provide important context for boundary issues. A varied and helpful literature explores boundary questions for therapists working in closely knit communities. Examples include some lesbian, gay, bisexual, and transgender communities (Brown, 1989; Greene, 1997a, 1997b; Greene & Croom, 1999; Kessler & Waehler, 2005), some ethnic minority communities (Comas-Diaz & Greene, 1994; Landrine, 1995; Pack-Brown & Williams, 2003; Ridley, Liddle, Hill, and Li, 2001; Sue & Sue, 2003; Vasquez, 2005; Velasquez, Arellano, & McNeil, 2004), and some rural communities (Barnett & Yutrzenka, 1995; Brownlee, 1996; Campbell & Gordon, 2003; Faulkner & Faulkner, 1997; Gripton & Valentich, 2004; Harowski, Turner, LeVine, Schank, & Leichter, 2006; Jennings, 1992; Schank & Skovholt, 1997; Simon & Williams, 1999).

A central theme of this book is that we cannot shift responsibility to a set of rules, reflexively applied. Every client is unique in some ways, as is every therapist. Each situation is unique in some ways, and situations continue to change. Nothing can spare us the personal responsibility of making the best effort we can to assess the potential effects of boundary crossings, which tend to occur more often in small communities, and to act in the most ethical, informed, aware, and creative way possible.

The Feminist Therapy Institute's feminist code of ethics (1987) and the APA Multicultural Guidelines (APA, 2003b) encourage advocacy efforts, community involvement, and activism (see also Arredondo et al., 1996; Constantine & Sue, 2005; Harper & McFadden, 2003; Moodley & Palmer, 2006; Pack-Brown & Williams, 2003; Roysircar, Sandu, & Bibbins, 2003; Sue, 1995). These activities may create overlapping relationships among therapists and clients, which require careful attention to informed consent, privacy and confidentiality issues, power differentials, and potential pitfalls.

Vasquez (2005) described how small communities and other contexts brought awareness that it is often useful to think of boundaries as continuous rather than dichotomous features of our work. In some small communities, for example, therapists encounter clients and clients' families and friends almost any time they set foot outside. Vasquez addresses decision making in areas like self-disclosure, nonsexual touch (see also the section on nonsexual touch in Chapter Thirteen), giving and receiving gifts, attending an important event for a client (for example, a wedding or funeral), and others. Culture can be critical (see Chapter Fifteen). For example, refusing to accept a gift can create a shaming experience in some cultures.

SOURCES OF GUIDANCE

Although Chapter Nine provides steps useful in thinking through ethical issues and making ethical decisions, there are thoughtful, widely used decision-making guides that focus specifically on multiple relationships. Here are six of the more widely used decision-making guides that readers may find helpful when considering multiple relationships and other boundary issues:

- Gottlieb's "Avoiding Exploitive Dual Relationships: A Decision-Making Model" (1993, available at http://kspope.com/dual/index.php)
- Faulkner and Faulkner's guide for practice in rural settings: "Managing Multiple Relationships in Rural Communities: Neutrality and Boundary Violations" (1997)
- Lamb and Catanzaro's model in "Sexual and Nonsexual Boundary Violations Involving Psychologists, Clients, Supervisees, and Students: Implications for Professional Practice" (1998)
- Younggren's model in "Ethical Decision-Making and Dual Relationships" (2002, available at http://kspope.com/dual/index.php)

- Campbell and Gordon's five-step approach for considering multiple relationships in rural communities: "Acknowledging the Inevitable: Understanding Multiple Relationships in Rural Practice" (2003)
- Sonne's "Nonsexual Multiple Relationships: A Practical Decision-Making Model for Clinicians" (2005, available at http://kspope.com)

In addition, Pope, Sonne, and Greene (2006) provide a decision-making model for when we are stuck and have no idea what to do. It was created for those times when "our best understanding of the situation may suggest a course of action that seems productive yet questionable and potentially harmful. To refrain from a contemplated action may shut the door to our spontaneity, creativity, intuition, and ability to help; to refrain may stunt the patient's progress or impede recovery. To engage in the contemplated action, however, may lead to disaster." They suggest eight steps that can help therapists and counselors find their ways through such impasses.

For internship settings, Burian and Slimp provide a thoughtful approach to making decisions in "Social Dual-Role Relationships During Internship: A Decision-Making Model" (2000; see also Slimp & Burian, 1994).

ADDITIONAL RESOURCES

A Web page ("Dual Relationships, Multiple Relationships, & Boundary Decisions") at http://kspope.com/dual/index.php provides resources that may be helpful in thinking through possible dual relationships, multiple relationships, and other boundary issues. The Web page's resources fall into three categories:

1. Widely used decision-making guides (Sonne's "Nonsexual Multiple Relationships: A Practical Decision-Making Model for Clinicians" (2005); Younggren's "Ethical Decision-Making and Dual Relationships" (2002); and Gottlieb's "Avoiding Exploitive Dual Relationships: A Decision-Making Model" (1993).
2. Excerpts addressing dual relationships and multiple relationships from the standards of professional associations (with links to the original documents) including American Association for Marriage and Family Therapy; American Association of Christian

Counselors; American Association of Pastoral Counselors; American Association of Sex Educators, Counselors and Therapists; American Board of Examiners in Clinical Social Work; American Counseling Association; American Mental Health Counselors Association; American Music Therapy Association; American Psychoanalytic Association; American Psychological Association; American School Counselor Association; Association of State and Provincial Psychology Boards; Australian Association of Social Workers; Australian Psychological Society; British Association for Counselling and Psychotherapy; British Association of Social Workers; British Columbia Association of Clinical Counsellors; California Association for Counseling and Development; California Association of Marriage and Family Therapists; Canadian Counselling Association; Canadian Psychological Association; Canadian Traumatic Stress Network [Reseau Canadien du Stress Traumatique]; European Association for Body-Psychotherapy; European Federation of Psychologists' Associations; Feminist Therapy Institute; Irish Association for Counseling and Therapy; National Association of Social Workers; National Council for Hypnotherapy; and Psychological Society of Ireland

3. Articles on dual relationships, multiple relationships, and other boundary topics from *American Psychologist, Professional Psychology,* and other journals

SCENARIOS FOR DISCUSSION

You decide to teach a course in basic psychopathology as part of the local community college's associate of arts degree program. You show up on the first day of class and see that there are ten students who have signed up. Two of them are current psychotherapy clients in your practice.

1. How do you feel?
2. Does their presence change how you teach your first class session?
3. What options do you have for addressing this issue?
4. What do you think you would do?
5. How, if at all, would you address this issue in the chart notes for these two clients?

You live in a very small community. You are the only psychotherapist providing services through the local managed care plan. One day one of your closest friends, someone you have known for several decades, shows up at your office, seeking therapy.

1. How do you feel?
2. Do you share any of your feelings or concerns with the client during this session? If so, what do you say?
3. Assume that you do not believe that you can serve as therapist in the light of your close friendship with this person. However, the client points out that not only are you the only one designated to provide therapy under the managed care plan, but that since you are also virtually the only one anywhere near this small community who matches the client in terms of characteristics that the client feels are important (this person believes that only someone who matches the patient's gender, race, and sexual orientation will understand the issues and be able to help), the client cannot really get help from anyone but you. How do you address this? What are your options? What steps would you take?

You have been suffering some financial losses and are close to bankruptcy. You will likely lose everything if you are unable to sell your house. You have been trying to sell your house for close to two years and have not received a serious offer. You hold yet another open house. The only person to show up is one of your psychotherapy clients who says, "This is a great house! I'd love to buy it. And although I'd be buying it anyway, its nice that it'll end up helping you."

1. How do you feel?
2. What do you think you would say?
3. What options do you consider?
4. What do you think you'd end up doing?

A couple, who are your close friends, are aware that you will likely be spending Thanksgiving alone. They invite you to share Thanksgiving day with them, preparing the meal during the morning, feasting at lunch, going for a leisurely walk in the woods during the afternoon, then returning for a light dinner. You show up to discover that they have, without letting you know, invited another unattached person who is presumably your blind date for the day. That person is currently a client to whom you have been providing psychotherapy for two years.

1. How do you feel?
2. What are your options?
3. What do you think you would do?
4. How, if at all, would your feelings, options, or probable course change were the person a former client?
5. What if the other guest were your therapy supervisor rather than your client?
6. What if the other guest were your own therapist?

During a session, a client mentions that because of her job, she receives many free tickets to concerts, plays, and other events. She loves giving them to her various doctors because she greatly appreciates their hard work and because it costs her nothing. She tells you that the day before, she mailed you a pair of tickets to an upcoming concert because you had happened to mention that you are a fan of the performer, who has never held a concert in your part of the country before. You have tried to find tickets to take your daughter, who very much wants to attend, but tickets were immediately sold out and no source seems to have them available at any price.

1. What do you feel?
2. What issues do you consider?
3. Is there any more information that you would want before deciding what to do? If so, what information would you seek?
4. Under what conditions, if any, would you accept the tickets?
5. After the session is over, how, if at all, would you describe this situation in your chart notes?

You are very involved in your community, and you have been appointed to a new board that is engaged in the kind of activism that you value. When you attend your first board meeting, you discover that one of your new clients is also on the board. Your client comes over at a break to tell you how pleased she is that you share similar values and will be working together.

1. How do you feel?
2. What feelings do you imagine that your client might be experiencing?
3. What issues do you consider?
4. What do you think you would say to your client?
5. Would you remain on the board? What reasoning leads you to this decision?
6. How, if at all, would you chart this interaction?

CHAPTER FIFTEEN

Culture, Context, and Individual Differences

We live and work in countries of rich diversity. Different groups develop in different contexts, often revealing striking patterns. For example, Jeanne Miranda (2006) wrote that

> Rates of depression and substance abuse disorders are low among Mexican Americans born in Mexico (Vega et al., 1998), and immigrant Mexican American women have a lifetime rate of depression of 8%, similar to the rates of nonimmigrant Mexicans (Vega et al., 1998). However, after 13 years in the United States, rates of depression for those women who immigrated to the U.S. rise precipitously. U.S.-born women of Mexican heritage experience lifetime rates of depression similar to those of the White population in the United States, nearly twice the rate of immigrants. These findings are mirrored in other indicators of health. . . . Despite high rates of poverty, Mexican American immigrant women have low rates of physical and mental health problems (Vega et al., 1998), Chinese American immigrant women have a lifetime rate of major depression near 7%, approximately half that of White women (Takeuchi et al., 1998). These results suggest that some aspects of culture may protect against culture [pp. 115–116].

We also live amid diversity of languages. Glenn Flores (2006) wrote: "Some 49.6 million Americans (18.7 percent of U.S. residents) speak a language other than English at home; 22.3 million (8.4 percent) have limited English proficiency, speaking English less than 'very well,' according to self-ratings. Between 1990 and 2000, the number of Americans who spoke a language other than English at home grew by 15.1 million (a 47 percent increase), and the number with limited English proficiency grew by 7.3 million (a 53 percent increase . . .). The numbers are particularly high in some places: in 2000, 40 percent of Californians and 75 percent of Miami residents spoke a language other than English at home, and 20 percent of Californians and 47 percent of Miami residents had limited English proficiency" (p. 229). Similarly, Statistics Canada (2006) reports that "about one in four children under 18 living in Toronto and Vancouver were recent immigrants or born in Canada to parents who were recent immigrants. Most of these children lived in homes where the main language spoken by the parents was neither English nor French."

This diversity of cultures, languages, and other factors has ethical implications for therapists and counselors. Both the American Psychological Association (2002) and the Canadian Psychological Association (2000) offer helpful guidance in their ethics codes for situations in which there are significant social class, cultural, or other group differences. Therapists can also find useful resources in CPA's (2001c) *Guidelines for Nondiscriminatory Practice;* APA's *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (2003b); APA's *Guidelines for Psychological Practice with Older Adults* (2004); APA's *Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients* (2003a); and APA's *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations* (1990b).

CONTEXT, COMPETENCE, AND PERSONAL RESPONSIBILITY

Our personal responsibility in this area begins with an honest appraisal of our own competence in a specific situation. The CPA Code of Ethics Standard II.10, in the section on competence and self-knowledge, encourages psychologists to "evaluate how their own experiences, attitudes, culture, beliefs, values, social context, individual differences, specific training, and stresses influence their interactions with others, and integrate this awareness into all efforts to benefit and not harm others" (2002, p. 22). Standard IV.15 requires that psychologists "acquire an adequate knowledge of the culture, social structure, and customs of a community before beginning any major work there" (p. 35).

APA Ethics Code Standard 2.01b, Boundaries of Competence, states:

> Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies [2002, pp. 1063–1064].

Competence includes adequate awareness of both individual and group differences. On the one hand, the clinician must become adequately knowledgeable and respectful of the client's relevant cultural or socioeconomic contexts. Therapists who ignore cultural values, attitudes, and behaviors different from their own deprive themselves of crucial information and may tend to impose their own worldview and assumptions on clients in a misguided and harmful approach. On the other hand, the clinician must avoid making simplistic, unfounded assumptions on the basis of cultural or socioeconomic contexts. Knowledge of cultural and socioeconomic contexts becomes the basis for informed inquiry rather than the illusion of uniform group characteristics with which to stereotype the client. Neither variation between groups nor within groups can be discounted or ignored.

Some readers may object to the apparent restriction of this twofold ethical responsibility to clinical situations in which the clinician and client are of different cultural or socioeconomic backgrounds. They might argue that the need to understand any client's background or context and avoid assuming that the individual can somehow be summarized by certain group characteristics are essential ethical responsibilities in any clinical endeavor. We agree with that view. As Pedersen, Draguns, Lonner, and Trimble (1989, p. 1) emphasize in *Counseling Across Cultures,* "Multicultural counseling is not an exotic topic that applies to remote regions, but is the heart and core of good counseling with any client."

Our training, however, sometimes fails to teach us how to apply the basic principles of therapy and counseling beyond the values and views of the majority culture. Greene (1997a), for example, notes that sometimes the empirical literature does not take account of cultural and other differences:

> A preponderance of the empirical research on or with lesbians and gay men has been conducted with overwhelmingly white, middle-class respondents (Chan, 1989, 1992; Gamets & Kimmel, 1991; Gock, 1985; Greene, 1994, 1996; Greene & Boyd-Franklin, 1996; Mays & Cochran, 1988; Morales, 1992). Similarly, research on members of ethnic minority groups rarely acknowledges differences in sexual orientation among group members. Hence there has been little exploration of the complex interaction between sexual orientation and ethnic identity development, nor have the realistic social tasks and stressors that are a component of gay and lesbian identity formation in conjunction with ethnic identity formation been taken into account. Discussion of the vicissitudes of racism and ethnic identity in intra- and interracial couples of the same gender and their effects on these couples' relationships has also been neglected in the narrow focus on heterosexual relationships found in the literature on ethnic minority clients. There has been an equally narrow focus on predominantly white couples in the gay and lesbian literature [pp. 216–217].

Yet even within such a complex framework of cultural and other forms of difference, it may be deceptively tempting to view each person as a fixed set of characteristics or descriptors:

> Although identity is a fluid concept in psychological and sociological terms, we tend to speak of identities in fixed terms. In particular, those aspects of identity that characterize observable physical characteristics, such as race or gender, are perceived as unchanging ascribed identities. Examples of these would include identifications such as *Chinese woman,* or *Korean American woman,* or even broader terms such as *woman of color,* which are ways of grouping together individuals who are not of the hegemonic "white" race in the United States. We base these constructions of identity upon physical appearance and an individual's declaration of identity. However, even these seemingly clear distinctions are not definitive. For example, I, as a woman of Asian racial background, may declare myself a woman of color because I see

> myself as belonging to a group of ethnic/racial minorities. However, my (biological) sister could insist that she is not a woman of color because she does not feel an affiliation with our group goals, even though she is a person of Chinese ancestry. Does her nonaffiliation take her out of the group of people of color? Or does she remain in regardless of her own self-identification because of her obvious physical characteristics? Generally, in the context of identities based upon racial and physical characteristics, ascribed identities will, rightly or wrongly, continue to be attributed to individuals by others. It is left up to individuals themselves to assert their identities and demonstrate to others that they are or are <u>not</u> what they might appear to be upon first notice [Chan, 1997, pp. 240–241; see also Wyatt, 1997].

These aspects of what we know about cultural and other contexts and how we think about them can be influenced by how we feel about them. For any of us, various cultural, racial, ethnic, political, religious, and other groups—or topics related to these groups—may evoke an emotional response. The response may be subtle or powerful. We may be ashamed of it or embrace it as important. We may be reluctant to mention it to certain people. We may view it as not politically correct or—a more forbidding barrier for many of us—as not emotionally correct (Pope, Sonne, & Greene, 2006). These psychological reactions may block or diminish our competence to work with certain issues or certain groups. It is important to assess not only our intellectual competence but also what Pope and Brown (1996) termed *emotional competence for therapy.*

Our awareness of the client's culture or context must be balanced with an awareness of our own culture or context. Easy to recognize in theory, the influence of our own culture and context can sometimes be hard to appreciate in practice. A remarkable book, *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* (Fadiman, 1997), illustrates the potential costs of overlooking the influence of culture and context on everyone involved. The book describes the efforts of a California hospital staff and a Laotian refugee family to help a Hmong child whose American doctors had diagnosed with epilepsy. Everyone involved had the best of intentions and worked hard to help the girl, but a lack of awareness of cultural differences had tragic effects. The book quotes medical anthropologist Arthur Kleinman: "As powerful an influence as the culture of the Hmong patient and her family is on this case, the culture of biomedicine is equally powerful. If you can't see that your own culture has its own set of interests, emotions, and biases, how can you expect to deal successfully with someone else's culture?" (p. 261).

In "Do We Practice What We Preach? An Exploratory Survey of Multicultural Psychotherapy Competencies," Nancy Hansen and her colleagues presented the results of a study that found that "overall and for 86% of the individual items, participants did not practice what they preached" (2006, p. 66) in terms of what they endorsed as the need for multicultural competencies. They concluded that "psychotherapists need to recognize their vulnerability to not following through with what they know to be competent practice, and they need, in advance, to problem solve creative solutions. It would be helpful to identify your personal barriers in this regard: Are you anxious about raising certain issues with racially/ethnically different clients? Are you uncertain about how best to intervene? Do you fear you will 'get in over your head' exploring these issues? What will it take to work through (or around) these barriers to become more racially/ethnically responsive in your psychotherapy work?" (p. 72). The next section focuses on recognizing those barriers and overcoming them.

OVERCOMING BARRIERS TO ETHICAL SERVICES

The following steps exemplify approaches that can be helpful in recognizing and overcoming barriers to ethical services.

Acknowledging Socioeconomic Differences

One initial step in an ethical approach to the issue of difference is maintaining active awareness of the socioeconomic differences that exist in our society. It is exceptionally easy for us to create a cognitive map of the world in which over 90 percent of the area is represented by our own immediate environment. We lose active awareness that many people live in significantly different contexts. We minimize the differences and forget the contrasts and their implications. An epidemiological study of New York City published in the *New England Journal of Medicine* (McCord & Freeman, 1990) provides an example of the extreme conditions for some U.S. citizens. The analysis showed that 54 of the 353 health areas in New York City had at least double the anticipated mortality rate for people under sixty-five years old.

With only one exception, all of these 54 areas were predominantly African American or Hispanic. "Survival analysis showed that black men in Harlem were less likely to reach the age of 65 than men in Bangladesh" (p. 173). The authors pointed out that their findings were similar to those for natural disaster areas.

What does it mean to us as therapists and counselors that fellow citizens live in such conditions? At a minimum, it requires that we acknowledge the reality of such conditions and inform ourselves adequately when we provide professional services to those from such lethal conditions or from other distinct contexts that differ from our own.

But such conditions also confront us with inescapable ethical questions regarding the degree to which we as individuals and as a profession view ourselves as responsible in some part for addressing these conditions, regardless of whether circumstances bring clients from those conditions to our offices. There is an extensive literature exploring these questions from diverse perspectives (APA, 2003b; Arredondo et al., 1996; Brown, 1994b; Casas & Vasquez, 1989; Constantine & Sue, 2005; Feminist Therapy Institute, 1987; Goodyear & Sinnett, 1984; Harper & McFadden, 2003; Lott & Bullock, 2001, 2007; Moodley & Palmer, 2006; Pack-Brown & Williams, 2003; Pope, 1990b; Roysircar, Sandhu, & Bibbins, 2003; Sue, 1995).

Potential Problems with Assessment Instruments

A second useful step in addressing the issue of difference is to remain alert to the possibility that standardized tests and other assessment instruments may manifest bias. APA Ethics Code Standard 9.06, Interpreting Assessment Results, speaks to competency in assessment in reminding psychologists that when interpreting assessment results, they take into account various factors, including situational, personal, linguistic, and cultural differences that might affect psychologists' judgments or reduce the accuracy of their interpretations (APA, 2002).

LaFromboise and Foster (1989), for example, discuss the case of *Larry P.* v. *Riles* in which the intelligence testing that led to the placement of an African American student into a special education class was unlawful because of the bias of the tests used. They describe two instruments that were specifically developed to avoid racial or cultural bias in assessment of abilities: the Adaptive Behavior Scale (American Association on Mental Deficiency, 1974) and the System of Multicultural Pluralistic Assessment (Mercer, 1979).

An example of a standardized personality test that has been called into question in regard to potential bias is the original Minnesota Multiphasic Personality Inventory (MMPI; not the revised MMPI-2). African Americans, Native Americans, Hispanics, and Asian Americans were among the groups omitted from the sample from which the original MMPI norms were developed. What implications does this exclusion have for the ethical use of the test? Faschingbauer (1979, p. 385) vividly described his reservations: "The original Minnesota group seems to be an inappropriate reference group for the 1980s. The median individual in that group had an eighth-grade education, was married, lived in a small town or on a farm, and was employed as a lower level clerk or skilled tradesman. None was under 16 or over 65 years of age, and all were white. As a clinician I find it difficult to justify comparing anyone to such a dated group. When the person is 14 years old, Chicano, and lives in Houston's poor fifth ward, use of original norms seems sinful."

A former president of the APA Division of the Society for Personality Assessment, Phil Erdberg (1988), reported that in one research study, a single item from the original MMPI discriminated perfectly on the basis of race, that is, it differentiated all African American test takers from all Caucasian test takers in this rural community. These problems were carefully considered in the revision process leading to the MMPI-2 and MMPI-A (Pope, Butcher, & Seelen, 2006).

Fallacies of Difference

Another useful step in addressing issues of difference effectively is to remain mindfully aware of common fallacies in the interpretation of group and individual differences. Pat O'Neill (2005), a former president of the Canadian Psychological Association, discusses the common fallacy of misinterpreting correlation between a particular difference and a problem as the difference causing the problem: "In those days (the early 1970s), we early community psychology graduate students were reading William Ryan's (1971) *Blaming the Victim.* Ryan presented example after example of social problems being reduced to individual differences. The strategy, Ryan said, was to find out how the afflicted person differed from others, then treat that difference as the cause of the problem. He called this 'the art of savage discovery'" (p. 13).

Potential Problems in the Clinical Relationship

Maintaining active awareness of the subtle ways that issues of difference affect our relationship with clients can be an essential step to avoiding pitfalls. Whether we are conducting an assessment or conducting therapy or counseling, our interaction with the client is of great significance. J. M. Jones (1990b) reviewed a variety of research studies demonstrating the degree to which such factors as race could, if not addressed carefully, undermine the process. For example, failing to take such factors into account can contribute to a high premature dropout rate for minorities seeking mental health services.

One set of studies conducted by Word, Zanna, and Cooper (1974) demonstrates the degree to which subtle, unintentional discrimination by the individual conducting the assessment can lead to impaired performance by the person being assessed. In the first part of the study, white interviewers asked questions of both white and African American individuals. There were significant differences in interviewer behavior. Those conducting the assessment spent more time with the white interviewees, looked directly at white interviewees a greater portion of the time, maintained less physical distance from white interviewees, and made fewer speech errors with white interviewees.

For the second part of the study, white interviewers were trained to become aware of and use both styles of interview. They were then asked to interview a number of white people. With half of the white interviewees, the interviewer conducted the interview in a style consistent for white interviewees (for example, a longer interview at less distance). With the other half of the white interviewees, the interviewer followed a style consistent for black interviewees (shorter interview, more distance). The latter interviewees performed much less well on a series of objective measures during the assessment interview. Thus, even if the tests or assessment instruments themselves are relatively free of bias, the behavior of the interviewer can influence those who are being assessed in a discriminatory way that impairs performance.

In "Why Can't We Just Get Along? Interpersonal Biases and Interracial Distrust," Dovidio, Gaertner, Kawakami, and Hodson (2002) reviewed a series of studies showing that contemporary racism can be subtle, unintentional, and below the level of awareness. The ways that racial bias—operating outside awareness—can influence interactions between two people (for example, a therapist and client) may create or nurture race-based self-fulfilling processes. Taking into consideration research findings by Dovidio and his colleagues and others who study this area may help enable us to acknowledge and address these issues more directly.

Understanding the Context

Addressing the issue of difference involves more than acknowledging important differences and avoiding prejudice and stereotyping; it involves an active appreciation of the context in which clients live and understand their lives. Westermeyer (1987, pp. 471–472) provides an example of this appreciation:

> A 48 year old ethnic Chinese woman had been receiving antipsychotic and antidepressant medication for psychotic depression. On this regimen, the patient had lost even more weight and more hope and had become more immobilized. A critical element in this diagnosis of psychosis was the woman's belief that her deceased mother, who had been appearing in her dreams, had traveled from the place of the dead to induce the patient's own death and to bring her to the next world. We interpreted this symptom not as a delusional belief but as a culturally consistent belief in a depressed woman who had recently begun to see her deceased mother in her dreams (a common harbinger of death in the dreams of some Asian patients). This patient responded well after the antipsychotic medication was discontinued, the antidepressant medication was reduced in dosage, and weekly psychotherapy was instituted.

Similarly, the research of Amaro, Russo, and Johnson (1987) demonstrates the importance of an attentive and informed appreciation of different contexts. In comparing sources of strength and stress for Hispanic and Anglo female professionals, they found similar family and work characteristics to be associated with positive mental health. Income was the most consistently related demographic factor across all measures of psychological well-being. In addition, Hispanic women's psychological well-being was related to the experience of discrimination, which was reported by more than 82 percent of the sample. Those of us who are not subject to discrimination in our day-to-day lives may find it easy to misinterpret and mistreat the distress and dysfunction that can result from prejudice.

In some cases, cultural and other forms of difference are relevant to therapists and counselors in assessing their fundamental competence to render services:

> When approached by people in need, therapists need to evaluate whether the anticipated issues fall within their realm of competence or expertise. To use an extreme example, an Anglo therapist who speaks only English and has never learned about or conducted clinical work with abuse victims should evaluate carefully whether he or she is the best person to work with a Hispanic patient who speaks very little English and who has recently recovered memories of childhood sexual abuse. Even when therapist and client speak the same basic language, it can be important to attend carefully to possible regional cultural or language differences that could lead to potentially problematic confusions of meaning. In one instance, a woman born in Puerto Rico walked into her office and found someone rifling through her purse. The potential thief ran off in the midst of an emotional confrontation, although no one was touched. Later, the woman described this event in Spanish to a social worker who had been born in Cuba. She used the word *asalto* to mean a "confrontation." The social worker, however, understood this term to refer to a physical assault . . . because the term was used differently in Cuban Spanish than in Puerto Rican Spanish [Pope & Brown, 1996, pp. 179–180].

Creativity

Yet another step involves a creative and thorough approach to human diversity. In a careful series of studies at Harvard University, Langer, Bashner, and Chanowitz (1985) asked children to consider individuals who were different from the mainstream in that they were physically disabled. In one study, the experimental group of children were asked to think of as many ways as possible that a disabled person might meet a particular challenge, and the control group children were simply asked if the disabled person could meet the challenge. For example, children were shown a picture of a woman in a wheelchair and were asked either *how* the woman could drive a car or *whether* the woman could drive a car. In another study, children in the experimental group were asked to give numerous reasons not only that a disabled individual—a blind person, for example—might be bad at a particular profession but also why he or she might be good at it.

In these and other studies, Langer (1989) found that creativity in responding to forms of human difference can indeed be taught and that it can lead to more realistic, less prejudiced reactions to individuals who differ in some way from the mainstream. The research showed

> that children can be taught that handicaps are function-specific and not person-specific. Those given training in making mindful distinctions learned to be discriminating without prejudice. This group was also less likely than the control group to avoid a handicapped person. In essence, the children were taught that attributes are relative and not absolute, that whether or not something is a disability depends on context [pp. 169–170].

Whether we practice in private offices, HMOs, hospitals, clinics, community mental health centers, university settings, or elsewhere, we must remain alert and creative in regard to the contexts in which we work and the characteristics of those who need our help. Is our setting responsive to the needs of those who use wheelchairs, those for whom English is a new language, those who use American Sign Language to communicate, or those who are blind? For whom is our setting open, inviting, accessible, and genuinely helpful? Who is shut out or discouraged from approaching? To what degree do we acknowledge or assume responsibility for the nature of the settings in which we practice?

Speaking Openly, Honestly, and Directly

Racial, cultural, and other group differences can make us uncomfortable. Pope, Sonne, and Greene (2006) discussed the ways in which certain topics have become taboo, the myths that flourish in the absence of frank discussion, and the harm that often follows. It is important that relevant issues be addressed openly and frankly. This process obviously does not mean replacing silence and avoidance with politically correct (or psychologically correct) clichés but rather approaching the issues honestly. Discussing how race, religion, and culture influenced clinical work with older people, Hinrichsen (2006) wrote:

> How are ethnic or minority service providers perceived by White older clients? An African American psychology intern in her mid-20s whom I supervised began to conduct psychotherapy with a man in his 70s

> for the treatment of depression triggered by an increasing number of health problems. The intern mentioned that the older client persisted with telling stories about "Negro fellas" in the army during World War II. The emphasis of the stories was usually on how much he liked his Black comrades and the contributions that they made to the army. When asked how she handled this issue, the intern reported she said to the older client, "I guess you noticed I'm Black." This statement led to a productive discussion of a variety of concerns that included worry that he might say something racially related that would offend the intern and concern about whether a Black service provider could understand his experience. At times, during intakes into our geriatric clinic, a prospective client will frankly state, "I'd like a White doctor" or "I want a Jewish doctor." Clinical geropsychologists sometimes have noted that some older adults will make disparaging racial or ethnic remarks rarely made by younger adults. In part, open expression of these remarks reflects the reality that the current generation of older adults grew into adulthood during a time when racial and ethnic segregation were government and institution sanctioned and that it was socially acceptable in some circles to publicly and unfavorably caricature racial or ethnic minorities [p. 32].

SCENARIOS FOR DISCUSSION

You are conducting an intake examination at an HMO. The client's first words to you are, "I'm having some problems with my sexual identity, but I think I can only work with someone who understands where I'm coming from, who has faced these same issues, and who knows what its like. What's your sexual orientation?"

1. How do you feel?
2. What goals would you have in mind in responding to the client?
3. Under what conditions, if any, would you disclose your sexual identity to the client?
4. To what extent has your training included research and theory relevant to sexual identity?

You share a suite of offices with several other therapists. The name of each therapist is on the door to that therapist's office. One morning you find that the door to one of the offices has been broken in and the office vandalized. The name on the door was Jewish. Swastikas along with epithets have been spray-painted on the walls, desk, floor, and bookshelves. You have no evidence but believe the vandal may have been one of your patients—someone who has expressed strong anti-Semitic views during therapy sessions, embraces the view that the Holocaust is fiction, and has described fantasies of vandalizing synagogues. But if you were to ask him during the next therapy session whether he had anything to do with vandalizing your colleague's office, he would deny it.

1. How do you feel?
2. What would you like to do?
3. What do you would actually do?
4. Would you mention your suspicion that your client may have vandalized your colleague's office to the colleague, the police, or anyone else? If so, how do you address issues of client privacy and confidentiality?
5. Would you mention your suspicion to your client? If so, how?
6. How, if at all, would you address your client's anti-Semitism in therapy?

You are a Latino therapist who speaks Spanish only moderately well. Your policy is to try to refer all those who speak only Spanish to fluent Spanish speakers, but you will see Spanish speakers who also speak English if they wish. A South American client who speaks fluent English and Spanish sees you because you are the only Latino available on her HMO list. At the first session, she insists that you should be ashamed for not speaking better Spanish and that you therefore have no culture.

1. How do you feel?
2. What are your thoughts and feelings about this client?
3. How would you respond to this client?
4. Under what conditions would you continue to see or decline to see this client?

You have been leading a therapy group at a large mental health facility. As one of the session begins, a group member interrupts you and says, "I want to ask you about something. Have you noticed how none of the doctors here are black, Latino, or Latina but almost all the cleaning crew are? Why do you work in a system like that? Don't you think that has any effects on us patients?"

1. How do you feel?
2. What are the possible replies you consider?
3. What do you think you would say?
4. What effects, if any, such a system might have on clients?

You work in a large office building. As your therapy client, a Sikh, is getting ready to leave your office, the police show up at the door, handcuff him, and say they are taking him to the station for questioning. When they leave, the accountant across the hall comes over and says that someone saw your client in the lobby, thought he was acting suspiciously, and called the police to report someone who seemed to be an Arab terrorist.

1. How do you feel?
2. What do you consider doing?
3. What would you like to do?
4. What do you think you would do?
5. How, if at all, might this affect the therapy?
6. How, if at all, would you chart this?

You are working with a client who is of a different race and sexual orientation from you and your supervisor. One day the client is fifteen minutes late for a session, and you spend some of the session discussing the reasons for the client's not being on time. When you bring up the topic to your supervisor, the response is, "Oh, that lateness doesn't mean anything psychological. That's just the way those people are."

1. How do you feel?
2. What possible responses to your supervisor's comments do you consider?
3. What do you think that you'd actually say to your supervisor?
4. When you imagined this scenario, what race and sexual orientation did you imagine the client was? Why?

A married couple come to you for counseling. Both believe that men are the natural leaders in a marriage and that a woman's rightful place is to be obedient to her husband. However, they often have what they describe as "slips," when he seems to look to her for guidance or when she finds it hard to accept his decisions. They are seeking marital counseling to help them eliminate these "slips."

1. How do you feel?
2. What are your thoughts and feelings about the wife?
3. What are your thoughts and feelings about the husband?
4. What are your thoughts and feelings about the marital relationship that they value and have chosen for themselves?
5. How do you think you would respond?

You are a therapist at an agency with a policy that says that if a client misses two appointments without calling, the therapy automatically terminates. A client who is a single mother, uses public transportation, has no telephone, and is often distressed by a babysitter who does not show up, misses her appointment for the second time. Your supervisor insists that you terminate by letter, given the long waiting list of potential clients.

1. What feelings do you experience?
2. What are your assumptions about the client's not showing up? In what way, if any, might her diagnosis be relevant?
3. What do you think and feel about the relevance of the policy for clients such as this one?
4. What are your options in responding to your supervisor? To the agency policy? To the client?

CHAPTER SIXTEEN

Confidentiality

The area of confidentiality has been full of pitfalls for therapists.[1] Many of them seem related to the first of this book's seven basic assumptions: ethical awareness is a continuous, active process. Fatigue, stress, and routine can dull our awareness, lull us into ethical sleep, put us on automatic when we need to wake up to what we are missing. It is crucial that we practice continued alertness to the ethical implications of what we do.

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[1] Over half (62 percent) of the therapists in one national study reported unintentionally violating their patients' confidences (Pope, Tabachnick, & Keith-Spiegel, 1987). Another national study found that the most frequently reported intentional violation of the law or ethical standards by senior, prominent psychologists involved confidentiality (Pope & Bajt, 1988). In 21 percent of the cases, therapists violated confidentiality in transgression of law. In another 21 percent of the cases, therapists refused to breach confidentiality to make legally required reports of child abuse. Therapists may have experienced violations of confidentiality when they themselves were patients. In one national survey, about 10 percent of the therapists who had been in therapy reported that their own therapist had violated their rights to confidentiality (Pope & Tabachnick, 1994).

Too often, lack of alertness leads to violations of confidentiality. We do the hard work of sorting through the national and local legislation and case law that governs confidentiality (and the related concept of privilege) in our local jurisdiction, study the relevant ethics codes and professional guidelines, perhaps consult with an attorney, and keep up with the evolving standards of care. But the familiar routine of day-to-day practice obscures many avoidable pitfalls. This chapter highlights some of those easy-to-overlook pitfalls that can lead to violations of confidentiality.

REFERRAL SOURCES

We tend to be very grateful to colleagues, friends, and anyone else who refer patients to us. But should we tell the referral source whether a specific individual has scheduled an appointment with us, whether the individual kept the initial appointment, or what might have been discussed or decided if the client has not authorized the disclosure? Unfortunately, therapists may unintentionally violate confidentiality by sending referral sources a thank-you note mentioning a specific client and providing a detail or two about what happened.

PUBLIC CONSULTATION

There are few resources as valuable as consultation to our meeting the highest ethical, legal, and clinical standards. It provides easy access to new information, support, informal peer review, and a different perspective. Psychologists in a national study rated “consultation with colleagues” as the most effective source of guidance for practice (Pope, Tabachnick, & Keith-Spiegel, 1987). Participants judged such consultation to be more effective than fourteen other possible sources, such as graduate programs, internships, state licensing boards, and continuing education programs.

Such consultation, however, deserves the same confidentiality as the therapy it focuses on. We lead busy lives and want to make the most of our time. Often the most convenient way to obtain a colleague’s advice about the therapy we are conducting is to do so as we are walking through the halls of a clinic, or sitting together at a large table while waiting for the last arrivals so that a meeting can begin, or at a restaurant during a lunch break, or in other public places. The problem with such on-the-run consultations is that confidential information is often discussed within earshot of people who are not authorized to receive the information. Many of us have probably overheard such consultations in clinic hallways or elevators. Sometimes we may have known (socially) the person who was being discussed. In one case, a therapist consulted a colleague on a crowded elevator about a particularly "difficult" patient, unaware that the patient was standing only a few feet behind her, listening with intense interest and dismay.

When consulting, making sure that there is adequate privacy is an important ethical responsibility.

GOSSIP

Few would argue that therapy is easy work. Sometimes it involves considerable stress, and we need to blow off steam. Occasionally this gives rise to the impulse to talk about our work with others—at lunch, in the staff lounge, on the racquetball court, at parties. At such times, it is easy to let slip the identity of one of our clients or some other bit of confidential information.

Some of our clients may be in the news or tell us fascinating information. The urge to tell others that we know them can be almost overwhelming. Many of us may know through the grapevine who is in treatment with whom and even what led them to seek therapy. To the extent that the information nourishing the grapevine is provided by counselors or therapists rather than by the clients, it is a clear ethical breach.

CASE NOTES AND PATIENT FILES

Have you ever seen a patient chart you were not authorized to see? It is likely that at least some—if not most—of this book's readers have happened to see unsecured documents containing patient names and other confidential information. Some institutions and individuals may have difficulty meeting their responsibility to keep confidential records confidential. During a visit to a prestigious university-affiliated teaching hospital, one of the authors noticed, while walking down a public hallway, that the mental health clinic's patient charts were stacked along the walls. The hallway was unattended. The names of the patients were clearly visible, and had the author opened any of the charts, he could have read a wealth of confidential information. When he asked later about charts being left in the hall, he was assured that this was temporary: due to insufficient funds, additional storage space was not yet available, and this manner of "filing" was most convenient for the business office personnel.

Similarly, some of us may have visited colleagues who leave charts and other patient information lying on top of their desks. Not only patients' names but also other information may be in full view.

There are at least two important issues here. One is keeping information about clients out of sight of people who are not authorized to see that information. Making sure that documents are inside the chart (or some other protective covering), the chart folder is closed, and the client's name does not appear on the outside of the chart (a coding system can provide for convenient filing and retrieval) are useful steps to take when charts are visible in a well-attended area open to the public or other patients. The protection of even the patient's name may seem excessive to some, yet the fact that a person is consulting a therapist is a fact worth treating confidentially.

The second important issue concerns the security of charts left in an unattended area. There should be a lock between the charts and anyone not authorized to see them. Regarding the security of charts, as in so many other aspects of maintaining appropriate confidentiality, the Golden Rule can be a useful guide. What steps would we want a therapist to take if it were our chart, containing our deepest secrets, our personal history, our conflicts, our diagnosis, the medications we were taking, and our prognosis? What steps would we want our therapist to take to ensure that part or all of this confidential information was not carelessly made available to whoever—other patients, our employer or employees, neighbors, relatives, colleagues—might, for any reason, pass by? How much care would we want our own therapist to use in handling these documents?

PHONES, FAXES, AND MESSAGES

Some of this book's readers may have visited clinics in which telephone messages mentioning a patient's name, telephone number, and reason for calling were left out where they could be seen by those without legitimate access to that information. Some may have visited a colleague's office just as a fax about a patient was coming in and . . . well, just could not help seeing who it was from and what it was about. Some readers may have been present when a therapist took a telephone call from a patient and could hear both sides of the conversation (and may have been surprised to recognize the patient's voice).

Answering machines create special pitfalls for confidentiality. It is tempting, if our time for lunch is limited, to play back accumulated messages—some from patients—while a colleague or friend is waiting to accompany us to the nearest restaurant. Similarly, if our answering machine is at home, it may take special measures to ensure that family members, friends, and others do not overhear messages as they are recorded or played back. Again, the Golden Rule can provide a useful guide to anticipating potential problems and recognizing the need to remain constantly mindful, aware, and alert.

COMPUTERS

Desktop computers and their progeny (for example, laptops, notebooks, personal digital assistants) present special challenges to confidentiality. The following questions may be helpful.

Where Is the Computer?

Some readers may have visited clinics and seen confidential information about patients on a computer screen. One of the first questions to ask is, When this computer is on, who can see the screen? Can anyone who is not authorized see patient names or other sensitive information on the screen? This can be a problem for those who work with confidential information on portable computers during long flights or in terminals, waiting rooms, and other public spaces.

When the computer is unattended—whether for only a few minutes or overnight—is there a secure barrier between it and anyone who might want to access it or steal it? If you were to offer someone a considerable sum of money to access the computer without authorization or to steal it, how confident are you that you would not lose your money?

Is the Computer Protected from Hackers?

If the computer is hooked up to the Internet, a software or hardware firewall can help protect against unauthorized entry. Note the word *help.* No method of protection is foolproof. All have strengths but also vulnerabilities. The more layers of protection you use, the more secure your confidential data will be. If one or two layers fail to block unauthorized entry, others may work. Like a house with many locks and forms of security, a well-protected computer may discourage all but the most determined and skilled hackers.

Is the Computer Protected from Malicious Code That Can Access Confidential Information?

When computers connect to the Internet, they are vulnerable. Security hardware and software can lower but not remove the vulnerability. Viruses, Trojans, worms, and other malware continue to find more devious paths to fool a computer's defenses. E-mails formatted in HTML can mask malicious code. E-mail attachments can infect a computer before they are opened. A visit to a Web site may result in a malicious program downloading into the computer without the user's knowledge. These programs can look for a computer's most sensitive files (for example, those that fit the patterns of social security numbers, credit card numbers, passwords, financial statements; those that contain words like *private, confidential, clinical,* or *medical*). They can transmit those files to a temporary throwaway address in another country, post them on an anonymous Web site, or send them to every e-mail address in your computer's memory.

One approach to protecting confidential information on a computer is a two-step process: (1) keep several layers of protection on the computer and (2) keep the information encrypted on a removable medium (such as a portable external hard drive, CD, or DVD). The removable medium would always be kept secure and would be hooked up to the computer only when the therapist is using it.

An approach that offers more protection is to use one computer for connecting with the Internet and storing nonconfidential data and a separate computer that is never hooked up to the Internet or other networks to store confidential information. Because the confidential information is stored on a completely isolated, stand-alone computer, there is no wired or wireless link from it to any network and it cannot transmit data to unauthorized recipients.

Is the Computer Password-Protected?

If someone finds a computer unattended or steals it, a system of passwords can make it difficult to access confidential information. Loading the operating system when turning on the computer, gaining access to a set of files, and opening a particular file can be made contingent on passwords.

Words do not make the most secure passwords. Dictionary programs are readily available to hackers, who use them to enter a password-protected computer. A password is likely to block password-breaking software if it has a combination of lowercase letters, uppercase letters, and symbols and if it runs at least a dozen characters long.

Any password is useless if someone who is determined to access your computer sees it written down somewhere. Someone sitting at your computer and attempting to gain unauthorized access is likely to look through the papers on and in your desk (including under the keyboard and on the monitor) to see if the password has been jotted down.

Is Confidential Information Encrypted?

Even if someone defeats your password protection, he or she will still face a formidable layer of protection if your electronic protected health information as outlined by the Health Insurance Portability and Accountability Act is encrypted. Apple, Microsoft, and other makers of the major computer operating systems as well as other companies (for example, PGP at http://www.pgp.com) provide software programs that will encrypt files.

How Are Confidential Files Deleted?

On most computers, using the Delete key to get rid of a file leaves virtually all of the file on the hard disk, where it can be easily retrieved by an inexpensive data recovery program. To dispose confidential files, it is useful to use some form of secure deleting, such as one that involves repeatedly overwriting the old file with random characters.

How Are Computer Disks Discarded?

From time to time, the news media report what has become a standard story: someone sells or discards a computer on which confidential information is discovered. If a computer disk or other electronic storage medium stored confidential information, it should be completely degaussed or physically destroyed.

THE HOME OFFICE

As discussed in prior editions of this book and in *How to Survive and Thrive as a Therapist* (Pope & Vasquez, 2005), home offices pose special challenges to confidentiality and privacy if there are others living in the home. Is it likely that clients—some of whom may not want anyone else to know that they are in therapy—will encounter family members when arriving, waiting for the appointment, or leaving? Any chance that young children will interrupt therapy sessions? Will files, appointment books, message slips, and other documents be secure and out of sight when family members enter the office? Will family members be able to overhear telephone calls or other discussions with clients? Is any confidential information about clients stored on a computer that other family members use? If so, how is it secured against accidental discovery? Is the telephone answering machine that receives calls from or about patients shared with other family members? If so, how can those calls be protected against accidental playback for other family members? Are answering machine messages from or about clients ever played back in the presence of family members?

SHARING WITH LOVED ONES

Some therapists may hold back no secrets from a spouse, partner, or other loved ones. For some, sharing what happened during the day with a loved one may be a crucial act of intimacy. The ethical challenge is to do this without violating patient confidentiality.

COMMUNICATIONS IN GROUP OR FAMILY THERAPY

When therapy includes more than one individual, as in group and family therapy, clients have a right to know in advance, as part of the informed consent process, any limitations of privacy, confidentiality, or privilege affected by the presence of more than one client. For example, if a clinician is providing family therapy, will he or she keep confidential from other family members information conveyed in a telephone call from a minor son that he is using drugs, from a minor daughter that she is pregnant, from the father that he is engaging in an extramarital affair and plans to leave his wife, or from the mother that she has secretly withdrawn the family's savings and is using it to gamble?

Therapy involving more than one client emphasizes a major theme of this book: trust. The therapist and members of a therapy group may assume that everyone involved is trustworthy. But what if that is wrong? What if, for example, one of the group members is a newspaper or magazine reporter gathering information for an exposé of what the reporter considers bogus therapy groups, or of the therapist, or of what the reporter considers a "culture of dependency"? Or what if one of the group members later decides to write a memoir to be published in a magazine or book about what the experience of group therapy was like? Or what if some of the group members simply pass along what they learn about other group members to their family and friends and that information ripples outward to those who recognize and know members of the group? Group and family therapists must struggle with these difficult issues in a way that respects the clients' legitimate rights to privacy, confidentiality, and privilege and their right to know the limits—both legal and practical—of their privacy, confidentiality, and privilege.

Therapy involving more than one person also presents challenges to documentation. If, for example, the therapist keeps one set of therapy records for "the family" or "the group," what happens if one member of the family or group requests or subpoenas a copy of those records? How can a therapy record that mentions more than one patient by name be turned over without the informed consent or legal waiver of each patient? One of the approaches that some therapists and counselors use is to maintain a separate chart for each client in a family or group.

WRITTEN CONSENT

One common cause of needless problems is failing to obtain written informed consent to release confidential information. The "General Guidelines for Providers of Psychological Services" (APA, 1987b) emphasize that, unless authorized otherwise by law, "psychologists do not release confidential information, except with the written consent of the user involved, or of his or her legal representative, guardian, or other holder of the privilege on behalf of the user, and only after the user has been assisted to understand the implications of the release" (p. 717).

Obtaining written consent can help promote clarity of communication between therapist and client in situations when misunderstandings can be disastrous. Both need to understand exactly what information the therapist will release. Is the therapist free to discuss any aspect of the client's history, situation, and treatment? Is the therapist authorized to provide a written summary or all clinical files? When exactly does the client's authorization end? If the person who is to receive the confidential information contacts the therapist with additional requests for information next month, next year, or several years from now, does the written consent need to be renewed, or does it explicitly cover such future requests?

INSURANCE FORMS

Clients may not adequately understand the type of information that insurance companies require to authorize coverage and the degree to which information will or will not be sufficiently safeguarded by the insurance company. Keith-Spiegel and Koocher (1985) describe a hypothetical example of a therapist's routine statement to patients regarding insurance coverage: "If you choose to use your coverage, I shall have to file a form with the company telling them when our appointments were and what services I performed (i.e., psychotherapy, consultation, or evaluation). I will also have to formulate a diagnosis and advise the company of that. The company claims to keep this information confidential, although I have no control over the information once it leaves this office. If you have questions about this you may wish to check with the company providing the coverage. You may certainly choose to pay for my services out-of-pocket and avoid the use of insurance altogether, if you wish" (p. 76).

MANAGED CARE ORGANIZATIONS

One of the most easily overlooked aspects of confidentiality is how confidential information can circulate within health maintenance organizations and other managed care facilities. Many patients feel betrayed when records of their psychotherapy sessions become part of their general medical or health record in an HMO and may in turn find their way into the hands of third parties. One women was shocked to find her treatment mentioned on the employee relations bulletin board where she worked. Management and the union, eager to cut both sick leave and the costs for their health care plan, had decided to post all utilizations of the health care plan by employees. Under the terms of the contract that had been negotiated by labor and management, the date and reason for each utilization was provided by the health care organization to officials for both union and management.

Confidentiality issues have become more complex as managed care organizations have required more and more information traditionally regarded as private in order to monitor the allocation of resources and compliance with eligibility criteria:

> Managed care companies generally ask for much more information than third parties have traditionally requested from clinicians. The ethical explanations given for such requests generally have fallen into two categories. One is based on the known history of some clinicians to distort information on forms. . . . Then managed care companies began to discover that some clinicians charged for sessions not provided or approved. A more general reason applicable to all clinicians is to make sure that the intended treatment meets criteria of medical necessity as designated in the third-party benefits. In addition to treatment plans, managed care companies will often ask for copies of any notes kept on patients; they sometimes do on-site reviews of charts in hospitals, and on occasion they even talk directly to the patient to try to verify information [Moffic, 1997, p. 97].

The Council of the National Academies of Practice (including dentistry, medicine, nursing, optometry, osteopathic medicine, podiatric medicine, psychology, social work and veterinary medicine) has adopted *Ethical Guidelines for Professional Care in a Managed Care Environment* (1997; see Appendix F). Confidentiality is one of five guidelines listed as a primary concern. While the National Academies of Practice acknowledges that utilization and quality assurance reviews are appropriate functions in a health care system, they indicate the importance of safeguards to protect the privacy and confidentiality of patient data and the practitioner's clinical materials and of obtaining client consent. They state, "The rationale for this position is founded on the patient's autonomous right to control sensitive personal information. It is further based upon an historical recognition in the oath of Hippocrates and corroborated throughout the centuries, of the enduring value of preserving confidentiality in order to enhance mutual trust and respect in the patient-provider relationship" (p. 5).

Health care organizations may not always monitor who attends case conferences, and discussions of a patient's condition may be overheard inadvertently by an inappropriate audience. Who participates in treatment planning, implementation, and review can be a particularly challenging issue in small towns. In one instance, the chief health care administrator proposed a periodic case review of current patients to be conducted by staff psychologists. In this town of fewer than ten thousand people, the psychologists would have known many of the patients in a variety of social and business roles. The patients had not given informed consent for this review. This confidentiality issue is not easily addressed. One solution would be for the administrator to agree to hire a psychologist from another community who did not know the population served by the hospital to visit the hospital once a month to review the cases and make sure that patients understood the review process.

DISCLOSING CONFIDENTIAL INFORMATION FOR MANDATED REPORTS ONLY TO THE EXTENT REQUIRED BY LAW

Evolving legislation and case law in each jurisdiction define the limits of information to reveal in making legally mandated reports. As an example, a psychologist was contacted by a mother who wished to arrange appointments for her daughter and her daughter's stepfather to see the therapist regarding allegations that the stepfather engaged in sexual intimacies with his stepdaughter. The psychologist agreed to meet with him and immediately filed a formal report of suspected child abuse.

The next day, a deputy sheriff contacted the psychologist for information. The psychologist furnished information concerning his meeting with the daughter. He would meet with the stepfather later in the day. The deputy called later and asked for information concerning the session with the stepfather and, reading from the Child Abuse Reporting Law, emphasized that the psychologist was obligated to supply additional information, which the psychologist reluctantly provided.

The stepfather claimed in court that the psychologist, after making the initial formal report, should not have disclosed any additional information. The Supreme Court of California agreed with the stepfather: "The psychologist was under no statutory obligation to make a second report concerning the same activity. . . . We have recognized the contemporary value of the psychiatric [sic] profession, and its potential for the relief of emotional disturbances and of the inevitable tensions produced in our modern, complex society. . . . That value is bottomed on a confidential relationship; but the doctor can be of assistance only if the patient may freely relate his thoughts and actions, his fears and fantasies, his strengths and weaknesses, in a completely uninhibited manner" (*People* v. *Stritzinger,* 1983, p. 437).

Therapists who disclose confidential information even in court settings may be subject to suit by the client. California, for example, has general legislation protecting individuals from lawsuits for any statements made as part of court proceedings. Nevertheless, a district court of appeal ruled that a psychologist "can be sued for disclosing privileged information in a court proceeding when it violates the patient's constitutional right of privacy" (Chiang, 1986, p. 1).

PUBLISHING CASE STUDIES

Publishing case studies or other confidential information about clients requires exceptional care. Merely changing the client's name and a few other details may not be sufficient. Pope, Simpson, and Weiner (1978), for example, discussed a case in New York in which a therapist was successfully sued for publishing a book in which he described his treatment of a patient. The patient asserted that the therapist had not obtained her consent to write about her treatment and had not adequately disguised the presentation of her history.

APA's *Casebook on Ethical Principles of Psychologists* (1987a, p. 72) presents a situation in which a psychologist wished to write a book about an assessment:

> Psychologist G conducted a professional evaluation of the accused murderer in a sensational and well-publicized case in which six teenage girls, who vanished over a period of 18 months, were later found stabbed to death in an abandoned waterfront area of the city. The lurid nature of the crimes attracted nationwide publicity, which only increased as allegations of negligence were pressed against the city administration and the police force. In order to construct a psychological diagnostic profile, Psychologist G spent several days with the accused, conducting interviews and psychometric tests. He presented his findings in court with the full consent of the accused.
>
> Six months later, following the sentencing of the now convicted murderer, Psychologist G determined that he would like to write a book about the murderer and the psychology behind the crimes, which he anticipated would be a lucrative undertaking.

> Psychologist G wrote to the Ethics Committee to inquire whether it would be ethical for him to do so. The convicted murderer had refused permission to publish in a book the results of the psychological evaluation, despite the fact that the information was now considered part of the public domain because it had been admitted in court as evidence.
>
> Opinion: The Ethics Committee responded to Psychologist G that to write the proposed book would be a legal but unethical undertaking. The fact that material has entered the public domain or that there may have been an implied waiver of consent does not free the psychologist from the obligation under Principle 5.b of the Ethical Principles to obtain prior consent before presenting in a public forum personal information acquired through the course of professional work. In this case, the ethics code sets a higher standard than the law would require. Psychologist G thanked the Committee for its advice and dropped the idea of writing the book.

DISTRACTION

This chapter opened with a fundamental theme of this book: the importance of active, continuous alertness and awareness. A momentary distraction can cause problems. No matter how senior our status, how extensive our training, or how naturally skilled any of us may be, none of us is perfect. All of us have moments when we are tired, overwhelmed, rushing, or careless. James F. Masterson, a prominent therapist who has written extensively concerning borderline personality disorders, showed courage in writing about an instance in which he betrayed a patient's confidence because of a disconcerting event in his own life: "One morning I was late and dented my car as I parked in the office garage. A bit frazzled from the experience, I rushed into my office and admitted my first patient who asked me how another patient of mine was doing, calling her by name. I was startled because their appointments were at very different times. I wondered if they had met socially, or if he was dating her. Then I realized what had happened. Worried about my dented fender, I had inadvertently picked her file out of the drawer instead of his, and he had read her name on the folder. My distraction represented a countertransferential failure to pay proper attention to my patient. I apologized for taking out the wrong chart and told him I was distracted by the accident" (Masterson, 1989, p. 26).

SCENARIOS FOR DISCUSSION

You have been working for two years with a client who has multiple problems and has disclosed extremely sensitive information to you. The insurance company sends you a letter requesting the entire file, including all of your chart notes and all raw data from the psychological assessment, in order to determine whether further therapy is warranted and, if so, in what form. When you call the insurance company to discuss the matter, the head of claims review (not a mental health professional and whose previous job was quality control officer in a paper clip company) tells you that they must have all these materials within five business days or else therapy will be discontinued.

1. How do you feel?
2. What options do you consider?
3. If the client refuses to provide consent for you to send the materials, even though it means there are no longer resources to pay for the therapy, and decides to terminate therapy rather than allow the information to go to third parties, what do you do?

You have been working with a fourteen-year-old client for several months. During one session, the client suddenly discloses having sex with a parent for the past four years. The client, who has been chronically depressed, threatens, "If you tell anyone about this, I will find a way to kill myself." You believe that this is not an idle threat.

1. How do you feel?
2. Under what circumstances, if any, do you believe you might disclose information about the client's claim of having been sexually involved with a parent to any of the following: (a) child protective services or other governmental agency authorized to receive reports of suspected child abuse, (b) your clinical supervisor, (c) any family member, or (d) anyone else?
3. What objectives or priorities would shape your interventions?
4. To what extent, if at all, would your own potential legal liability affect your emotional responses to this situation and your course of action?

You are working with a client who engages in unprotected sex with a variety of partners. Two months ago, the client became infected with HIV. Recent sessions have focused on many topics, one of which is the client's decision not to begin using protection during sex and not to disclose the HIV status to any partners. The client shows no likelihood of changing this decision.

1. How do you feel?
2. Does the client's decision affect your ability to empathize in any way?
3. Under what conditions, if any, would you act against the client's wishes and communicate information about the client's HIV status and sexual activity to third parties? What information would you disclose, to whom would you disclose it, and what are the likely or possible outcomes?

You work for an HMO, spending four hours a day, three days a week, providing outpatient therapy at its facility. Four other clinicians provide therapy in the same office. According to HMO policy, all patient charts of all clinicians using that room must remain locked in a single filing cabinet in the corner of the room. Each clinician has a key to the filing cabinet. You become aware that several of your clients have social relationships with the other therapists. You are also aware that their charts contain extremely sensitive information about them. You also notice the names of two of your friends on the charts of the other clinicians. The HMO refuses to change this policy.

1. How do you feel?
2. What courses of action do you consider?
3. Are the clients entitled to know about this arrangement? If so, at what point should they be made aware of it?
4. If you were the client in such a situation, do you believe that you would be entitled to know about this arrangement?

You have reached a therapeutic impasse with a client. For weeks, the therapy has seemed stalled, but you have not understood what is wrong. During the past few supervision sessions, you discovered that this client has stirred up some intense emotions in you. You've mentioned to your supervisor some painful events in your own history about which you have felt ashamed and confused. You have yet to discuss these events with anyone else, even your own therapist. One afternoon you head to the staff lounge but pause just before entering the room. Through the door, you hear your supervisor talking with others about the painful events you had discussed in supervision.

1. How do you feel?
2. Which of the following do you think you'd do and why: (a) leave immediately, hoping no one saw you; (b) linger at the door, hoping to hear more; (c) enter the room, pretending that you hadn't heard anything; (d) enter the room and indicate that you had heard what they had said; or (e) something else?
3. Under what circumstances, if any, do you believe that clinical supervisors should discuss what their supervisees tell them? In your experience, have these boundaries of confidentiality been explicit and well understood by supervisees and supervisors? In your experience, have supervisors respected these boundaries?
4. Have the clinical supervisors you have known or known of kept notes or otherwise documented the supervision sessions? What ethical, legal, or other considerations affect the privacy and confidentiality of supervision notes (for example, are they legally privileged communications)?

CHAPTER SEVENTEEN

Responding to Suicidal Risk

Few other responsibilities are so heavy and intimidating as responding to suicidal risk. The need for careful assessment is great. Suicide remains among the top dozen causes of death in the United States, as high as number two for some groups. Homicide rates seize popular attention, but far more people kill themselves than kill others. Authorities in the field are almost unanimous in their view that the reported figures vastly understate the actual incidence because of problems in reporting procedures.

Evaluating and responding to suicidal risk is a source of extraordinary stress for many therapists. This aspect of our work focuses virtually all of the troublesome issues that run through this book: questions of the therapist's influence, competence, efficacy, fallibility, over- or underinvolvement, responsibility, and ability to make life-or-death decisions. Litman's study (1965) of over two hundred clinicians soon after their clients had committed suicide found the experience to have had an almost nightmarish quality. They tended to have intense feelings of grief, loss, and sometimes depression as anyone else—professional or nonprofessional—might at the death of someone they cared about. But they also had feelings associated with their professional role as psychotherapist: guilt, inadequacy, self-blame, and fears of being sued, investigated, or vilified in the media. In a similar study, both the short-term and permanent effects of a client's suicide on the therapist were so intense that Goldstein and Buongiorno (1984) recommended providing support groups for surviving therapists.

Solo practitioners may be even more vulnerable than their colleagues who practice within the contexts of institutions with their natural support systems. Those in training may constitute one of the most vulnerable groups. Kleespies, Smith, and Becker (1990) found that "trainees with patient suicides reported stress levels equivalent to that found in patient samples with bereavement and higher than that found with professional clinicians who had patient suicides" (p. 257). They recommend that all training programs have a protocol for assisting trainees with client suicide: "There is a need for an immediate, supportive response to the student to prevent traumatization and minimize isolation . . . and . . . for a safe forum that will allow the student to express his or her feelings, will ensure positive learning from the experience, and will help the student to integrate it constructively into future work with high-risk patients" (pp. 262–263).

If the challenges of helping the suicidal client evoke extraordinary feelings of discomfort from many therapists, they also show the extraordinary efforts that some therapists take to help their clients stay alive. Davison and Neale (1982), for instance, described the ways in which "the clinician treating a suicidal person must be prepared to devote more energy and time than he or she usually does even to psychotic patients. Late-night phone calls and visits to the patient's home may be frequent."

Bruce Danto, a former director of the Detroit Suicide Prevention Center and former president of the American Association of Suicidology, stated: "With these problems, you can't simply sit back in your chair, stroke your beard and say, 'All the work is done right here in my office with my magical ears and tongue.' There has to be a time when you shift gears and become an activist. Support may involve helping a patient get a job, attending a graduation or play, visiting a hospital, even making house calls. I would never send somebody to a therapist who has an unlisted phone number. If therapists feel that being available for phone contact is an imposition, then they're in the wrong field or they're treating the wrong patient. They should treat only well people. Once you decide to help somebody, you have to take responsibility down the line" (Colt, 1983, p. 50).

Norman Farberow, one of the preeminent pioneers in the treatment of the suicidal client, described instances in which the therapist provided very frequent and very long sessions (some lasting all day) to a severely suicidal client as "examples of the extraordinary measures which are sometimes required to enable someone to live. Providing this degree of availability to the client gives the client evidence of caring when that caring is absolutely necessary to convince that client that life is both livable and worth living, and nothing less extreme would be effective in communicating the caring. In such circumstances, all other considerations—dependence, transference, countertransference, and so on—become secondary. The overwhelming priority is to help the client stay alive. The secondary issues—put 'on hold' during the crisis—can be directly and effectively addressed once the client is in less danger" (Farberow, 1985, p. C9).

Stone (1982) describes a vivid example of the lengths to which a therapist can go to communicate caring in an effective and therapeutic manner to a client in crisis. Suffering from schizophrenia, a young woman who had been hospitalized during a psychotic episode continuously vilified her therapist for "not caring" about her. Without warning, she escaped from the hospital: "The therapist, upon hearing the news, got into her car and canvassed all the bars and social clubs in Greenwich Village which her patient was known to frequent. At about midnight, she found her patient and drove her back to the hospital. From that day forward, the patient grew calmer, less impulsive, and made great progress in treatment. Later, after making substantial recovery, she told her therapist that all the interpretations during the first few weeks in the hospital meant very little to her. But after the 'midnight rescue mission' it was clear, even to her, how concerned and sincere her therapist had been from the beginning" (p. 271).

ASSESSING SUICIDAL RISK

Awareness of the following twenty-one factors may be useful to clinicians evaluating suicidal risk. Four qualifications are particularly important. First, the comments concerning each factor are extremely general, and exceptions are frequent. In many instances, two or more factors may interact. For example, being married and being younger, taken as individual factors, tend to be associated with lower risk for suicide. However, married teenagers have historically shown an extremely high suicide rate (Peck & Seiden, 1975). Second, the figures are not static; new research is refining our understanding of the data as well as reflecting apparent changes. The suicide rate for women, for example, has been increasing, bringing it closer to that for men. Third, the list is not comprehensive. Fourth, these factors may be useful as general guidelines but cannot be applied in an unthinking, mechanical, conclusive manner. A given individual may rank in the lowest-risk category of each of these factors and nonetheless commit suicide. These factors can legitimately function as aids to, not as substitutes for, a comprehensive, humane, and personal evaluation of suicidal risk for a unique person. Again it is worth emphasizing a central theme of this book's approach to ethics: perhaps the most frequent threat to ethical behavior is the therapist's inattention. Making certain that we consider such factors with each client can help us prevent the ethical lapses that come from neglect:

1. *Direct verbal warning.* A direct statement of intention to commit suicide is one of the most useful single predictors. Take any such statement seriously. Resist the temptation to reflexively dismiss such warnings as "a hysterical bid for attention," "a borderline manipulation," "a clear expression of negative transference," "an attempt to provoke the therapist," or "yet another grab for power in the interpersonal struggle with the therapist." It may be any or all of those and yet still foreshadow suicide.
2. *Plan.* The presence of a plan increases the risk. The more specific, detailed, lethal, and feasible the plan is, the greater the risk posed.
3. *Past attempts.* Most, and perhaps 80 percent of, completed suicides were preceded by a prior attempt. Schneidman (1975) found that the client group with the greatest suicidal rate were those who had entered into treatment with a history of at least one attempt.
4. *Indirect statements and behavioral signs.* People planning to end their lives may communicate their intent indirectly through their words and actions—for example, talking about "going away," speculating on what death would be like, giving away their most valued possessions, or acquiring lethal instruments.
5. *Depression.* The suicide rate for those with clinical depression is about twenty times greater than for the general population. Guze and Robins (1970; see also Vuorilehto, Melartin, & Isometsa, 2006), in a review of seventeen studies concerning death in primary affective disorder, found that 15 percent of the individuals suffering from this disorder killed themselves. Effectively treating depression may lower

the risk of suicide (Gibbons, Hur, Bhaumik, & Mann, 2005; Mann, 2005).

6. *Hopelessness.* The sense of hopelessness appears to be more closely associated with suicidal intent than any other aspect of depression (Beck, 1990; Beck, Kovaks, & Weissman, 1975; Maris, 2002; Petrie & Chamberlain, 1983; Wetzel, 1976; however, see also Nimeus, Traskman-Bendz, & Alsen, 1997).

7. *Intoxication.* Between one-fourth and one-third of all suicides are associated with alcohol as a contributing factor; a much higher percentage may be associated with the presence of alcohol (without clear indication of its contribution to the suicidal process and lethal outcome). Moscicki (2001; see also Kõlves, Värnik, Tooding, & Wasserman, 2006; Sher, 2006) notes that perhaps as many as half of those who kill themselves are intoxicated at the time. Hendin, Haas, Maltsberger, Koestner, and Szanto's study, "Problems in Psychotherapy with Suicidal Patients" (2006), emphasized that "addressing and treating suicidal patients' substance abuse, particularly alcohol abuse, is critical in effective treatment of other problems, including lack of response to antidepressant medication" (p. 71).

8. *Clinical syndromes.* People suffering from depression or alcoholism are at much higher risk for suicide. Other clinical syndromes may also be associated with an increased risk. Perhaps as many as 90 percent of those who take their own lives have a diagnosis from the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994; Moscicki, 2001). Kramer, Pollack, Redick, and Locke (1972) found that the highest suicide rates exist among clients diagnosed as having primary mood disorders and psychoneuroses, with high rates also among those having organic brain syndrome and schizophrenia. Palmer, Pankratz, and Bostwick (2005) found that the lifetime risk for suicide among people with schizophrenia was around 5 percent. Drake, Gates, Cotton, and Whitaker (1984) discovered that those suffering from schizophrenia who had very high internalized standards were at particularly high risk. In a long-term study, Tsuang (1983) found that the suicide rate among the first-degree relatives of schizophrenic and manic-depressive clients was significantly higher than that for a control group of relatives of surgery patients; furthermore, relatives of clients who had committed suicide showed a higher rate than relatives of clients who did not take their lives. Using meta-analytic techniques, Harris and Barraclough (1997) obtained results suggesting that "virtually all mental disorders

have an increased risk of suicide excepting mental retardation and dementia. The suicide risk is highest for functional and lowest for organic disorders" (p. 205).

9. *Sex.* The suicide rate for men is about four times that for women (Joiner, 2005). For youths, the rate is closer to five to one (see Safer, 1997). The rate of suicide attempts for women is about three times that for men.

10. *Age.* The risk for suicide tends to increase over the adult life cycle, with the decade from the mid-fifties to the mid-sixties constituting the age span of highest risk. Attempts by older people are much more likely to be lethal. The ratio of attempts to completed suicides for those up to age sixty-five is about seven to one; it is two to one for those over age sixty-five. Suicide risk assessment differs also according to whether the client is an adult or a minor. The assessment of suicidal risk among minors presents special challenges. Safer's review of the literature indicated that the "frequent practice of combining adult and adolescent suicide and suicide behavior findings can result in misleading conclusions" (1997, p. 61). Zametkin, Alter, and Yemini (2001) note that the "rate of suicide among adolescents has significantly increased in the past 30 years. In 1998, 4153 young people aged 15 to 24 years committed suicide in the United States, an average of 11.3 deaths per day. Suicide is the third leading cause of death in this age group and accounts for 13.5% of all deaths. . . . Children younger than 10 years are less likely to complete suicide, and the risk appears to increase gradually in children between 10 and 12 years of age. However, on average, 170 children 10 years or younger commit suicide each year" (p. 3122).

11. *Race.* Generally in the United States, Caucasians tend to have one of the highest suicide rates. Gibbs (1997) discusses the apparent cultural paradox: "African-American suicide rates have traditionally been lower than White rates despite a legacy of racial discrimination, persistent poverty, social isolation, and lack of community resources" (p. 68). EchoHawk (1997) notes that the suicide rate for Native Americans is "greater than that of any other ethnic group in the U.S., especially in the age range of 15–24 years" (p. 60).

12. *Religion.* The suicide rates among Protestants tend to be higher than those among Jews and Catholics.

13. *Living alone.* The risk of suicide tends to be reduced if someone is not living alone, reduced even more if he or she is living with a spouse, and reduced even further if there are children.

14. *Bereavement.* Brunch, Barraclough, Nelson, and Sainsbury (1971) found that 50 percent of those in their sample who had committed suicide had lost their mothers within the past three years (compared with a 20 percent rate among controls matched for age, sex, marital status, and geographical location). Furthermore, 22 percent of the suicides, compared with only 9 percent of the controls, had experienced the loss of their father within the past five years. Krupnick's review of studies (1984) revealed "a link between childhood bereavement and suicide attempts in adult life," perhaps doubling the risk for depressives who had lost a parent compared to depressives who had not experienced the death of a parent. Klerman and Clayton (1984; see also Beutler, 1985) found that suicide rates are higher among the widowed than the married (especially among elderly men) and that among women, the suicide rate is not as high for widows as for the divorced or separated.

15. *Unemployment.* Unemployment tends to increase the risk for suicide.

16. *Health status.* Illness and somatic complaints are associated with increased suicidal risk, as are disturbances in patterns of sleeping and eating. Clinicians who are helping people with AIDS, for example, need to be sensitive to this risk (Pope & Morin, 1990).

17. *Impulsivity.* Those with poor impulse control are at increased risk for taking their own lives (Patsiokas, Clum, & Luscumb, 1979).

18. *Rigid thinking.* Suicidal individuals often display a rigid, all-or-none way of thinking (Maris, 2002; Neuringer, 1964). A typical statement might be, "If I don't find work within the next week, then the only real alternative is suicide."

19. *Stressful events.* Excessive numbers of undesirable events with negative outcomes have been associated with increased suicidal risk (Cohen-Sandler, Berman, & King, 1982; Isherwood, Adam, & Homblow, 1982). Bagley, Bolitho, and Bertrand (1997), in a study of 1,025 adolescent women in grades 7 to 12, found that "15% of 38 women who experienced frequent, unwanted sexual touching had 'often' made suicidal gestures or attempts in the previous 6 months, compared with 2% of 824 women with no experience of sexual assault" (p. 341; see also McCauley et al., 1997). Some types of recent events may place clients at extremely high risk. For example, Ellis, Atkeson, and Calhoun (1982) found that 52 percent of their sample of multiple-incident victims of sexual assault had attempted suicide.

20. *Release from hospitalization.* Beck (1967, p. 57) has noted that "the available figures clearly indicate that the suicidal risk is greatest during weekend leaves from the hospital and shortly after discharge."

21. *Lack of a sense of belonging.* Joiner's review of the research and his own studies led him to conclude that "an unmet need to belong is a contributor to suicidal desire: suicidal individuals may experience interactions that do not satisfy their need to belong (e.g., relationships that are unpleasant, unstable, infrequent, or without proximity) or may not feel connected to others and cared about" (2005, p. 97).

SPECIAL CONSIDERATIONS

The risk of client suicide creates a special set of responsibilities. The themes stressed throughout this book gain exceptional importance: failure of the therapist to take necessary steps can literally be fatal for the client. The following steps, which extend or supplement this book's themes, may be helpful in identifying and coping with the chance that a client may be at risk for suicide:

1. *Screen all clients for suicidal risk during initial contact, and remain alert to this issue throughout the therapy.* Even clients who are seriously thinking of taking their own life may not present the classic picture of agitated depression or openly grim determination that is stereotypically (and sometimes falsely) portrayed as characteristic of the suicidal individual. Some suicidal clients seem, during initial sessions, calm, composed, and concerned with a seemingly minor presenting problem. Clients who are not suicidal during initial sessions and who sought therapy for a relatively minor problem may, during the course of therapy, become suicidal. The increase in suicidal risk may be due to external events, such as the loss of a job or a loved one, or to internal events, such as setting aside psychological defenses or the onset of what appears to be Alzheimer's disease. What is crucial is an assessment of the client's suicidal potential at adequate intervals. In some cases, comprehensive psychological testing or the use of standardized scales developed to evaluate suicidal risk may be useful (see, for example, Beck, Resnick, & Lettieri, 1974; Butcher, Graham, Williams, & Ben-Porath, 1990; Lettieri, 1982; Neuringer, 1974; Nugent, 2006; Schulyer, 1974; Weisman & Worden, 1972). Range and Knott (1997) evaluated twenty suicide assessment instruments for validity and reliability. On the basis

of their analysis, they recommended three most highly: Beck's Scale for Suicide Ideation series, Linehan's Reasons for Living Inventory, and Cole's self-administered adaptation of Linehan's structured interview called the Suicidal Behaviors Questionnaire.

2. *Work with the suicidal client to arrange an environment that will not offer easy access to the instruments the client might use to commit suicide.* Suicidal clients who have purchased or focused on a specific gun or other weapon may agree to place the weapon where they will not have access to it until the crisis or period of greatest risk is over. Suicidal clients who are currently taking psychotropic or other medication may be planning an overdose. The use of materials prescribed by and associated with mental health professionals may have great symbolic meaning for the client. Arrange that the client does not have access to sufficient quantities of the medication to carry out a suicidal plan.

3. *Work with the client to create an actively supportive environment.* To what extent can family, friends, and other resources such as community agencies and group or family therapy help a suicidal person through a crisis?

4. *While not denying or minimizing the client's problems and desire to die, also recognize and work with the client's strengths and (though temporarily faint) desire to live.*

5. *Make every effort to communicate and justify realistic hope.* Discuss practical approaches to the client's problems.

6. *Explore any fantasies the client may have regarding suicide.* Reevaluating unrealistic beliefs about what suicide will and will not accomplish can be an important step for clients attempting to remain alive.

7. *Make sure communications are clear, and evaluate the probable impact of any interventions.* Ambiguous or confusing messages are unlikely to be helpful and may cause considerable harm. The literature documents the hazards of using such techniques as paradoxical intention with suicidal clients. Even well-meant and apparently clear messages may go awry in the stress of crisis. Beck (1967, p. 53) provides an example: "One woman, who was convinced by her psychotherapist that her children needed her even though she believed herself worthless, decided to kill them as well as herself to 'spare them the agony of growing up without a mother.' She subsequently followed through with her plan."

8. *When considering hospitalization as an option, explore the drawbacks as fully as the benefits, the probable long-term and the immediate*

effects of this intervention. Norman Farberow (see Colt, 1983, p. 58), cofounder and former codirector and chief of research at the Los Angeles Suicide Prevention Center, warns: "We tend to think we've solved the problem by getting the person into the hospital, but psychiatric hospitals have a suicide rate more than 35 percent greater than in the community."

9. *Be sensitive to negative reactions to the client's behavior.* James Chu (quoted by Colt, 1983, p. 56), a psychiatrist in charge of Codman House at McLean Hospital, a psychiatric hospital near Boston, comments:

> When you deal with suicidal people day after day after day, you just get plain tired. You get to the point of feeling, 'All right, get it over with.' The potential for fatigue, boredom, and negative transference is so great that we must remain constantly alert for signs that we are beginning to experience them. Maltsberger and Buie discuss therapists' repression of such feelings. A therapist may glance often at his watch, feel drowsy, or daydream—or rationalize referral, premature termination, or hospitalization just to be rid of the patient. (Many studies have detailed the unintentional abandonment of suicidal patients; in a 1967 review of 32 suicides . . . Bloom found 'each . . . was preceded by rejecting behavior by the therapist.') Sometimes, in frustration, a therapist will issue an ultimatum. Maltsberger recalls one who, treating a chronic wrist-cutter, just couldn't stand it, and finally she said, 'If you don't stop that I'll stop treatment.' The patient did it again. She stopped treatment and the patient killed herself'" [Colt, 1983, p. 57].

10. *Perhaps most important, communicate caring.* Therapists differ in how they attempt to express this caring. A therapist (cited by Colt, 1983, p. 60) recounts an influential event early in her career:

> I had a slasher my first year in the hospital. She kept cutting herself to ribbons—with glass, wire, anything she could get her hands on. Nobody could stop her. The nurses were getting very angry. . . . I didn't know what to do, but I was getting very upset. So I went to the director, and in my best Harvard Medical School manner began in a very intellectual way to describe the case. To my horror, I couldn't go on, and I began to weep. I couldn't stop. He said, 'I think if you showed the patient what you showed me, I think she'd know you cared.' So I did. I told her that I cared, and that it was distressing to me. She stopped. It was an important lesson.

The home visits, the long and frequent sessions, the therapist's late-night search for a runaway client, and other special measures already noted are ways some therapists have found useful to communicate this caring, although such approaches obviously do not fit all therapists, all clients, or all theoretical orientations. One of the most fundamental aspects of this communication of caring is the therapist's willingness to listen, to take seriously what the client has to say. Farberow (1985, p. C9) puts it well: "If the person is really trying to communicate how unhappy he is, or his particular problems, then you can recognize that one of the most important things is to be able to hear his message. You'd want to say, 'Yes, I hear you. Yes, I recognize that this is a really tough situation. I'll be glad to listen. If I can't do anything, then we'll find someone who can.'"

AVOIDABLE PITFALLS: ADVICE FROM EXPERTS

A central theme of this book is that inattention or a lack of awareness is a—if not the most—frequent cause for a therapist's violation of his or her clinical responsibilities and of the client's trust. We asked a number of prominent therapists with expertise in identifying and responding to suicidal risk to discuss factors that contribute to therapists' inattention or lack of awareness when working with potentially suicidal clients. Careful attention to these factors can enable therapists to practice more responsively and responsibly.

Norman Farberow, Ph.D., cofounder and former codirector and chief of research at the Los Angeles Suicide Prevention Center, believes that there are four main problem areas. First, therapists tend to feel uncomfortable with the subject; they find it difficult to explore and investigate suicidal risk: "We don't want to hear about it. We discount it. But any indication of risk or intention must be addressed." Second, we must appreciate that each client is a unique person: "Each person becomes suicidal in his or her own framework. The person's point of view is crucial." Third, we tend to forget the preventive factors: "Clinicians run scared at the thought of suicide. They fail to recognize the true resources." Fourth, we fail to consult: "Outside opinion is invaluable."

Marsha Linehan, Ph.D., ABPP, is a professor of psychology, adjunct professor of psychiatry and behavioral sciences at the University of Washington and director of the Behavioral Research and Therapy Clinic. Her primary research is the development of effective treatments for suicidal behaviors, drug abuse, and borderline personality disorder. She believes that

> the single biggest problem in treating suicidal clients is that most therapists have inadequate training and experience in the assessment and treatment of suicidal behaviors. More distressing than that is that there does not appear to be a hue and cry from practicing therapists demanding such training. Deciding to limit one's practice to non-suicidal clients is not a solution because individuals can and do become suicidal after entering treatment. Secondary problems are as follows. 1) Therapists treating clients with disorders that make them high risk for suicide (e.g., depression, borderline personality disorder, bipolar disorder) do not ask about suicide ideation and planning in a routine, frequent way: depending on clients who have decided to kill themselves to first communicate risk directly or indirectly can be a fatal mistake. 2) Fears of legal liability often cloud therapists' abilities to focus on the welfare of the client: fear interferes with good clinical judgment. Many outpatient therapists simply "dump" their suicidal clients onto emergency and inpatient facilities believing that this will absolve them of risk. There is no empirical data that emergency department and/or inpatient treatment reduces suicide risk in the slightest and the available literature could support a hypothesis that it may instead increase suicide risk. 3) Therapists often do not realize that when treating a highly suicidal client they must be available by phone and otherwise after hours: treating a highly suicidal client requires personally involved clinical care.

Nadine J. Kaslow, Ph.D., ABPP, professor and chief psychologist at Emory School of Medicine, a well-funded researcher on the assessment and treatment of abused and suicidal African American women and the recipient of the American Psychological Association's 2004 award for Distinguished Contributions to Education and Training, told us that

> assessment and intervention of suicidal persons need to be culturally competent, gender sensitive, and developmentally informed. Our approach to suicidal individuals needs to consider both the relevant evidence base and sensitive attention to the person's unique struggles, strengths, and sociocultural context. We need to interact with suicidal people with compassion and a desire to understand why their pain

> feels so intolerable that they believe that suicide will offer the only form of relief. It is always important to take suicidal concerns seriously, convey an appreciation for the person's plight, and engage in a collaborative process. Since suicidal people often feel socially isolated and social support is a buffer against suicidal behavior, it is imperative that we assist suicidal men and women in mobilizing their social support networks. We must build on people's strengths, help them find meaning and hope, and empower them to overcome the trials and tribulations that lead them to feel and think that life is not worth living. As therapists, we will find our own countertransference reactions to be a very useful guide with regard to risk assessment, disposition planning, and the implementation of therapeutic strategies. Our own histories with suicide, whether that be our own suicidality, the loss of a loved one to suicide, or the death of a former patient to suicide, will greatly impact how we approach and respond to people who think actively about suicide, take steps to end their own life, or actually kill themselves. Our histories and reactions can also be instrumental in our efforts to help suicidal people heal from their pain so that they find life worth living. This in turn, enriches our own lives.

Ricardo F. Muñoz, Ph.D., is professor of psychology at the University of California, San Francisco, and principal investigator on the Depression Prevention Research Project involving English-, Spanish-, and Chinese-speaking populations, funded by the National Institute of Mental Health. Here are his thoughts:

> First, clinicians often fail to identify what suicidal clients have that they care about, that they are responsible for, that they can live for. Include animals, campaigns, projects, religious values. Second, inexperienced liberal therapists in particular may fall into the trap of attempting to work out their philosophy regarding the right to die and the rationality or reasonableness of suicide while they are working with a client who is at critical risk. These issues demand careful consideration, but postponing them until the heat of crisis benefits no one. In the same way that we try to convince clients that the darkest hour of a severe depressive episode is not a good time to decide whether to live or die, clinicians must accept that while attempting to keep a seriously suicidal person alive is not a good time to decide complex philosophical questions. Third, don't overestimate your ability to speak someone

> else's language. Recently, a Spanish-speaking woman, suicidal, came to the emergency room talking of pills. The physician, who spoke limited Spanish, obtained what he thought was her promise not to attempt suicide and sent her back to her halfway house. It was later discovered that she'd been saying that she'd already taken a lethal dose of pills and was trying to get help.

Jessica Henderson Daniel, Ph.D., ABPP, director of training in psychology in the Department of Psychiatry and associate director of the Leadership Education in Adolescent Health Training Program in the Division of Adolescent Medicine at Boston's Children's Hospital, states:

> As some adolescents can be prone to be dramatic, that is, saying things that they do not mean, there can be a reluctance to take comments about suicide seriously. The adolescent may make several statements before actually engaging in suicidal behavior. The adolescent needs to know that such comments are in fact taken seriously and that action may be taken: follow-up by their therapist, evaluation in the emergency room, and/or in-patient hospitalization. Also, adolescents can become very upset about matters that may seem trivial to adults. Providers are reminded that the perspective of the patient trumps their views. When adolescents are in the midst of despair, minimizing the worry, hurt, and hopelessness can be problematic. Some providers may feel that life really cannot be that bad. Then, parents matter. With adolescents, state regulations can determine the legal role of parents. It is important to know this information. Should parents be legally responsible for their adolescent, providers may be reluctant to override the decision of parents who cannot bear to think that their child may be suicidal and who insist on taking them home. When the patient is a child or an adolescent, the parents are a critical part of the management of the case and may need their own providers as well. Finally, consultation is critical in thinking through how to best provide under the particular circumstances.

M. David Rudd, Ph.D., is professor and chair of the Department of Psychology at Texas Tech University; past president of the American Association of Suicidology; and president elect of APA, Division 12, Section VII (Behavioral Emergencies). He told us:

> One of the all-too-frequently neglected areas in suicide risk assessment is recognizing, discussing, and implementing a distinction between acute and chronic risk. Assessment of acute risk alone is how the overwhelming majority of clinicians approach the task. Over the past decade, converging scientific evidence suggests it is important to address enduring or "chronic" suicidality in patients. More specifically, those who have made two or more suicide attempts likely have a "chronic" aspect to their presentation. Although acute risk may well resolve, it is important for the clinician to make a note about the individual's enduring vulnerabilities and continuing suicide risk. It's as straightforward as making a note such as: "Although acute risk has resolved, the patient has made three previous suicide attempts and there are aspects of the clinical scenario that suggest chronic risk for suicide. More specifically, the patient's history of previous sexual abuse, episodic alcohol and cannabis abuse, along with two previous major depressive episodes, all indicate the need for longer-term and continuing care in order to more effectively treat these chronic markers of risk."

David H. Barlow, Ph.D., is a diplomate in clinical psychology and director of the Center for Anxiety and Related Disorders at Boston University. He is former president of the Society of Clinical Psychology of APA and maintains a private practice. He believes that there are two common problems often encountered in working with young or inexperienced therapists confronting a possible suicidal patient:

> First, after forming an alliance with a new patient, some therapists begin to spin away from a professional, objective clinical stance and treat seemingly offhand comments about not wanting to live as casual conversation that might be occurring after work over a drink with a friend or in a college dormitory. Thus, they may respond sympathetically but not professionally by downplaying the report: "Sometimes I feel that way too—I can understand how you'd get to that place." Of course, one must always step back if this comes up and conduct the proper exam for intent, means, etc., and take appropriate action. Second, some therapists undervalue the power of a contract, since patients sometimes say something like, "Well . . . I'll say that if you want me to, but I don't know if my word is worth anything." The fact is, in the context of a good therapeutic relationship, the contract is very powerful, the occasional report to the contrary notwithstanding.

The late *Erika Fromm,* Ph.D., a diplomate in both clinical psychology and clinical hypnosis, was professor emeritus of psychology at the University of Chicago, clinical editor of the *Journal of Clinical and Experimental Hypnosis,* and recipient of the American Psychological Association Division 39 (Psychoanalysis) 1985 Award for Distinguished Contributions to the Field. She stated:

> Perhaps it's the countertransference or the highly stressful nature of this work, but some clinicians seem reluctant to provide suicidal patients anything more than minimal reassurance. We need to realize that the people who are about to take their own lives are crying out, are communicating their feelings that no one really cares about them. They are crying, in the only way they know how: "Show me that you really care!" It is so important for us to communicate that we care about them. When my patients are suicidal, I tell them that I care deeply about them and am fond of them. I do everything I can to let them know this.

Larke Nahme Huang, Ph.D., formerly on the faculty of the University of California, Berkeley, is currently an independent research and clinical consultant in the Washington, D.C., area. She stresses the problems involved in treating people with schizophrenia:

> Especially as the treatment becomes a matter of years, there's a tendency to become less sensitive, to forget how painful their life can be. This can lead to problems as the clinician sets ever higher goals as the client continues to improve. A client can experience these goals as insufferable pressure. Frequently the client may make a very serious suicide attempt in an effort to escape the pressure. In working with people with severe disorders, clinicians may need to use hospitalization in times of crisis. Inpatient management issues, power struggles, rivalries between professional disciplines, and so on can aggravate the client's crisis. Don't wait until the last minute, when you're in the midst of a crisis, to learn about these realities and to take steps to prevent them from adding to your client's distress.

Gary Schoener, clinical psychologist and executive director of the Walk-In Counseling Center in Minneapolis for more than thirty-three years, consults, trains, and testifies around North America concerning professional boundaries and clinical supervision. He states:

> Four most common deadly failures are (1) the failure to screen for the possession of firearms (it's not enough to ask about "weapons") with all distressed clients; (2) when acute suicidality becomes chronic, failure to appropriately refer to a DBT [dialectic behavior therapy] program or qualified provider for cases of chronic suicidality; (3) reliance on the QPR [question, persuade, refer] method with refugees and others, especially Muslims, for whom suicide is a serious sin and who should not be asked directly about suicidal thinking; and (4) overreliance on "no-suicide agreements" despite the fact that they do not work. (No problem in using them clinically, but don't count on them.)

Marla C. Craig, Ph.D., is psychologist and director of outreach services and special projects at the St. Edward's University Counseling and Consultation Center in Austin, Texas, and an instructor and coordinator of a campuswide suicide prevention program. She reported:

> Most clinicians may not know that suicide is the second leading cause of death among college students. This information is important since there may be a tendency for clinicians not to take college students' presenting concerns seriously enough. Presenting concerns such as academic and relationship difficulties may mask the underlying condition of depression. Also, stereotypes of college students' being overly dramatic and emotional with fluctuating moods and situations can interfere with a clinician's judgment to thoroughly assess for suicide. It also may be easy for clinicians to forget that traditional college students are still adolescents transitioning into young adulthood, and they may or may not be able to verbally identify what is going on internally/emotionally. Hence, it is important to assess for suicide even if the college student does not present as depressed. Finally, due to confidentiality and college students being eighteen years of age and older, clinicians may be reluctant to get parents involved. If the parents are a source of support, do not hesitate to work with the college student to get them involved.

Jesse Geller, Ph.D., formerly director of the Yale University Psychological Services Clinic and director of the Psychotherapy Division of the Connecticut Mental Health Center, currently maintains an independent practice. He told us:

> One of the two main problems in treating suicidal patients is our own anger and defensiveness when confronted by someone who does not

> respond positively—and perhaps appreciatively—to our therapeutic efforts. It can stir up very primitive and childish feelings in us—we can start to feel vengeful, withholding, and spiteful. The key is to become aware of these potential reactions and not to act them out in our relationship with the patient. The other main problem seems to be more prevalent among beginning therapists. When we are inexperienced, we may be very cowardly regarding the mention of suicide in our initial interviews. We passively wait for the patient to raise the subject and we may unconsciously communicate that the subject is "taboo." If the subject does come up, we avoid using "hot" language such as "murder yourself" or "blow your brains out." Our avoidance of clear and direct communication, our clinging to euphemisms implies to the patient that we are unable to cope with his or her destructive impulses.

Don Hiroto, Ph.D., maintains a private practice, is chief of the Depression Research Laboratory at the Brentwood Veterans Administration Medical Center, and is a former president of the Los Angeles Society of Clinical Psychologists. He believes that a major area of difficulty involves alcohol use:

> Alcoholics may constitute the highest-risk group for violent death. The potential for suicide among alcoholics is extraordinarily high. At least 85 percent of completed suicides show the presence of at least some level of alcohol in their blood. There are two aspects to the problem for the clinician. First, there is the tendency for us to deny or minimize alcohol consumption as an issue when we assess all of our clients. Second, we are not sufficiently alert to the suicidal risk factors that are especially associated with alcoholics: episodic drinking, impulsivity, increased stress in relationships (especially separation), alienation, and the sense of helplessness.

The late *Helen Block Lewis,* Ph.D., was a diplomate in clinical psychology who maintained a private practice in New York and Connecticut; she also was professor emeritus at Yale University, president of the American Psychological Association Division of Psychoanalysis, and editor of *Psychoanalytic Psychology.* She believed that therapists tend to pay insufficient attention to the shame and guilt their clients experience. For example, clients may experience a sense of shame for needing psychotherapy and for being "needy" in regard to the therapist. The shame often leads to rage, which in turn leads to guilt because the client is not sure if the rage is justified. According to Lewis, the resultant "shame/rage" or "humiliated fury" can be a major factor in client suicides:

> Clients may experience this progression of shame-rage-guilt in many aspects of their lives. It is important for the therapist to help the client understand the sequence not only as it might be related to a current incident "out there" but also as it occurs in the session. Furthermore, it is helpful for clients who are in a frenzied suicidal state to understand that the experience of shame and guilt may represent their attempt to maintain attachments to important people in their lives. Understanding these sequences is important not only for the client but also for the therapist. It is essential that we maintain good feelings for our clients. Sometimes this is difficult when the client is furious, suicidal, and acting out. Our understanding that such feelings and behaviors by a client represent desperate attempts to maintain a connection can help us as therapists to function effectively and remain in touch with our genuine caring for the client.

Michael Peck, Ph.D., a diplomate in clinical psychology, maintains a private practice and was a consultant to the Los Angeles Suicide Prevention Center. He observes, "Many therapists fail to consult. Call an experienced clinician or an organization like the L.A. Suicide Prevention Center. Review the situation and get an outside opinion. Therapists may also let a client's improvement (for example, returning to school or work) lull them to sleep. Don't assume that if the mood is brighter, then the suicidal risk is gone." He stresses the importance of keeping adequate notes, including at least the symptoms, the clinician's response, and consultations and inquiries. "There are special issues in treating adolescents," Peck adds. "When they're under sixteen, keep the parents informed. If they are seventeen (when the client, rather than the parents, possesses the privilege) or older but still living with the parents, tell the client that you will breach confidentiality only to save his or her life. In almost every case, the family's cooperation in treatment is of great importance."

The late *Hans Strupp,* Ph.D., a diplomate in clinical psychology, is distinguished professor of psychology and director of clinical training at Vanderbilt University. He believed that one of the greatest pitfalls is the failure to assess suicidal potential comprehensively during initial sessions. Another frequent error, he said, is that there too often is a failure to have in place a network of services appropriate for suicidal clients in crisis: “Whether it is an individual private practitioner, a training program run by a university . . . , a small . . . clinic, or [therapists] associated in group practice—there needs to be close and effective collaboration with other mental health professions . . . and with facilities equipped to deal with suicidal emergencies. I’m not talking about pro forma arrangements but a genuine and effective working relationship. In all cases involving suicidal risk, there should be frequent consultation and ready access to appropriate hospitals.”

SCENARIOS FOR DISCUSSION

You have been working with a moderately depressed client for four months. You feel that you have a good rapport, but the treatment plan does not seem to be doing much good. Between sessions, you check your answering machine and find this message from the client: “I want to thank you for trying to help me, but now I realize that nothing will do me any good. I won’t be seeing you or anyone else ever again. I’ve left home and won’t be returning. I didn’t leave any notes because there really isn’t anything to say. Thank you again for trying to help. Good-bye.” Your next client is scheduled to see you in two minutes, and you have clients for the next four hours.

1. What feelings do you experience?
2. What do you want to do?
3. What are your options?
4. What do you think you would do?
5. If there are things that you want to do but don’t do, why do you reject these options?
6. What do you believe that your ethical and legal obligations are? Are there any contradictions between your legal responsibilities and constraints and what you believe is ethical?
7. To what extent do you believe that your education and training have prepared you to deal with this situation?

You have been working with a client within a managed care framework. You believe that the client is at considerable risk for suicide. The case reviewer disagrees and, noting that the approved number of sessions have been provided, declines, despite your persistent protests, to approve any additional sessions.

1. How do you feel?
2. What are your options?
3. What do you believe your legal obligations to client are?
4. What do you believe your ethical responsibilities to the client are?
5. What would you do?

You have been providing family therapy to a mother and father and their three adolescents for four sessions. After the fourth session, you find that one of the adolescents has left a note on your desk. Here is what the note says: "My father has molested me for the past two years. He has threatened to kill my mother and me if anyone else finds out. I could not take it if you told anyone else. If you do, I will find a way to kill myself." Your clinical judgment, based on what you have learned during the course of the four sessions, is that the adolescent is extremely likely to commit suicide under those circumstances.

1. How do you feel?
2. More specifically, what are your feelings about the client who left you the note? What are your feelings about the father? What are your feelings about the mother? What are your feelings about the other two adolescents?
3. What do you believe that your legal obligations are?
4. What do you believe that your ethical responsibilities are?
5. What, if any, conflicts do you experience? How do you go about considering and deciding what to do about these conflicts?
6. What do you believe that you would do?

A client you have been seeing in outpatient therapy for two years does not show up for an appointment. The client has been depressed and has recently experienced some personal and occupational disappointments, but the risk of suicide as you have assessed it has remained at a very low level. You call the client at home to see if this person has forgotten the appointment or if there has been a mix-up in scheduling. You reach a family member, who tells you that the client has committed suicide.

1. What do you feel?
2. Are there any feelings that are difficult to identify or put into words?

3. What options do you consider?
4. Do you tell the family member that you were the person's therapist? Why or why not? What, if anything, do you volunteer to tell the family?
5. Do you send flowers? Why or why not? Do you attend the funeral? Why or why not?
6. If a family member says that the suicide must have been your fault, what do you feel? What would you do?
7. Do you tell any of your friends or colleagues? Why? What concerns, if any, do you have?
8. Do your case notes and documentation show your failure to assess accurately the client's suicidal risk? Why or why not? Do you have any concerns about your documentation?

You have been discussing a new HMO client, whom you have seen for three outpatient sessions, with your clinical supervisor and the chief of outpatient services. The chief of services strongly believes that the client is at substantial risk for suicide, but the clinical supervisor believes just as strongly that there is no real risk. You are caught in the middle, trying to create a treatment plan that makes sense in the light of the conflicting views of the two people to whom you report. One morning you arrive at work and are informed that your clinical supervisor has committed suicide.

1. What do you feel?
2. Are there any feelings that are particularly difficult to identify, acknowledge, or articulate?
3. How, if at all, do you believe that this might influence your work with any of your clients?
4. Assume that at the first session, you obtained the client's written informed consent for the work to be discussed with this particular clinical supervisor who has been countersigning the client's chart notes. What, if anything, do you tell the client about the supervisor's suicide or the fact that the clinical work will now be discussed with a new supervisor?
5. To what extent has your graduate training and internship addressed issues of clinicians' own suicidal ideation, impulses, or behaviors?

CHAPTER EIGHTEEN

The Supervisory Relationship

This closing chapter addresses supervision, a key task for many clinicians that brings into focus many of the themes running through this book. All of us began our clinical careers as supervisees. It is not hard to think of important ways, some of them perhaps unintentional, in which our supervisors influenced our development. The supervisory relationship involves considerable power, trust, and caring, although they take different forms than in therapeutic or counseling relationships.

CLEAR TASKS, ROLES, AND RESPONSIBILITIES

Because supervision involves at least three people—client, supervisee, and supervisor—relationships and agendas can easily become confused. The supervisor has an ethical responsibility to clarify the tasks, roles, and responsibilities. He or she, for example, must ensure that the supervisee is neither encouraged nor allowed to become the supervisor's therapy patient. Some forms of supervision may share common aspects with some forms of therapy. Sometimes supervisees, in the course of supervision, become aware of personal concerns, psychological problems, or behavioral difficulties that might benefit from therapy. If the supervisee decides to seek therapy, he or she should consult a separate therapist.

Although the supervisor has responsibilities for the client's care and the supervisee's professional growth, the client's welfare must be primary. The supervisor must make sure that no aspect of training puts the client at undue risk. Supervision often takes place in a hospital or clinic, and the therapist-trainees may have predetermined internships or rotations (for example, six months or an academic calendar year). Such time sequences and boundaries must be taken into account when considering the client's welfare. Frequent terminations and transfers can cause significant problems for some clients. The informed consent process should include letting the client know if a therapist will be available for only a few months.

When a therapist-trainee becomes licensed and leaves a setting, do the clients remain at the setting or follow the newly licensed therapist? Who decides? Who keeps the therapy records? These issues are best addressed before training begins and should be clarified in a written agreement. Otherwise disagreements can result in formal complaints and lawsuits (Pope, 1990a).

The supervisor is ultimately responsible, ethically and legally, for the clinical services that the supervisee provides. The supervisor and supervisee must address any conflicts about treatment approaches promptly, honestly, and comprehensively. Both may avoid addressing—or even acknowledging—conflicts they are uncomfortable with (Pope, Sonne, & Greene, 2006). Unaddressed conflicts between a supervisor and supervisee almost always interfere with therapy and supervision. These conflicts are often acted out or otherwise recreated in the relationship between a supervisee and client. Similarly, the dynamics of the relationship between a supervisee and client are often recreated or echoed in the supervisor-supervisee relationship. The ways that unaddressed conflicts affect the therapy and supervision are a normal part of training. They are not a sign that the therapy is terribly misguided, the supervisee needs to withdraw from graduate training and seek a line of work that does not involve being around other people, or the supervisor is a monster suffering from delusions of adequacy. What they do signal is that important dynamics of the supervisor-supervisee-client triad need to be addressed.

Nonsexual dual relationships can complicate the supervisor's ethical responsibility to clarify roles. Should a supervisor enter into various social relationships with a supervisee? The answer, as it so often is in our work, is that it depends. A fundamental theme running through this book is that codes, laws, and standards are the beginning—not the end—of our ethical considerations. Nothing can spare us the struggle with complex questions involving unique people in unique situations. The codes, laws, and standards inform—but do not replace—our efforts to think through issues. Burian and Slimp (2000; see also Slimp & Burian, 1994) provide a thoughtful model for thinking through social dual-role relationships during internships that can be adapted to many supervision settings. Their decision-making model helps supervisors to consider a variety of useful issues like the reasons for the relationship, the power difference between supervisor or supervisee, the nature of the social activities, and the effects on other supervisees.

Kitchener (2000) also addresses multiple-role relationships in supervision and uses social role theory to promote understanding of the ambiguity inherent in role conflicts. Supervision implicitly involves multiple obligations, including to help the trainee develop, evaluate the supervisee, protect the public from incompetent or inept therapists, and ensure the client receives a decent standard of care. Kitchener (2000) points out that the supervisee may be involved with the supervisor in a variety of other roles, including consulting, coauthoring papers or presentations, and attending social functions together. These multiple roles are complicated because supervisees may be much more personally vulnerable than those who are in a teacher-student relationship, given the revelation of personal secrets that may be blocking work with clients. Yet supervision is different from therapy, partly because of the evaluative component in supervision and partly because confidentiality does not have the same status in supervision as it does in psychotherapy and counseling.

COMPETENCE

Like therapy, supervision requires demonstrable competence. "It is vital that the supervisor be well trained, knowledgeable, and skilled in the practice of clinical supervision" (Stoltenberg & Delworth, 1987, p. 175). It would be no more ethical to improvise supervision if one lacked education, training, and supervised experience than if one were to improvise hypnotherapy, systematic desensitization, or a neuropsychological assessment without adequate preparation. Carol Falender and Edward Shafranske (2004) emphasize supervision as a distinct professional activity when they define the term:

> Supervision is a distinct professional activity in which education and training aimed at developing science-informed practice are facilitated through a collaborative interpersonal process. It involves observation, evaluation, feedback, the facilitation of supervisee self-assessment, and the acquisition of knowledge and skills by instruction, modeling, and mutual problem solving. In addition, by building on the recognition of the strengths and talents of the supervisee, supervision encourages self-efficacy. Supervision ensures that clinical consultation is conducted in a competent manner in which ethical standards, legal prescriptions, and professional practices are used to promote and protect the welfare of the client, the profession, and society at large [p. 3].

As with other aspects of professional work, supervisory knowledge must be continually updated so that the supervision is informed by the evolving research and theory.

In addition to maintaining competence in supervision, the supervising therapist must be competent in the approaches used to assess and treat the client and must ensure that the supervisee is at least minimally competent to provide services to the client. A temptation for some supervisors is to form a relationship with a promising supervisee who has had course work in clinical techniques for which the supervisor may have only superficial or outdated knowledge. Such supervisors may, if they are not scrupulously careful, find themselves supervising interventions in which they themselves have no demonstrable competence. For example, supervisors whose practice is exclusively psychoanalytical and who have no training in cognitive-behavioral techniques may find themselves supervising students who are using covert conditioning; supervisors who have worked only with adults may find themselves supervising child therapy; supervisors who take an existential-humanistic approach and do not use standardized tests may find themselves trying to help a supervisee interpret an MMPI-2.

Constant questioning has been a theme throughout this book. It is important for supervisors to ask themselves repeatedly, "Even though I have solid competence in supervision and the approaches used to assess and help the client, are there other relevant issues for which I lack competence? For example, are there any issues of background, culture, language, religion, or values among the client, the supervisee, and me that make it difficult for us to understand each other and work together? If so, is that issue related to competence and how is it best addressed?" Some resources that may be helpful include the Canadian Psychological Association's "Guidelines for Ethical Practice with Diverse Populations" (part of the Canadian Psychological Association's *Guidelines for Non-Discriminatory Practice,* 2001b) and the American Psychological Association's "Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations" (1993) and "Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists" (2003b).

ASSESSMENT AND EVALUATION

The supervisor must assess continually both the clinical services provided to the client and the supervisee's professional development. This significant responsibility can make many of us supervisors uncomfortable.

Being evaluated may make supervisees uncomfortable. In graduate training programs, internships, arrangements in which supervised hours are accumulated as a prerequisite to licensure, and many institutional settings, the supervisor must report to third parties an assessment of the supervisee's strengths, weaknesses, and progress. These reports may profoundly influence the supervisee's opportunities for continuing in the training program or for future employment.

Supervisors must clearly, frankly, and promptly communicate *to* supervisees their assessment of strengths, weaknesses, and development. Keith-Spiegel and Koocher (1995) point out that lack of timely feedback is the most common basis of ethics complaints regarding supervision.

In some cases, the supervisor may determine that the supervisee is unable, either temporarily or more permanently, to conduct clinical work. The supervisor must conscientiously seek to determine why the supervisee is unable to work. Some supervisees may be stressed by overwork, personal loss, or environmental stress. Others may find that doing therapy or counseling has brought to the surface personal conflicts or developmental issues that need to be acknowledged and worked through. Others may experience thought disorders, depression, or anxiety so severe that they are unable to function effectively. And still others may seem to suffer from relatively long-term developmental or personality disorders.

The supervisor's responsibility is clear and unavoidable in such circumstances. The APA's policy for training programs more generally is also relevant for individual supervisors. The Committee on Accreditation for the American Psychological Association (1989) stated that all programs "have special responsibility to assess continually the progress of each student" and that "students who exhibit continued serious difficulties and do not function effectively in academic and/or interpersonal situations should be counseled early, made aware of career alternatives, and, if necessary, dropped from the program" (p. B-10).

While supervisors must, when circumstances warrant, ensure that unsuitable and unqualified individuals do not become therapists or counselors—a responsibility we owe to future clients who might be harmed by incompetent or unscrupulous practice—we must do so in a way that is not unnecessarily hurtful for the supervisee.

INFORMED CONSENT

Supervisors have an ethical responsibility to accord appropriate informed consent to both supervisee and client. Supervisees have a right to know how they will be evaluated—what sorts of information the supervisor will use for forming an opinion and what criteria will be used for evaluating that information. They must understand clearly what is expected of them and what resources are available to them. They need to know to what degree or under what conditions what they reveal to the supervisor will be kept confidential. For example, supervisees may disclose in the course of supervision that they are in therapy, are members of a twelve-step program, or were abused as children. They must understand clearly whether such information will be shared with third parties.

Clients whose therapists are being supervised also have an ethical right to informed consent to the supervisory arrangements. The first step, of course, is simply to make sure that they know that the clinical services they are receiving are being formally supervised. On January 30, 1984, the APA's Committee on Scientific and Professional Ethics and Conduct (currently termed the Ethics Committee) issued a formal statement about supervision:

> During the onset of a professional relationship with a client, a client should be informed of the psychologist's intended use of supervisors/consultants, and the general nature of the information regarding the case which will be disclosed to the supervisor/consultant. This permits

> the client to make an informed decision regarding the psychological services with an understanding of the limits of confidentiality attendant to the relationship. Failure to inform the client of such limits violates the patient's confidentiality when the psychologist, without the patient's awareness, discusses the patient/client and his/her diagnosis and treatment or consultation with a supervisor/consultant. The Committee feels that during the onset of a professional relationship with a client/patient, the client/patient should be clearly informed of the limits of confidentiality in that relationship.

Subsequently the 2002 Ethical Principles of Psychologists and Code of Conduct (APA) Standard 10.01c states: "When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor" (p. 1072).

The Canadian Code of Ethics for Psychologists (CPA, 2000), Standard II.22, requires that psychologists "make no attempt to conceal the status of a trainee, and if a trainee is providing direct client service, ensure that the client is informed of that fact" (p. 25).

In some cases, state laws or regulations may specify the obligation of supervisees to disclose their status. Section 1396.4 of California's Rules of Professional Conduct (Title 16) states, "A psychological assistant shall at all times and under all circumstances identify himself or herself to patients or clients as a psychological assistant to his or her employer or responsible supervisor when engaged in any psychological activity in connection with that employment."

Both supervisor and supervisee have an ethical responsibility to make sure that the client understands the supervisee's qualifications and credentials (Pope, 1990a). Clinicians may engage in extensive rationalizations regarding fraudulently presenting supervisees as possessing a level of training that they have not achieved. For example, in many hospital settings, psychological interns may be presented to patients as "Dr." even though they have not yet received the doctorate. Clients have a fundamental right to know whether their therapist possesses the doctorate and a license to practice independently.

SEXUAL ISSUES

Sexual attraction to clients is a common occurrence for psychotherapists. Supervisors have an important ethical responsibility to ensure that the supervisory relationship provides a safe and supportive opportunity to learn to recognize and handle appropriately such feelings.

Supervisors also have an ethical responsibility to ensure that a sexual relationship between supervisor and supervisee does not occur. The ethics code of the American Psychological Association (2002), for example, states in Section 7.07 ("Sexual Relationships with Students and Supervisees"), "Psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority. (See also Standard 3.05, Multiple Relationships.)" The ethics code of the Canadian Psychological Association (2000) states in Section 11.28 that psychologists should "not encourage or engage in sexual intimacy with students or trainees with whom the psychologist has an evaluative or other relationship of direct authority. (Also see Standard III.31.)"

Anonymous surveys have gathered information about sexual involvements between psychologists and their trainees (Glaser & Thorpe, 1986; Harding, Shearn, & Kitchener, 1989; Pope, Levenson, & Schover, 1979; Robinson & Reid, 1985). The evidence strongly suggests that female trainees, much more than male trainees, are involved in such sexual relationships, even when data are adjusted for the relative numbers of male and female supervisors and of male and female supervisees. One study found that one of every four women who had received her doctorate in psychology within the past six years had engaged in sexual intimacies with at least one of her psychology educators (Pope et al., 1979; see also Pope, 1989b). Glaser and Thorpe (1986) found that in most cases (62 percent), the intimacy occurred either before or during the student's working relationship with the educator.

Supervisors bear the responsibility not only of seeing that such intimacies do not occur but also of ensuring that sexual issues arising in the therapy are addressed frankly, sensitively, and respectfully: "Students need to feel that discussion of their sexual feelings will not be taken as seductive or provocative or as inviting or legitimizing a sexualized relationship with their educators. . . . Educators must display the same frankness, honesty, and integrity regarding sexual attraction that they expect their students to emulate. Psychologists need to acknowledge that they may feel sexual attraction to their students as well as their clients. They need to establish with clarity and maintain with consistency unambiguous ethical and professional standards regarding appropriate and inappropriate handling of these feelings" (Pope, Keith-Spiegel, & Tabachnick, 1986, p. 157; see also Pope, Sonne, & Greene, 2006).

SUPERVISEE PERCEPTIONS OF SUPERVISOR'S UNETHICAL BEHAVIOR

Supervisors serve as ethics mentors and models for supervisees. In some cases, they may model unethical behavior. Susan Neufeldt (2003) reviewed research suggesting that most supervisees believe that their supervisors have committed at least one ethical violation. She wrote: "As a supervisor, you should particularly watch the most frequently violated guidelines noted by supervisees: adequate performance evaluation, confidentiality of supervision sessions, and ability to work with and at least respect alternative perspectives. You cannot count on your supervisees' letting you know about their dissatisfactions. If you can create a safe environment where your supervisees can comfortably reveal their feelings and ideas, and especially their negative feelings about you as the supervisor, you will likely have a successful supervisory relationship" (p. 215).

BEGINNINGS AND ENDINGS, ABSENCE AND AVAILABILITY

From the beginning of supervision, the supervisee must clearly understand when the supervisor will and will not be available. If the client has an emergency, does the supervisee know how to reach the supervisor quickly? Will the supervisor be available for telephone supervision between scheduled sessions? Can the supervisor be reached during late-night hours, on weekends, or on holidays? Are there adequate preparations for supervisor absences, both planned and unanticipated? If the supervisor is unavailable during a crisis, does the supervisee have several options for securing necessary help?

Issues regarding the beginning and ending of the supervisory process must be adequately addressed. The termination is likely to elicit a variety of feelings. Both supervisor and supervisee may feel tempted to collude in avoiding issues related to the termination of patients. They may also find it easy to avoid issues related to the termination of supervision. If the process has not gone as well as expected, both supervisor and supervisee may feel frustration, regret, anger, and relief at the prospect that it is all—*finally*—over. Open and honest discussion of how the problems arose and why they were not resolved more effectively may be difficult. If the process has gone well, both may feel joy, pride, and exhilaration, but they may also experience a sense of loss and sorrow that the frequent meetings and shared, intense, productive work are ending.

Such responses should not be denied or neglected. An important aspect of the supervisory process—an aspect that is especially prominent during termination—involves supervisor and supervisee honestly confronting their reactions to each other and to their collaborative work together. What has each gained from the other? In what ways has each surprised, disappointed, angered, or hurt the other? In what ways has the relationship been characterized by interest, attentiveness, support, and creativity? In what ways has it been characterized by dishonesty, betrayal, and stubbornness? How has the setting influenced the relationship? How have power, trust, and caring manifested themselves in the relationship between supervisor and supervisee and during supervision?

The integrity of the supervisory process depends on the degree to which we acknowledge and confront such issues. We begin our clinical work as supervisees, and unless we are exceptionally afraid or uncaring, our growth and development as therapists and counselors continue during our career. If we do not continue in supervision, we must find alternate ways to nurture this process.

We have chosen work that can involve intense and intimate relationships with other people. It is work with great influence but also great vulnerability. Whether our relationships with our clients and supervisees are helpful or hurtful depends to a great extent on fulfilling our ethical responsibilities in regard to power, trust, and caring.

SCENARIOS FOR DISCUSSION

After receiving your doctorate in psychology, you decide you want to live in an area of the country you have never visited before. After a long search, you secure a job at the only clinic in a small town. You'll be able to secure the year's worth of postdoc supervised hours required for licensing. You pack up and move and find you love the new town and your job at the clinic. Ten months into the year, your supervisor says, "I have some bad news. The clinic has decided to get rid of us psychologists, so we're both losing our jobs as of the end of this week. I've decided to retire and travel for the next year or so. I know that there's no other job for you here in town, and that leaves you without the supervised hours you need for licensure. But you've been a great supervisee and I'm willing to give you credit for the last two months. I'll just put down on the form that you worked under my supervision for a year."

1. How do you feel?
2. How do you weigh the possibilities?
3. What would you like to say to your supervisor?
4. What do you think you would say to your supervisor?

You are conducting family therapy with a family of five. The mother, age thirty-one, is Caucasian. The mother's partner, age fifty-four, is Hispanic. The three children are preteens. You discuss with your supervisor the tensions that the family members are experiencing and your beliefs about the causes of those tensions. Your supervisor says: "I think maybe you're seeing it that way because you are [your own race or ethnicity]."

1. How do you feel?
2. What do you think you might say to your supervisor?
3. What would you like to say to your supervisor?
4. Would your supervisor's race or ethnicity make any difference in how you feel or how you react to this situation? If so, what difference would it make, and why?
5. Did you imagine the mother's partner as male or female? What do you believe influenced whether you imagined the person as a man or a woman?

You have just completed an intake session with a person who is extremely fearful, hears voices, and seems to have a thought disorder. Your provisional diagnosis is some form of schizophrenia, although there are other possibilities you plan to explore during the next session. You meet with your supervisor, review your notes for the intake, state your opinion that the difficulty likely involves a schizophrenic process, and list the questions that you plan to address in your next session. Your supervisor's first comment is, "Boy, those schizos really are interesting, aren't they!"

1. How do you feel?
2. What responses do you consider giving to this comment?
3. How do you think you actually would respond to this comment?
4. If this supervisor had a reputation as extremely thin-skinned and averse to criticism and if this supervisor were also someone with considerable power over your training, how, if at all, might this affect your decision about responding?

You are a supervisor who has had a very challenging supervisee. The supervisee has, for example, made demeaning and passive-aggressive comments to patients and often jokes about them in a cruel and disrespectful way. You have attempted to provide feedback throughout supervision, documenting these attempts and their (lack of) effect. The supervisee schedules an additional session with you and says, "I've been looking at my evaluation forms, and I think you've been very unfair with me. I've talked to some other people, and they agree with me. It is important that you change some of these ratings so that they reflect a fair and unbiased evaluation. If you don't, it will continue to hurt my career. My attorney believes that I have a legal right to a fair evaluation that does not defame me."

1. How do you feel?
2. How, if at all, would your feelings differ depending on the supervisee's gender, race, age, or other demographics?
3. What are your options for responding?
4. How would you like to respond? How do you think you would respond? If there is any difference between your answers to these two questions, what causes the difference?
5. How, if at all, would the way you responded be affected by the supervisee's gender, race, age, or other demographics?

You have been working with a client who is in desperate need of treatment for multiple serious problems. Without treatment, the client, a single parent, is likely to decompensate and perhaps place the children at risk. Suicide is a possibility. Unfortunately, the client does not qualify for therapy in the light of the current symptoms and the terms of insurance coverage. Your supervisor and you discuss all the alternatives, none of which seems acceptable. Finally, your supervisor says, "Look, the only way to get this client the help that is absolutely necessary is to come up with a diagnosis that will meet the terms of the insurance coverage." The supervisor then suggests a diagnosis that will ensure coverage but clearly does not fit the client in any way.

1. How do you feel? Are there any feelings that are difficult to acknowledge, disclose, or consider?
2. Aside from your feelings, what thoughts do you have about your supervisor's suggestion?
3. What courses of action do you consider in the light of your supervisor's suggestion? What are your feelings in regard to each one?
4. What do you think you would end up doing?
5. How, if at all, would your chart notes be affected by your supervisor's suggestion?

You are working with a client who describes graphic sexual fantasies that make you somewhat uncomfortable. At your next supervision session, you tell the supervisor about the counseling session and also about your discomfort with the fantasies. Your supervisor says, "So you are uncomfortable with that kind of sexual fantasizing. What kind of sexual fantasies are you comfortable with?"

1. How do you feel?
2. What would you like to say to your supervisor?
3. What do you think you would end up saying to your supervisor?
4. If there is any difference between your answers to questions 2 and 3, why is there a difference?
5. Does the gender, sexual orientation, age, or race of your supervisor make any difference in terms of the feelings you experience or the responses you would make or would like to make?

You and your supervisor have had substantial disagreements about clients' diagnoses and treatment planning. You discuss your differences extensively, but neither convinces the other. During one supervision session, your supervisor says, "I've been concerned about the difficulties you seem to have in conceptualizing these cases and in formulating effective treatment plans. I believe that there are some personal factors interfering with your clinical judgment. I've discussed these issues with the director of clinical training and senior staff, and we think that you need to enter psychotherapy to address these problems."

1. How do you feel? Are there any feelings that are particularly hard to acknowledge, disclose, or discuss?
2. What are the possible ways you might respond to the supervisor's comments?
3. How would you like to respond to the comments?
4. How do you think you would end up responding to the comments?
5. If there is any difference between your response to questions 3 and 4, what is the difference, and what is the reason for the difference?
6. If you were the supervisor and you believed that the supervisee was experiencing personal problems that interfered with clinical judgment, how would you address it? What feelings would you experience as you addressed this situation? How, if at all, would your feelings affect your ability to address this situation effectively and humanely?
7. If you ever experienced problems that interfered with your clinical judgment or competence and you were unaware of the situation, how would you like others to respond? What would you find helpful and what would you find hurtful?

APPENDIX A

American Psychological Association Ethical Principles of Psychologists and Code of Conduct

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American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57*, 1060–1073. Copyright 2002 by the American Psychological Association. Reprinted with permission.

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INTRODUCTION AND APPLICABILITY

The American Psychological Association's (APA's) Ethical Principles of Psychologists and Code of Conduct (hereinafter referred to as the Ethics Code) consists of an Introduction, a Preamble, five General Principles (A–E), and specific Ethical Standards. The Introduction discusses the intent, organization, procedural considerations, and scope of application of the Ethics Code. The Preamble and General Principles are aspirational goals to guide psychologists toward the highest ideals of psychology. Although the Preamble and General Principles are not themselves enforceable rules, they should be considered by psychologists in arriving at an ethical course of action. The Ethical Standards set forth enforceable rules for conduct as psychologists. Most of the Ethical Standards are written broadly, in order to apply to psychologists in varied roles, although the application of an Ethical Standard may vary depending on the context. The Ethical Standards are not exhaustive. The fact that a given conduct is not specifically addressed by an Ethical Standard does not mean that it is necessarily either ethical or unethical.

This Ethics Code applies only to psychologists' activities that are part of their scientific, educational, or professional roles as psychologists. Areas covered include but are not limited to the clinical, counseling, and school practice of psychology; research; teaching; supervision of trainees; public service; policy development; social intervention; development of assessment instruments; conducting assessments; educational counseling; organizational consulting; forensic activities; program design and evaluation; and administration. This Ethics Code applies to these activities across a variety of contexts, such as in person, postal, telephone, Internet, and other electronic transmissions. These activities shall be distinguished from the purely private conduct of psychologists, which is not within the purview of the Ethics Code.

Membership in the APA commits members and student affiliates to comply with the standards of the APA Ethics Code and to the rules and procedures used to enforce them. Lack of awareness or misunderstanding of an Ethical Standard is not itself a defense to a charge of unethical conduct.

The procedures for filing, investigating, and resolving complaints of unethical conduct are described in the current Rules and Procedures of the APA Ethics Committee. APA may impose sanctions on its members for violations of the standards of the Ethics Code, including termination of APA membership, and may notify other bodies and individuals of its actions. Actions that violate the standards of the Ethics Code may also lead to the imposition of sanctions on psychologists or students whether or not they are APA members by bodies other than APA, including state psychological associations, other professional groups, psychology boards, other state or federal agencies, and payors for health services. In addition, APA may take action against a member after his or her conviction of a felony, expulsion or suspension from an affiliated state psychological association, or suspension or loss of licensure. When the sanction to be imposed by APA is less than expulsion, the 2001 Rules and Procedures do not guarantee an opportunity for an in-person hearing, but generally provide that complaints will be resolved only on the basis of a submitted record.

The Ethics Code is intended to provide guidance for psychologists and standards of professional conduct that can be applied by the APA and by other bodies that choose to adopt them. The Ethics Code is not intended to be a basis of civil liability. Whether a psychologist has violated the Ethics Code standards does not by itself determine whether the psychologist is legally liable in a court action, whether a contract is enforceable, or whether other legal consequences occur.

The modifiers used in some of the standards of this Ethics Code (e.g., *reasonably, appropriate, potentially*) are included in the standards when they would (1) allow professional judgment on the part of psychologists, (2) eliminate injustice or inequality that would occur without the modifier, (3) ensure applicability across the broad range of activities conducted by psychologists, or (4) guard against a set of rigid rules that might be quickly outdated. As used in this Ethics Code, the term *reasonable* means the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time.

This version of the APA Ethics Code was adopted by the American Psychological Association's Council of Representatives during its meeting, August 21, 2002, and is effective beginning June 1, 2003. Inquiries concerning the substance or interpretation of the APA Ethics Code should be addressed to the Director, Office of Ethics, American Psychological Association, 750 First Street, NE, Washington, DC 20002–4242. The Ethics Code and information regarding the Code can be found on the APA Web site, http://www.apa.org/ethics. The standards in this Ethics Code will be used to adjudicate complaints brought concerning alleged conduct occurring on or after the effective date. Complaints regarding conduct occurring prior to the effective date will be adjudicated on the basis of the version of the Ethics Code that was in effect at the time the conduct occurred.

The APA has previously published its Ethics Code as follows:

American Psychological Association. (1953). *Ethical standards of psychologists.* Washington, DC: Author. American Psychological Association. (1959). Ethical standards of psychologists. *American Psychologist, 14,* 279–282. American Psychological Association. (1963). Ethical standards of psychologists. *American Psychologist, 18,* 56–60. American Psychological Association. (1968). Ethical standards of psychologists. *American Psychologist, 23,* 357–361. American Psychological Association. (1977, March). Ethical standards of psychologists. *APA Monitor,* 22–23. American Psychological Association. (1979). *Ethical standards of psychologists.* Washington, DC: Author. American Psychological Association. (1981). Ethical principles of psychologists. *American Psychologist, 36,* 633–638. American Psychological Association. (1990). Ethical principles of psychologists (Amended June 2, 1989). *American Psychologist, 45,* 390–395. American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47,* 1597–1611. Request copies of the APA's Ethical Principles of Psychologists and Code of Conduct from the APA Order Department, 750 First Street, NE, Washington, DC 20002–4242, or phone (202) 336–5510.

In the process of making decisions regarding their professional behavior, psychologists must consider this Ethics Code in addition to applicable laws and psychology board regulations. In applying the Ethics Code to their professional work, psychologists may consider other materials and guidelines that have been adopted or endorsed by scientific and professional psychological organizations and the dictates of their own conscience, as well as consult with others within the field. If this Ethics Code establishes a higher standard of conduct than is required by law, psychologists must meet the higher ethical standard. If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner. If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing authority in keeping with basic principles of human rights.

PREAMBLE

Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness. This Ethics Code provides a common set of principles and standards upon which psychologists build their professional and scientific work.

This Ethics Code is intended to provide specific standards to cover most situations encountered by psychologists. It has as its goals the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students, and the public regarding ethical standards of the discipline. The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees, and colleagues; and to consult with others concerning ethical problems.

GENERAL PRINCIPLES

This section consists of General Principles. General Principles, as opposed to Ethical Standards, are aspirational in nature. Their intent is to guide and inspire psychologists toward the very highest ethical ideals of the profession. General Principles, in contrast to Ethical Standards, do not represent obligations and should not form the basis for imposing sanctions. Relying upon General Principles for either of these reasons distorts both their meaning and purpose.

Principle A: Beneficence and Nonmaleficence

Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.

Principle B: Fidelity and Responsibility

Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues' scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.

Principle C: Integrity

Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.

Principle D: Justice

Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices.

Principle E: Respect for People's Rights and Dignity

Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

ETHICAL STANDARDS

1. Resolving Ethical Issues

1.01 MISUSE OF PSYCHOLOGISTS' WORK

If psychologists learn of misuse or misrepresentation of their work, they take reasonable steps to correct or minimize the misuse or misrepresentation.

1.02 CONFLICTS BETWEEN ETHICS AND LAW, REGULATIONS, OR OTHER GOVERNING LEGAL AUTHORITY

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to the Ethics Code and take steps to resolve the conflict. If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing legal authority.

1.03 CONFLICTS BETWEEN ETHICS AND ORGANIZATIONAL DEMANDS

If the demands of an organization with which psychologists are affiliated or for whom they are working conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and to the extent feasible, resolve the conflict in a way that permits adherence to the Ethics Code.

1.04 INFORMAL RESOLUTION OF ETHICAL VIOLATIONS

When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved. (See also Standards 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority, and 1.03, Conflicts Between Ethics and Organizational Demands.)

1.05 REPORTING ETHICAL VIOLATIONS

If an apparent ethical violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution under Standard 1.04, Informal Resolution of Ethical Violations, or is not resolved properly in that fashion, psychologists take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, to state licensing boards, or to the appropriate institutional authorities. This standard does not apply when an intervention would violate confidentiality rights or when psychologists have been retained to review the work of another psychologist whose professional conduct is in question. (See also Standard 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority.)

1.06 COOPERATING WITH ETHICS COMMITTEES

Psychologists cooperate in ethics investigations, proceedings, and resulting requirements of the APA or any affiliated state psychological association to which they belong. In doing so, they address any confidentiality issues. Failure to cooperate is itself an ethics violation. However, making a request for deferment of adjudication of an ethics complaint pending the outcome of litigation does not alone constitute noncooperation.

1.07 IMPROPER COMPLAINTS

Psychologists do not file or encourage the filing of ethics complaints that are made with reckless disregard for or willful ignorance of facts that would disprove the allegation.

1.08 UNFAIR DISCRIMINATION AGAINST COMPLAINANTS AND RESPONDENTS

Psychologists do not deny persons employment, advancement, admissions to academic or other programs, tenure, or promotion, based solely upon their having made or their being the subject of an ethics complaint. This does not preclude taking action based upon the outcome of such proceedings or considering other appropriate information.

2. Competence

2.01 BOUNDARIES OF COMPETENCE

(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.

(c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

(d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.

(e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless 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.

(f) When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles.

2.02 PROVIDING SERVICES IN EMERGENCIES

In emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied. The services are discontinued as soon as the emergency has ended or appropriate services are available.

2.03 MAINTAINING COMPETENCE

Psychologists undertake ongoing efforts to develop and maintain their competence.

2.04 BASES FOR SCIENTIFIC AND PROFESSIONAL JUDGMENTS

Psychologists' work is based upon established scientific and professional knowledge of the discipline. (See also Standards 2.01e, Boundaries of Competence, and 10.01b, Informed Consent to Therapy.)

2.05 DELEGATION OF WORK TO OTHERS

Psychologists who delegate work to employees, supervisees, or research or teaching assistants or who use the services of others, such as interpreters, take reasonable steps to (1) avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity; (2) authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided; and (3) see that such persons perform these services competently. (See also Standards 2.02, Providing Services in Emergencies; 3.05, Multiple Relationships; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.02, Use of Assessments; 9.03, Informed Consent in Assessments; and 9.07, Assessment by Unqualified Persons.)

2.06 PERSONAL PROBLEMS AND CONFLICTS

(a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.

(b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties. (See also Standard 10.10, Terminating Therapy.)

3. Human Relations

3.01 UNFAIR DISCRIMINATION

In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law.

3.02 SEXUAL HARASSMENT

Psychologists do not engage in sexual harassment. Sexual harassment is sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with the psychologist's activities or roles as a psychologist, and that either (1) is unwelcome, is offensive, or creates a hostile workplace or educational environment, and the psychologist knows or is told this or (2) is sufficiently severe or intense to be abusive to a reasonable person in the context. Sexual harassment can consist of a single intense or severe act or of multiple persistent or pervasive acts. (See also Standard 1.08, Unfair Discrimination Against Complainants and Respondents.)

3.03 OTHER HARASSMENT

Psychologists do not knowingly engage in behavior that is harassing or demeaning to persons with whom they interact in their work based on factors such as those persons' age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status.

3.04 AVOIDING HARM

Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

3.05 MULTIPLE RELATIONSHIPS

(a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.

(b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.

(c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur. (See also Standards 3.04, Avoiding Harm, and 3.07, Third-Party Requests for Services.)

3.06 CONFLICT OF INTEREST

Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation.

3.07 THIRD-PARTY REQUESTS FOR SERVICES

When psychologists agree to provide services to a person or entity at the request of a third party, psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations involved. This clarification includes the role of the psychologist (e.g., therapist, consultant, diagnostician, or expert witness), an identification of who is the client, the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality. (See also Standards 3.05, Multiple Relationships, and 4.02, Discussing the Limits of Confidentiality.)

3.08 EXPLOITATIVE RELATIONSHIPS

Psychologists do not exploit persons over whom they have supervisory, evaluative, or other authority such as clients/patients, students, supervisees, research participants, and employees. (See also Standards 3.05, Multiple Relationships; 6.04, Fees and Financial Arrangements; 6.05, Barter with Clients/Patients; 7.07, Sexual Relationships with Students and Supervisees; 10.05, Sexual Intimacies with Current Therapy Clients/Patients; 10.06, Sexual Intimacies with Relatives or Significant Others of Current Therapy Clients/Patients; 10.07, Therapy with Former Sexual Partners; and 10.08, Sexual Intimacies with Former Therapy Clients/Patients.)

3.09 COOPERATION WITH OTHER PROFESSIONALS

When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately. (See also Standard 4.05, Disclosures.)

3.10 INFORMED CONSENT

(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.

(d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

3.11 PSYCHOLOGICAL SERVICES DELIVERED TO OR THROUGH ORGANIZATIONS

(a) Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about (1) the nature and objectives of the services, (2) the intended recipients, (3) which of the individuals are clients, (4) the relationship the psychologist will have with each person and the organization, (5) the probable uses of services provided and information obtained, (6) who will have access to the information, and (7) limits of confidentiality. As soon as feasible, they provide information about the results and conclusions of such services to appropriate persons.

(b) If psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of the service.

3.12 INTERRUPTION OF PSYCHOLOGICAL SERVICES

Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability, relocation, or retirement or by the client's/patient's relocation or financial limitations. (See also Standard 6.02c, Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work.)

4. Privacy and Confidentiality

4.01 MAINTAINING CONFIDENTIALITY

Psychologists 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 professional or scientific relationship. (See also Standard 2.05, Delegation of Work to Others.)

4.02 DISCUSSING THE LIMITS OF CONFIDENTIALITY

(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent.)

(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

(c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.

4.03 RECORDING

Before recording the voices or images of individuals to whom they provide services, psychologists obtain permission from all such persons or their legal representatives. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing with Informed Consent for Research; and 8.07, Deception in Research.)

4.04 MINIMIZING INTRUSIONS ON PRIVACY

(a) Psychologists include in written and oral reports and consultations, only information germane to the purpose for which the communication is made.

(b) Psychologists discuss confidential information obtained in their work only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

4.05 DISCLOSURES

(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.

(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (See also Standard 6.04e, Fees and Financial Arrangements.)

4.06 CONSULTATIONS

When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation. (See also Standard 4.01, Maintaining Confidentiality.)

4.07 USE OF CONFIDENTIAL INFORMATION FOR DIDACTIC OR OTHER PURPOSES

Psychologists do not disclose in their writings, lectures, or other public media, confidential, personally identifiable information concerning their clients/patients, students, research participants, organizational clients, or other recipients of their services that they obtained during the course of their work, unless (1) they take reasonable steps to disguise the person or organization, (2) the person or organization has consented in writing, or (3) there is legal authorization for doing so.

5. Advertising and Other Public Statements

5.01 AVOIDANCE OF FALSE OR DECEPTIVE STATEMENTS

(a) Public statements include but are not limited to paid or unpaid advertising, product endorsements, grant applications, licensing applications, other credentialing applications, brochures, printed matter, directory listings, personal resumes or curricula vitae, or comments for use in media such as print or electronic transmission, statements in legal proceedings, lectures and public oral presentations, and published materials. Psychologists do not knowingly make public statements that are false, deceptive, or fraudulent concerning their research, practice, or other work activities or those of persons or organizations with which they are affiliated.

(b) Psychologists do not make false, deceptive, or fraudulent statements concerning (1) their training, experience, or competence; (2) their academic degrees; (3) their credentials; (4) their institutional or association affiliations; (5) their services; (6) the scientific or clinical basis for, or results or degree of success of, their services; (7) their fees; or (8) their publications or research findings.

(c) Psychologists claim degrees as credentials for their health services only if those degrees (1) were earned from a regionally accredited educational institution or (2) were the basis for psychology licensure by the state in which they practice.

5.02 STATEMENTS BY OTHERS

(a) Psychologists who engage others to create or place public statements that promote their professional practice, products, or activities retain professional responsibility for such statements.

(b) Psychologists do not compensate employees of press, radio, television, or other communication media in return for publicity in a news item. (See also Standard 1.01, Misuse of Psychologists' Work.)

(c) A paid advertisement relating to psychologists' activities must be identified or clearly recognizable as such.

5.03 DESCRIPTIONS OF WORKSHOPS AND NON-DEGREE-GRANTING EDUCATIONAL PROGRAMS

To the degree to which they exercise control, psychologists responsible for announcements, catalogs, brochures, or advertisements describing workshops, seminars, or other non-degree-granting educational programs ensure that they accurately describe the audience for which the program is intended, the educational objectives, the presenters, and the fees involved.

5.04 MEDIA PRESENTATIONS

When psychologists provide public advice or comment via print, Internet, or other electronic transmission, they take precautions to ensure that statements (1) are based on their professional knowledge, training, or experience in accord with appropriate psychological literature and practice; (2) are otherwise consistent with this Ethics Code; and (3) do not indicate that a professional relationship has been established with the recipient. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

5.05 TESTIMONIALS

Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence.

5.06 IN-PERSON SOLICITATION

Psychologists do not engage, directly or through agents, in uninvited in-person solicitation of business from actual or potential therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence. However, this prohibition does not preclude

(1) attempting to implement appropriate collateral contacts for the purpose of benefiting an already engaged therapy client/patient or (2) providing disaster or community outreach services.

6. Record Keeping and Fees

6.01 DOCUMENTATION OF PROFESSIONAL AND SCIENTIFIC WORK AND MAINTENANCE OF RECORDS

Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law. (See also Standard 4.01, Maintaining Confidentiality.)

6.02 MAINTENANCE, DISSEMINATION, AND DISPOSAL OF CONFIDENTIAL RECORDS OF PROFESSIONAL AND SCIENTIFIC WORK

(a) Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium. (See also Standards 4.01, Maintaining Confidentiality, and 6.01, Documentation of Professional and Scientific Work and Maintenance of Records.)

(b) If confidential information concerning recipients of psychological services is entered into databases or systems of records available to persons whose access has not been consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers.

(c) Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice. (See also Standards 3.12, Interruption of Psychological Services, and 10.09, Interruption of Therapy.)

6.03 WITHHOLDING RECORDS FOR NONPAYMENT

Psychologists may not withhold records under their control that are requested and needed for a client's/patient's emergency treatment solely because payment has not been received.

6.04 FEES AND FINANCIAL ARRANGEMENTS

(a) As early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements.

(b) Psychologists' fee practices are consistent with law.

(c) Psychologists do not misrepresent their fees.

(d) If limitations to services can be anticipated because of limitations in financing, this is discussed with the recipient of services as early as is feasible. (See also Standards 10.09, Interruption of Therapy, and 10.10, Terminating Therapy.)

(e) If the recipient of services does not pay for services as agreed, and if psychologists intend to use collection agencies or legal measures to collect the fees, psychologists first inform the person that such measures will be taken and provide that person an opportunity to make prompt payment. (See also Standards 4.05, Disclosures; 6.03, Withholding Records for Nonpayment; and 10.01, Informed Consent to Therapy.)

6.05 BARTER WITH CLIENTS/PATIENTS

Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative. (See also Standards 3.05, Multiple Relationships, and 6.04, Fees and Financial Arrangements.)

6.06 ACCURACY IN REPORTS TO PAYORS AND FUNDING SOURCES

In their reports to payors for services or sources of research funding, psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided or research conducted, the fees, charges, or payments, and where applicable, the identity of the provider, the findings, and the diagnosis. (See also Standards 4.01, Maintaining Confidentiality; 4.04, Minimizing Intrusions on Privacy; and 4.05, Disclosures.)

6.07 REFERRALS AND FEES

When psychologists pay, receive payment from, or divide fees with another professional, other than in an employer–employee relationship, the payment to each is based on the services provided (clinical, consultative, administrative, or other) and is not based on the referral itself. (See also Standard 3.09, Cooperation with Other Professionals.)

7. Education and Training

7.01 DESIGN OF EDUCATION AND TRAINING PROGRAMS

Psychologists responsible for education and training programs take reasonable steps to ensure that the programs are designed to provide the appropriate knowledge and proper experiences, and to meet the requirements for licensure, certification, or other goals for which claims are made by the program. (See also Standard 5.03, Descriptions of Workshops and Non-Degree-Granting Educational Programs.)

7.02 DESCRIPTIONS OF EDUCATION AND TRAINING PROGRAMS

Psychologists responsible for education and training programs take reasonable steps to ensure that there is a current and accurate description of the program content (including participation in required course- or program-related counseling, psychotherapy, experiential groups, consulting projects, or community service), training goals and objectives, stipends and benefits, and requirements that must be met for satisfactory completion of the program. This information must be made readily available to all interested parties.

7.03 ACCURACY IN TEACHING

(a) Psychologists take reasonable steps to ensure that course syllabi are accurate regarding the subject matter to be covered, bases for evaluating progress, and the nature of course experiences. This standard does not preclude an instructor from modifying course content or requirements when the instructor considers it pedagogically necessary or desirable, so long as students are made aware of these modifications in a manner that enables them to fulfill course requirements. (See also Standard 5.01, Avoidance of False or Deceptive Statements.)

(b) When engaged in teaching or training, psychologists present psychological information accurately. (See also Standard 2.03, Maintaining Competence.)

7.04 STUDENT DISCLOSURE OF PERSONAL INFORMATION

Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.

7.05 MANDATORY INDIVIDUAL OR GROUP THERAPY

(a) When individual or group therapy is a program or course requirement, psychologists responsible for that program allow students in undergraduate and graduate programs the option of selecting such therapy from practitioners unaffiliated with the program. (See also Standard 7.02, Descriptions of Education and Training Programs.)

(b) Faculty who are or are likely to be responsible for evaluating students' academic performance do not themselves provide that therapy. (See also Standard 3.05, Multiple Relationships.)

7.06 ASSESSING STUDENT AND SUPERVISEE PERFORMANCE

(a) In academic and supervisory relationships, psychologists establish a timely and specific process for providing feedback to students and supervisees. Information regarding the process is provided to the student at the beginning of supervision.

(b) Psychologists evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.

7.07 SEXUAL RELATIONSHIPS WITH STUDENTS AND SUPERVISEES

Psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority. (See also Standard 3.05, Multiple Relationships.)

8. Research and Publication

8.01 INSTITUTIONAL APPROVAL

When institutional approval is required, psychologists provide accurate information about their research proposals and obtain approval prior to conducting the research. They conduct the research in accordance with the approved research protocol.

8.02 INFORMED CONSENT TO RESEARCH

(a) When obtaining informed consent as required in Standard 3.10, Informed Consent, psychologists inform participants about (1) the purpose of the research, expected duration, and procedures; (2) their right to decline to participate and to withdraw from the research once participation has begun; (3) the foreseeable consequences of declining or withdrawing; (4) reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort, or adverse effects; (5) any prospective research benefits; (6) limits of confidentiality; (7) incentives for participation; and (8) whom to contact for questions about the research and research participants' rights. They provide opportunity for the prospective participants to ask questions and receive answers. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing with Informed Consent for Research; and 8.07, Deception in Research.)

(b) Psychologists conducting intervention research involving the use of experimental treatments clarify to participants at the outset of the research (1) the experimental nature of the treatment; (2) the services that will or will not be available to the control group(s) if appropriate; (3) the means by which assignment to treatment and control groups will be made; (4) available treatment alternatives if an individual does not wish to participate in the research or wishes to withdraw once a study has begun; and (5) compensation for or monetary costs of participating including, if appropriate, whether reimbursement from the participant or a third-party payor will be sought. (See also Standard 8.02a, Informed Consent to Research.)

8.03 INFORMED CONSENT FOR RECORDING VOICES AND IMAGES IN RESEARCH

Psychologists obtain informed consent from research participants prior to recording their voices or images for data collection unless (1) the research consists solely of naturalistic observations in public places, and it is not anticipated that the recording will be used in a manner that could cause personal identification or harm, or (2) the research design includes deception, and consent for the use of the recording is obtained during debriefing. (See also Standard 8.07, Deception in Research.)

8.04 CLIENT/PATIENT, STUDENT, AND SUBORDINATE RESEARCH PARTICIPANTS

(a) When psychologists conduct research with clients/ patients, students, or subordinates as participants, psychologists take steps to protect the prospective participants from adverse consequences of declining or withdrawing from participation.

(b) When research participation is a course requirement or an opportunity for extra credit, the prospective participant is given the choice of equitable alternative activities.

8.05 DISPENSING WITH INFORMED CONSENT FOR RESEARCH

Psychologists may dispense with informed consent only (1) where research would not reasonably be assumed to create distress or harm and involves (a) the study of normal educational practices, curricula, or classroom management methods conducted in educational settings; (b) only anonymous questionnaires, naturalistic observations, or archival research for which disclosure of responses would not place participants at risk of criminal or civil liability or damage their financial standing, employability, or reputation, and confidentiality is protected; or (c) the study of factors related to job or organization effectiveness conducted in organizational settings for which there is no risk to participants' employability, and confidentiality is protected or (2) where otherwise permitted by law or federal or institutional regulations.

8.06 OFFERING INDUCEMENTS FOR RESEARCH PARTICIPATION

(a) Psychologists make reasonable efforts to avoid offering excessive or inappropriate financial or other inducements for research participation when such inducements are likely to coerce participation.

(b) When offering professional services as an inducement for research participation, psychologists clarify the nature of the services, as well as the risks, obligations, and limitations. (See also Standard 6.05, Barter with Clients/Patients.)

8.07 DECEPTION IN RESEARCH

(a) Psychologists do not conduct a study involving deception unless they have determined that the use of deceptive techniques is justified by the study's significant prospective scientific, educational, or applied value and that effective nondeceptive alternative procedures are not feasible.

(b) Psychologists do not deceive prospective participants about research that is reasonably expected to cause physical pain or severe emotional distress.

(c) Psychologists explain any deception that is an integral feature of the design and conduct of an experiment to participants as early as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the data collection, and permit participants to withdraw their data. (See also Standard 8.08, Debriefing.)

8.08 DEBRIEFING

(a) Psychologists provide a prompt opportunity for participants to obtain appropriate information about the nature, results, and conclusions of the research, and they take reasonable steps to correct any misconceptions that participants may have of which the psychologists are aware.

(b) If scientific or humane values justify delaying or withholding this information, psychologists take reasonable measures to reduce the risk of harm.

(c) When psychologists become aware that research procedures have harmed a participant, they take reasonable steps to minimize the harm.

8.09 HUMANE CARE AND USE OF ANIMALS IN RESEARCH

(a) Psychologists acquire, care for, use, and dispose of animals in compliance with current federal, state, and local laws and regulations, and with professional standards.

(b) Psychologists trained in research methods and experienced in the care of laboratory animals supervise all procedures involving animals and are responsible for ensuring appropriate consideration of their comfort, health, and humane treatment.

(c) Psychologists ensure that all individuals under their supervision who are using animals have received instruction in research methods and in the care, maintenance, and handling of the species being used, to the extent appropriate to their role. (See also Standard 2.05, Delegation of Work to Others.)

(d) Psychologists make reasonable efforts to minimize the discomfort, infection, illness, and pain of animal subjects.

(e) Psychologists use a procedure subjecting animals to pain, stress, or privation only when an alternative procedure is unavailable and the goal is justified by its prospective scientific, educational, or applied value.

(f) Psychologists perform surgical procedures under appropriate anesthesia and follow techniques to avoid infection and minimize pain during and after surgery.

(g) When it is appropriate that an animal's life be terminated, psychologists proceed rapidly, with an effort to minimize pain and in accordance with accepted procedures.

8.10 REPORTING RESEARCH RESULTS

(a) Psychologists do not fabricate data. (See also Standard 5.01a, Avoidance of False or Deceptive Statements.)

(b) If psychologists discover significant errors in their published data, they take reasonable steps to correct such errors in a correction, retraction, erratum, or other appropriate publication means.

8.11 PLAGIARISM

Psychologists do not present portions of another's work or data as their own, even if the other work or data source is cited occasionally.

8.12 PUBLICATION CREDIT

(a) Psychologists take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have substantially contributed. (See also Standard 8.12b, Publication Credit.)

(b) Principal authorship and other publication credits accurately reflect the relative scientific or professional contributions of the individuals involved, regardless of their relative status. Mere possession of an institutional position, such as department chair, does not justify authorship credit. Minor contributions to the research or to the writing for publications are acknowledged appropriately, such as in footnotes or in an introductory statement.

(c) Except under exceptional circumstances, a student is listed as principal author on any multiple-authored article that is substantially based on the student's doctoral dissertation. Faculty advisors discuss publication credit with students as early as feasible and throughout the research and publication process as appropriate. (See also Standard 8.12b, Publication Credit.)

8.13 DUPLICATE PUBLICATION OF DATA

Psychologists do not publish, as original data, data that have been previously published. This does not preclude republishing data when they are accompanied by proper acknowledgment.

8.14 SHARING RESEARCH DATA FOR VERIFICATION

(a) After research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release. This does not preclude psychologists from requiring that such individuals or groups be responsible for costs associated with the provision of such information.

(b) Psychologists who request data from other psychologists to verify the substantive claims through reanalysis may use shared data only for the declared purpose. Requesting psychologists obtain prior written agreement for all other uses of the data.

8.15 REVIEWERS

Psychologists who review material submitted for presentation, publication, grant, or research proposal review respect the confidentiality of and the proprietary rights in such information of those who submitted it.

9. Assessment

9.01 BASES FOR ASSESSMENTS

(a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

(b) Except as noted in 9.01c, psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations. (See also Standards 2.01, Boundaries of Competence, and 9.06, Interpreting Assessment Results.)

(c) When psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations.

9.02 USE OF ASSESSMENTS

(a) Psychologists administer, adapt, score, interpret, or use assessment techniques, interviews, tests, or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.

(b) Psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation.

(c) Psychologists use assessment methods that are appropriate to an individual's language preference and competence, unless the use of an alternative language is relevant to the assessment issues.

9.03 INFORMED CONSENT IN ASSESSMENTS

(a) Psychologists obtain informed consent for assessments, evaluations, or diagnostic services, as described in Standard 3.10, Informed Consent, except when (1) testing is mandated by law or governmental regulations; (2) informed consent is implied because testing is conducted as a routine educational, institutional, or organizational activity (e.g., when participants voluntarily agree to assessment when applying for a job); or (3) one purpose of the testing is to evaluate decisional capacity. Informed consent includes an explanation of the nature and purpose of the assessment, fees, involvement of third parties, and limits of confidentiality and sufficient opportunity for the client/patient to ask questions and receive answers.

(b) Psychologists inform persons with questionable capacity to consent or for whom testing is mandated by law or governmental regulations about the nature and purpose of the proposed assessment services, using language that is reasonably understandable to the person being assessed.

(c) Psychologists using the services of an interpreter obtain informed consent from the client/patient to use that interpreter, ensure that confidentiality of test results and test security are maintained, and include in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, discussion of any limitations on the data obtained. (See also Standards 2.05, Delegation of Work to Others; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.06, Interpreting Assessment Results; and 9.07, Assessment by Unqualified Persons.)

9.04 RELEASE OF TEST DATA

(a) The term *test data* refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of *test data.* Pursuant to a client/patient release, psychologists provide test data to the client/patient or other persons identified in the release. Psychologists may refrain from releasing test data to protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law. (See also Standard 9.11, Maintaining Test Security.)

(b) In the absence of a client/patient release, psychologists provide test data only as required by law or court order.

9.05 TEST CONSTRUCTION

Psychologists who develop tests and other assessment techniques use appropriate psychometric procedures and current scientific or professional knowledge for test design, standardization, validation, reduction or elimination of bias, and recommendations for use.

9.06 INTERPRETING ASSESSMENT RESULTS

When interpreting assessment results, including automated interpretations, psychologists take into account the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences, that might affect psychologists' judgments or reduce the accuracy of their interpretations. They indicate any significant limitations of their interpretations. (See also Standards 2.01b and c, Boundaries of Competence, and 3.01, Unfair Discrimination.)

9.07 ASSESSMENT BY UNQUALIFIED PERSONS

Psychologists do not promote the use of psychological assessment techniques by unqualified persons, except when such use is conducted for training purposes with appropriate supervision. (See also Standard 2.05, Delegation of Work to Others.)

9.08 OBSOLETE TESTS AND OUTDATED TEST RESULTS

(a) Psychologists do not base their assessment or intervention decisions or recommendations on data or test results that are outdated for the current purpose.

(b) Psychologists do not base such decisions or recommendations on tests and measures that are obsolete and not useful for the current purpose.

9.09 TEST SCORING AND INTERPRETATION SERVICES

(a) Psychologists who offer assessment or scoring services to other professionals accurately describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use.

(b) Psychologists select scoring and interpretation services (including automated services) on the basis of evidence of the validity of the program and procedures as well as on other appropriate considerations. (See also Standard 2.01b and c, Boundaries of Competence.)

(c) Psychologists retain responsibility for the appropriate application, interpretation, and use of assessment instruments, whether they score and interpret such tests themselves or use automated or other services.

9.10 EXPLAINING ASSESSMENT RESULTS

Regardless of whether the scoring and interpretation are done by psychologists, by employees or assistants, or by automated or other outside services, psychologists take reasonable steps to ensure that explanations of results are given to the individual or designated representative unless the nature of the relationship precludes provision of an explanation of results (such as in some organizational consulting, preemployment or security screenings, and forensic evaluations), and this fact has been clearly explained to the person being assessed in advance.

9.11 MAINTAINING TEST SECURITY

The term *test materials* refers to manuals, instruments, protocols, and test questions or stimuli and does not include *test data* as defined in Standard 9.04, Release of Test Data. Psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligations, and in a manner that permits adherence to this Ethics Code.

10. Therapy

10.01 INFORMED CONSENT TO THERAPY

(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality, and 6.04, Fees and Financial Arrangements.)

(b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation. (See also Standards 2.01e, Boundaries of Competence, and 3.10, Informed Consent.)

(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.

10.02 THERAPY INVOLVING COUPLES OR FAMILIES

(a) When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained. (See also Standard 4.02, Discussing the Limits of Confidentiality.)

(b) If it becomes apparent that psychologists may be called on to perform potentially conflicting roles (such as family therapist and then witness for one party in divorce proceedings), psychologists take reasonable steps to clarify and modify, or withdraw from, roles appropriately. (See also Standard 3.05c, Multiple Relationships.)

10.03 GROUP THERAPY

When psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality.

10.04 PROVIDING THERAPY TO THOSE SERVED BY OTHERS

In deciding whether to offer or provide services to those already receiving mental health services elsewhere, psychologists carefully consider the treatment issues and the potential client's/patient's welfare. Psychologists discuss these issues with the client/patient or another legally authorized person on behalf of the client/patient in order to minimize the risk of confusion and conflict, consult with the other service providers when appropriate, and proceed with caution and sensitivity to the therapeutic issues.

10.05 SEXUAL INTIMACIES WITH CURRENT THERAPY CLIENTS/PATIENTS

Psychologists do not engage in sexual intimacies with current therapy clients/patients.

10.06 SEXUAL INTIMACIES WITH RELATIVES OR SIGNIFICANT OTHERS OF CURRENT THERAPY CLIENTS/PATIENTS

Psychologists do not engage in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of current clients/patients. Psychologists do not terminate therapy to circumvent this standard.

10.07 THERAPY WITH FORMER SEXUAL PARTNERS

Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies.

10.08 SEXUAL INTIMACIES WITH FORMER THERAPY CLIENTS/PATIENTS

(a) Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy.

(b) Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient bear the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated; (2) the nature, duration, and intensity of the therapy; (3) the circumstances of termination; (4) the client's/patient's personal history; (5) the client's/patient's current mental status; (6) the likelihood of adverse impact on the client/patient; and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a posttermination sexual or romantic relationship with the client/patient. (See also Standard 3.05, Multiple Relationships.)

10.09 INTERRUPTION OF THERAPY

When entering into employment or contractual relationships, psychologists make reasonable efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the client/patient. (See also Standard 3.12, Interruption of Psychological Services.)

10.10 TERMINATING THERAPY

(a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.

(b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.

(c) Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate.

APPENDIX B

Canadian Psychological Association Code of Ethics for Psychologists

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Canadian Psychological Association. (2002). *Canadian code of ethics for psychologists* (3rd ed.). Ottowa, Onario: Canadian Psychological Association Société canadienne de psychologie.

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PREAMBLE

Introduction

Every discipline that has relatively autonomous control over its entry requirements, training, development of knowledge, standards, methods, and practices does so only within the context of a contract with the society in which it functions. This social contract is based on attitudes of mutual respect and trust, with society granting support for the autonomy of a discipline in exchange for a commitment by the discipline to do everything it can to assure that its members act ethically in conducting the affairs of the discipline within society; in particular, a commitment to try to assure that each member will place the welfare of the society and individual members of that society above the welfare of the discipline and its own members. By virtue of this social contract, psychologists have a higher duty of care to members of society than the general duty of care that all members of society have to each other.

The Canadian Psychological Association recognizes its responsibility to help assure ethical behaviour and attitudes on the part of psychologists. Attempts to assure ethical behaviour and attitudes include articulating ethical principles, values, and standards; promoting those principles, values, and standards through education, peer modelling, and consultation; developing and implementing methods to help psychologists monitor the ethics of their behaviour and attitudes; adjudicating complaints of unethical behaviour; and, taking corrective action when warranted.

This *Code* articulates ethical principles, values, and standards to guide all members of the Canadian Psychological Association, whether scientists, practitioners, or scientist practitioners, or whether acting in a research, direct service, teaching, student, trainee, administrative, management, employer, employee, supervisory, consultative, peer review, editorial, expert witness, social policy, or any other role related to the discipline of psychology.

Structure and Derivation of *Code*

Structure. Four ethical principles, to be considered and balanced in ethical decision making, are presented. Each principle is followed by a statement of those values that are included in and give definition to the principle. Each values statement is followed by a list of ethical standards that illustrate the application of the specific principle and values to the activities of psychologists. The standards range from minimal behavioural expectations (e.g., Standards I.28, II.28, III.33, IV.27) to more idealized, but achievable, attitudinal and behavioural expectations (e.g., Standards I.12, II.12, III.10, IV.6). In the margin, to the left of the standards, key words are placed to guide the reader through the standards and to illustrate the relationship of the specific standards to the values statement.

Derivation. The four principles represent those ethical principles used most consistently by Canadian psychologists to resolve hypothetical ethical dilemmas sent to them by the CPA Committee on Ethics during the initial development of the *Code.* In addition to the responses provided by Canadian psychologists, the values statements and ethical standards have been derived from interdisciplinary and international ethics codes, provincial and specialty codes of conduct, and ethics literature.

When Principles Conflict

All four principles are to be taken into account and balanced in ethical decision making. However, there are circumstances in which ethical principles will conflict and it will not be possible to give each principle equal weight. The complexity of ethical conflicts precludes a firm ordering of the principles. However, the four principles have been ordered according to the weight each generally should be given when they conflict, namely:

> Principle I: Respect for the Dignity of Persons. This principle, with its emphasis on moral rights, generally should be given the highest weight, except in circumstances in which there is a clear and imminent danger to the physical safety of any person.

> Principle II: Responsible Caring. This principle generally should be given the second highest weight. Responsible caring requires competence and should be carried out only in ways that respect the dignity of persons.
>
> Principle III: Integrity in Relationships. This principle generally should be given the third highest weight. Psychologists are expected to demonstrate the highest integrity in all of their relationships. However, in rare circumstances, values such as openness and straightforwardness might need to be subordinated to the values contained in the Principles of Respect for the Dignity of Persons and Responsible Caring.
>
> Principle IV: Responsibility to Society. This principle generally should be given the lowest weight of the four principles when it conflicts with one or more of them. Although it is necessary and important to consider responsibility to society in every ethical decision, adherence to this principle must be subject to and guided by Respect for the Dignity of Persons, Responsible Caring, and Integrity in Relationships. When a person's welfare appears to conflict with benefits to society, it is often possible to find ways of working for the benefit of society that do not violate respect and responsible caring for the person. However, if this is not possible, the dignity and well-being of a person should not be sacrificed to a vision of the greater good of society, and greater weight must be given to respect and responsible caring for the person.

Even with the above ordering of the principles, psychologists will be faced with ethical dilemmas that are difficult to resolve. In these circumstances, psychologists are expected to engage in an ethical decision-making process that is explicit enough to bear public scrutiny. In some cases, resolution might be a matter of personal conscience. However, decisions of personal conscience are also expected to be the result of a decision-making process that is based on a reasonably coherent set of ethical principles and that can bear public scrutiny. If the psychologist can demonstrate that every reasonable effort was made to apply the ethical principles of this *Code a*nd resolution of the conflict has had to depend on the personal conscience of the psychologist, such a psychologist would be deemed to have followed this *Code.*

The Ethical Decision-Making Process

The ethical decision-making process might occur very rapidly, leading to an easy resolution of an ethical issue. This is particularly true of issues for which clear-cut guidelines or standards exist and for which there is no conflict between principles. On the other hand, some ethical issues (particularly those in which ethical principles conflict) are not easily resolved, might be emotionally distressful, and might require time-consuming deliberation.

The following basic steps typify approaches to ethical decision making:

1. Identification of the individuals and groups potentially affected by the decision.
2. Identification of ethically relevant issues and practices, including the interests, rights, and any relevant characteristics of the individuals and groups involved and of the system or circumstances in which the ethical problem arose.
3. Consideration of how personal biases, stresses, or self-interest might influence the development of or choice between courses of action.
4. Development of alternative courses of action.
5. Analysis of likely short-term, ongoing, and long-term risks and benefits of each course of action on the individual(s)/group(s) involved or likely to be affected (e.g., client, client's family or employees, employing institution, students, research participants, colleagues, the discipline, society, self).
6. Choice of course of action after conscientious application of existing principles, values, and standards.
7. Action, with a commitment to assume responsibility for the consequences of the action.
8. Evaluation of the results of the course of action.
9. Assumption of responsibility for consequences of action, including correction of negative consequences, if any, or re-engaging in the decision-making process if the ethical issue is not resolved.
10. Appropriate action, as warranted and feasible, to prevent future occurrences of the dilemma (e.g., communication and problem solving with colleagues; changes in procedures and practices).

Psychologists engaged in time-consuming deliberation are encouraged and expected to consult with parties affected by the ethical problem, when appropriate, and with colleagues and/or advisory bodies when such persons can add knowledge or objectivity to the decision-making process. Although the decision for action remains with the individual psychologist, the seeking and consideration of such assistance reflects an ethical approach to ethical decision making.

Uses of the *Code*

This *Code* is intended to guide psychologists in their everyday conduct, thinking, and planning, and in the resolution of ethical dilemmas; that is, it advocates the practice of both proactive and reactive ethics.

The *Code* also is intended to serve as an umbrella document for the development of codes of conduct or other more specific codes. For example, the *Code* could be used as an ethical framework for the identification of behaviours that would be considered enforceable in a jurisdiction, the violation of which would constitute misconduct; or, jurisdictions could identify those standards in the *Code* that would be considered of a more serious nature and, therefore, reportable and subject to possible discipline. In addition, the principles and values could be used to help specialty areas develop standards that are specific to those areas. Some work in this direction has already occurred within CPA (e.g., *Guidelines for the Use of Animals in Research and Instruction in Psychology, Guidelines for Non-Discriminatory Practice, Guidelines for Psychologists in Addressing Recovered Memories*). The principles and values incorporated into this *Code,* insofar as they come to be reflected in other documents guiding the behaviour of psychologists, will reduce inconsistency and conflict between documents.

A third use of the *Code* is to assist in the adjudication of complaints against psychologists. A body charged with this responsibility is required to investigate allegations, judge whether unacceptable behaviour has occurred, and determine what corrective action should be taken. In judging whether unacceptable conduct has occurred, many jurisdictions refer to a code of conduct. Some complaints, however, are about conduct that is not addressed directly in a code of conduct. The *Code* provides an ethical framework for determining whether the complaint is of enough concern, either at the level of the individual psychologist or at the level of the profession as a whole, to warrant corrective action (e.g., discipline of the individual psychologist, general educational activities for members, or incorporation into the code of conduct). In determining corrective action for an individual psychologist, one of the judgments the adjudicating body needs to make is whether an individual conscientiously engaged in an ethical decision-making process and acted in good faith, or whether there was a negligent or willful disregard of ethical principles. The articulation of the ethical decision-making process contained in this *Code* provides guidance for making such judgements.

Responsibility of the Individual Psychologist

The discipline's contract with society commits the discipline and its members to act as a moral community that develops its ethical awareness and sensitivity, educates new members in the ethics of the discipline, manages its affairs and its members in an ethical manner, is as self-correcting as possible, and is accountable both internally and externally.

However, responsibility for ethical action depends foremost on the integrity of each individual psychologist; that is, on each psychologist's commitment to behave as ethically as possible in every situation. Acceptance to membership in the Canadian Psychological Association, a scientific and professional association of psychologists, commits members:

1. To adhere to the Association's *Code* in all current activities as a psychologist.
2. To apply conscientiously the ethical principles and values of the *Code* to new and emerging areas of activity.
3. To assess and discuss ethical issues and practices with colleagues on a regular basis.
4. To bring to the attention of the Association ethical issues that require clarification or the development of new guidelines or standards.
5. To bring concerns about possible unethical actions by a psychologist directly to the psychologist when the action appears to be primarily a lack of sensitivity, knowledge, or experience, and attempt to reach an agreement on the issue and, if needed, on the appropriate action to be taken.
6. To bring concerns about possible unethical actions of a more serious nature (e.g., actions that have caused or could cause serious harm, or actions that are considered misconduct in the jurisdiction) to the person(s) or body(ies) best suited to investigating the situation and to stopping or offsetting the harm.
7. To consider seriously others' concerns about one's own possibly unethical actions and attempt to reach an agreement on the issue and, if needed, take appropriate action.
8. In bringing or in responding to concerns about possible unethical actions, not to be vexatious or malicious.
9. To cooperate with duly constituted committees of the Association that are concerned with ethics and ethical conduct.

Relationship of *Code* to Personal Behaviour

This *Code* is intended to guide and regulate only those activities a psychologist engages in by virtue of being a psychologist. There is no intention to guide or regulate a psychologist's activities outside of this context. Personal behaviour becomes a concern of the discipline only if it is of such a nature that it undermines public trust in the discipline as a whole or if it raises questions about the psychologist's ability to carry out appropriately his/her responsibilities as a psychologist.

Relationship of *Code* to Provincial Regulatory Bodies

In exercising its responsibility to articulate ethical principles, values, and standards for those who wish to become and remain members in good standing, the Canadian Psychological Association recognizes the multiple memberships that some psychologists have (both regulatory and voluntary). The *Code* has attempted to encompass and incorporate those ethical principles most prevalent in the discipline as a whole, thereby minimizing the possibility of variance with provincial/territorial regulations and guidelines. Psychologists are expected to respect the requirements of their provincial/territorial regulatory bodies. Such requirements might define particular behaviours that constitute misconduct, are reportable to the regulatory body, and/or are subject to discipline.

Definition of Terms

For the purposes of this *Code:*

a) "*Psychologist*" means any person who is a Fellow, Member, Student Affiliate or Foreign Affiliate of the Canadian Psychological Association, or a member of any psychology voluntary association or regulatory body adopting this *Code.* (Readers are reminded that provincial/territorial jurisdictions might restrict the legal use of the term *psychologist* in their jurisdiction and that such restrictions are to be honoured.)

b) "*Client*" means an individual, family, or group (including an organization or community) receiving service from a psychologist.

c) Clients, research participants, students, and any other persons with whom psychologists come in contact in the course of their work, are "*independent*" if they can independently contract or give informed consent. Such persons are "*partially dependent*" if the decision to contract or give informed consent is shared between two or more parties (e.g., parents and school boards, workers and Workers' Compensation Boards, adult members of a family). Such persons are considered to be "*fully dependent*" if they have little or no choice about whether or not to receive service or participate in an activity (e.g., patients who have been involuntarily committed to a psychiatric facility, or very young children involved in a research project).

d) "*Others*" means any persons with whom psychologists come in contact in the course of their work. This may include, but is not limited to: clients seeking help with individual, family, organizational, industrial, or community issues; research participants; employees; students; trainees; supervisees; colleagues; employers; third party payers; and, members of the general public.

e) "*Legal or civil rights*" means those rights protected under laws and statutes recognized by the province or territory in which the psychologist is working.

f) "*Moral rights*" means fundamental and inalienable human rights that might or might not be fully protected by existing laws and statutes. Of particular significance to psychologists, for example, are rights to: distributive justice; fairness and due process; and, developmentally appropriate privacy, self-determination, and personal liberty. Protection of some aspects of these rights might involve practices that are not contained or controlled within current laws and statutes. Moral rights are not limited to those mentioned in this definition.

g) "*Unjust discrimination*" or "*unjustly discriminatory*" means activities that are prejudicial or promote prejudice to persons because of their culture, nationality, ethnicity, colour, race, religion, sex, gender, marital status, sexual orientation, physical or mental abilities, age, socio-economic status, or any other preference or personal characteristic, condition, or status.

h) "*Sexual harassment*" includes either or both of the following: (i) The use of power or authority in an attempt to coerce another person to engage in or tolerate sexual activity. Such uses include explicit or implicit threats of reprisal for noncompliance, or promises of reward for compliance. (ii) Engaging in deliberate and/or repeated unsolicited sexually oriented comments, anecdotes, gestures, or touching, if such behaviours: are offensive and unwelcome; create an offensive, hostile, or intimidating working, learning, or service environment; or, can be expected to be harmful to the recipient.[1]

i) The "*discipline of psychology*" refers to the scientific and applied methods and knowledge of psychology, and to the structures and procedures used by its members for conducting their work in relationship to society, to members of the public, to students or trainees, and to each other.

Review Schedule

To maintain the relevance and responsiveness of this *Code,* it will be reviewed regularly by the CPA Board of Directors, and revised as needed. You are invited to forward comments and suggestions, at any time, to the CPA office. In addition to psychologists, this invitation is extended to all readers, including members of the public and other disciplines.

PRINCIPLE I: RESPECT FOR THE DIGNITY OF PERSONS

Values Statement

In the course of their work as scientists, practitioners, or scientist-practitioners, psychologists come into contact with many different individuals and groups, including: research participants; clients seeking help with individual, family, organizational, industrial, or community issues; students; trainees; supervisees; employees; business partners; business competitors; colleagues; employers; third party payers; and, the general public.

In these contacts, psychologists accept as fundamental the principle of respect for the dignity of persons; that is, the belief that each person should be treated primarily as a person or an end in him/herself, not as an object or a means to an end. In so doing, psychologists acknowledge that all persons have a right to have their innate worth as human beings appreciated and that this worth is not dependent upon their culture, nationality, ethnicity, colour, race, religion, sex, gender, marital status, sexual orientation, physical or mental abilities, age, socio-economic status, or any other preference or personal characteristic, condition, or status.

Although psychologists have a responsibility to respect the dignity of all persons with whom they come in contact in their role as psychologists, the nature of their contract with society demands that their greatest responsibility be to those persons in the most vulnerable position. Normally, persons directly receiving or involved in the psychologist's activities are in such a position (e.g., research participants, clients, students). This responsibility is almost always greater than their responsibility to those indirectly involved (e.g., employers, third party payers, the general public).

Adherence to the concept of moral rights is an essential component of respect for the dignity of persons. Rights to privacy, self-determination, personal liberty, and natural justice are of particular importance to psychologists, and they have a responsibility to protect and promote these rights in all of their activities. As such, psychologists have a responsibility to develop and follow procedures for informed consent, confidentiality, fair treatment, and due process that are consistent with those rights.

As individual rights exist within the context of the rights of others and of responsible caring (see Principle II), there might be circumstances in which the possibility of serious detrimental consequences to themselves or others, a diminished capacity to be autonomous, or a court order, would disallow some aspects of the rights to privacy, self-determination, and personal liberty. Indeed, such circumstances might be serious enough to create a duty to warn or protect others (see Standards I.45 and II.39). However, psychologists still have a responsibility to respect the rights of the person(s) involved to the greatest extent possible under the circumstances, and to do what is necessary and reasonable to reduce the need for future disallowances.

Psychologists recognize that, although all persons possess moral rights, the manner in which such rights are promoted, protected, and exercised varies across communities and cultures. For instance, definitions of what is considered private vary, as does the role of families and other community members in personal decision making. In their work, psychologists acknowledge and respect such differences, while guarding against clear violations of moral rights.

In addition, psychologists recognize that as individual, family, group, or community vulnerabilities increase, or as the power of persons to control their environment or their lives decreases, psychologists have an increasing responsibility to seek ethical advice and to establish safeguards to protect the rights of the persons involved. For this reason, psychologists consider it their responsibility to increase safeguards to protect and promote the rights of persons involved in their activities proportionate to the degree of dependency and the lack of voluntary initiation. For example, this would mean that there would be more safeguards to protect and promote the rights of fully dependent persons than partially dependent persons, and more safeguards for partially dependent than independent persons.

Respect for the dignity of persons also includes the concept of distributive justice. With respect to psychologists, this concept implies that all persons are entitled to benefit equally from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists, regardless of the person's characteristics, condition, or status. Although individual psychologists might specialize and direct their activities to particular populations, or might decline to engage in activities based on the limits of their competence or acknowledgment of problems in some relationships, psychologists must not exclude persons on a capricious or unjustly discriminatory basis.

By virtue of the social contract that the discipline has with society, psychologists have a higher duty of care to members of society than the general duty of care all members of society have to each other. However, psychologists are entitled to protect themselves from serious violations of their own moral rights (e.g., privacy, personal liberty) in carrying out their work as psychologists.

Ethical Standards

In adhering to the Principle of Respect for the Dignity of Persons, psychologists would:

General respect	I.1	Demonstrate appropriate respect for the knowledge, insight, experience, and areas of expertise of others.

I.2 Not engage publicly (e.g., in public statements, presentations, research reports, or with clients) in degrading comments about others, including demeaning jokes based on such characteristics as culture, nationality, ethnicity, colour, race, religion, sex, gender, or sexual orientation.

I.3 Strive to use language that conveys respect for the dignity of persons as much as possible in all written or oral communication.

I.4 Abstain from all forms of harassment, including sexual harassment.

General rights

I.5 Avoid or refuse to participate in practices disrespectful of the legal, civil, or moral rights of others.

I.6 Refuse to advise, train, or supply information to anyone who, in the psychologist's judgement, will use the knowledge or skills to infringe on human rights.

I.7 Make every reasonable effort to ensure that psychological knowledge is not misused, intentionally or unintentionally, to infringe on human rights.

I.8 Respect the right of research participants, clients, employees, supervisees, students, trainees, and others to safeguard their own dignity.

Non-discrimination

I.9 Not practice, condone, facilitate, or collaborate with any form of unjust discrimination.

I.10 Act to correct practices that are unjustly discriminatory.

I.11 Seek to design research, teaching, practice, and business activities in such a way that they contribute to the fair distribution of benefits to individuals and groups, and that they do not unfairly exclude those who are vulnerable or might be disadvantaged.

Fair treatment/due process

I.12 Work and act in a spirit of fair treatment to others.

I.13 Help to establish and abide by due process or other natural justice procedures for employment, evaluation, adjudication, editorial, and peer review activities.

I.14 Compensate others fairly for the use of their time, energy, and knowledge, unless such compensation is refused in advance.

I.15 Establish fees that are fair in light of the time, energy, and knowledge of the psychologist and any associates or employees, and in light of the market value of the product or service. (Also see Standard IV.12.)

Informed consent

I.16 Seek as full and active participation as possible from others in decisions that affect them, respecting and integrating as much as possible their opinions and wishes.

I.17 Recognize that informed consent is the result of a process of reaching an agreement to work collaboratively, rather than of simply having a consent form signed.

I.18 Respect the expressed wishes of persons to involve others (e.g., family members, community members) in their decision making regarding informed consent. This would include respect for written and clearly expressed unwritten advance directives.

I.19 Obtain informed consent from all independent and partially dependent persons for any psychological services provided to them except in circumstances of urgent need (e.g., disaster or other crisis). In urgent circumstances, psychologists would proceed with the assent of such persons, but fully informed consent would be obtained as soon as possible. (Also see Standard I.29.)

I.20 Obtain informed consent for all research activities that involve obtrusive measures, invasion of privacy, more than minimal risk of harm, or any attempt to change the behaviour of research participants.

I.21 Establish and use signed consent forms that specify the dimensions of informed consent or that acknowledge that such dimensions have been explained and are understood, if such forms are required by law or if such forms are desired by the psychologist, the person(s) giving consent, or the organization for whom the psychologist works.

I.22 Accept and document oral consent, in situations in which signed consent forms are not acceptable culturally or in which there are other good reasons for not using them.

I.23 Provide, in obtaining informed consent, as much information as reasonable or prudent persons would want to know before making a decision or consenting to the activity. The psychologist would relay this information in language that the persons understand (including providing translation into another language, if necessary) and would take whatever reasonable steps are needed to ensure that the information was, in fact, understood.

I.24 Ensure, in the process of obtaining informed consent, that at least the following points are understood: purpose and nature of the activity; mutual responsibilities; confidentiality protections and limitations; likely benefits and risks; alternatives; the likely consequences of non-action; the option to refuse or withdraw at any time, without prejudice; over what period of time the consent applies; and, how to rescind consent if desired. (Also see Standards III.23–30.)

I.25 Provide new information in a timely manner, whenever such information becomes available and is significant enough that it reasonably could be seen as relevant to the original or ongoing informed consent.

I.26 Clarify the nature of multiple relationships to all concerned parties before obtaining consent, if providing services to or conducting research at the request or for the use of third parties. This would include, but not be limited to: the purpose of the service or research; the reasonably anticipated use that will be made of information collected; and, the limits on confidentiality. Third parties may include schools, courts, government agencies, insurance companies, police, and special funding bodies.

Freedom of consent

I.27 Take all reasonable steps to ensure that consent is not given under conditions of coercion, undue pressure, or undue reward. (Also see Standard III.32.)

I.28 Not proceed with any research activity, if consent is given under any condition of coercion, undue pressure, or undue reward. (Also see Standard III.32.)

I.29 Take all reasonable steps to confirm or re-establish freedom of consent, if consent for service is given under conditions of duress or conditions of extreme need.

I.30 Respect the right of persons to discontinue participation or service at any time, and be responsive to non-verbal indications of a desire to discontinue if a person has difficulty with verbally communicating such a desire (e.g., young children, verbally disabled persons) or, due to culture, is unlikely to communicate such a desire orally.

Protections for vulnerable persons

I.31 Seek an independent and adequate ethical review of human rights issues and protections for any research involving members of vulnerable groups, including persons of diminished capacity to give informed consent, before making a decision to proceed.

I.32 Not use persons of diminished capacity to give informed consent in research studies, if the research involved may be carried out equally well with persons who have a fuller capacity to give informed consent.

I.33 Seek to use methods that maximize the understanding and ability to consent of persons of diminished capacity to give informed consent, and that reduce the need for a substitute decision maker.

I.34 Carry out informed consent processes with those persons who are legally responsible or appointed to give informed consent on behalf of persons not competent to consent on their own behalf, seeking to ensure respect for any previously expressed preferences of persons not competent to consent.

I.35 Seek willing and adequately informed participation from any person of diminished capacity to give informed consent, and proceed without this assent only if the service or research activity is considered to be of direct benefit to that person.

I.36 Be particularly cautious in establishing the freedom of consent of any person who is in a dependent relationship to the psychologist (e.g., student, employee). This may include, but is not limited to, offering that person an alternative activity to fulfill their educational or employment goals, or offering a range of research studies or experience opportunities from which the person can select, none of which is so onerous as to be coercive.

Privacy

I.37 Seek and collect only information that is germane to the purpose(s) for which consent has been obtained.

I.38 Take care not to infringe, in research, teaching, or service activities, on the personally, developmentally, or culturally defined private space of individuals or groups, unless clear permission is granted to do so.

I.39 Record only that private information necessary for the provision of continuous, coordinated service, or for the goals of the particular research study being conducted, or that is required or justified by law. (Also see Standards IV.17 and IV.18.)

I.40 Respect the right of research participants, employees, supervisees, students, and trainees to reasonable personal privacy.

I.41 Collect, store, handle, and transfer all private information, whether written or unwritten (e.g., communication during service provision, written records, e-mail or fax communication, computer files, video-tapes), in a way that attends to the needs for privacy and security. This would include having adequate plans for records in circumstances of one's own serious illness, termination of employment, or death.

I.42 Take all reasonable steps to ensure that records over which they have control remain personally identifiable only as long as necessary in the interests of those to whom they refer and/or to the research project for which they were collected, or as required or justified by law (e.g., the possible need to defend oneself against future allegations), and render anonymous or destroy any records under their control that no longer need to be personally identifiable. (Also see Standards IV.17 and IV.18.)

Confidentiality

I.43 Be careful not to relay information about colleagues, colleagues' clients, research participants, employees, supervisees, students, trainees, and members of organizations, gained in the process of their activities as psychologists, that the psychologist has reason to believe is considered confidential by those persons, except as required or justified by law. (Also see Standards IV.17 and IV.18.)

I.44 Clarify what measures will be taken to protect confidentiality, and what responsibilities family, group, and community members have for the protection of each other's confidentiality, when engaged in services to or research with individuals, families, groups, or communities.

I.45 Share confidential information with others only with the informed consent of those involved, or in a manner that the persons involved cannot be identified, except as required or justified by law, or in circumstances of actual or possible serious physical harm or death. (Also see Standards II.39, IV.17, and IV.18.)

Extended responsibility

I.46 Encourage others, in a manner consistent with this *Code,* to respect the dignity of persons and to expect respect for their own dignity.

I.47 Assume overall responsibility for the scientific and professional activities of their assistants, employees, students, supervisees, and trainees with regard to Respect for the Dignity of Persons, all of whom, however, incur similar obligations.

PRINCIPLE II: RESPONSIBLE CARING

Values Statement

A basic ethical expectation of any discipline is that its activities will benefit members of society or, at least, do no harm. Therefore, psychologists demonstrate an active concern for the welfare of any individual, family, group, or community with whom they relate in their role as psychologists. This concern includes both those directly involved and those indirectly involved in their activities. However, as with Principle I, psychologists' greatest responsibility is to protect the welfare of those in the most vulnerable position. Normally, persons directly involved in their activities (e.g., research participants, clients, students) are in such a position. Psychologists' responsibility to those indirectly involved (e.g., employers, third party payers, the general public) normally is secondary.

As persons usually consider their own welfare in their personal decision making, obtaining informed consent (see Principle I) is one of the best methods for ensuring that their welfare will be protected. However, it is only when such consent is combined with the responsible caring of the psychologist that there is considerable ethical protection of the welfare of the person(s) involved.

Responsible caring leads psychologists to take care to discern the potential harm and benefits involved, to predict the likelihood of their occurrence, to proceed only if the potential benefits outweigh the potential harms, to develop and use methods that will minimize harms and maximize benefits, and to take responsibility for correcting clearly harmful effects that have occurred as a direct result of their research, teaching, practice, or business activities.

In order to carry out these steps, psychologists recognize the need for competence and self-knowledge. They consider incompetent action to be unethical per se, as it is unlikely to be of benefit and likely to be harmful. They engage only in those activities in which they have competence or for which they are receiving supervision, and they perform their activities as competently as possible. They acquire, contribute to, and use the existing knowledge most relevant to the best interests of those concerned. They also engage in self-reflection regarding how their own values, attitudes, experiences, and social context (e.g., culture, ethnicity, colour, religion, sex, gender, sexual orientation, physical and mental abilities, age, and socio-economic status) influence their actions, interpretations, choices, and recommendations. This is done with the intent of increasing the probability that their activities will benefit and not harm the individuals, families, groups, and communities to whom they relate in their role as psychologists. Psychologists define harm and benefit in terms of both physical and psychological dimensions. They are concerned about such factors as: social, family, and community relationships; personal and cultural identity; feelings of self-worth, fear, humiliation, interpersonal trust, and cynicism; self-knowledge and general knowledge; and, such factors as physical safety, comfort, pain, and injury. They are concerned about immediate, short-term, and long-term effects.

Responsible caring recognizes and respects (e.g., through obtaining informed consent) the ability of individuals, families, groups, and communities to make decisions for themselves and to care for themselves and each other. It does not replace or undermine such ability, nor does it substitute one person's opinion about what is in the best interests of another person for that other person's competent decision making. However, psychologists recognize that, as vulnerabilities increase or as power to control one's own life decreases, psychologists have an increasing responsibility to protect the well-being of the individual, family, group, or community involved. For this reason, as in Principle I, psychologists consider it their responsibility to increase safeguards proportionate to the degree of dependency and the lack of voluntary initiation on the part of the persons involved. However, for Principle II, the safeguards are for the well-being of persons rather than for the rights of persons.

Psychologists' treatment and use of animals in their research and teaching activities are also a component of responsible caring. Although animals do not have the same moral rights as persons (e.g., privacy), they do have the right to be treated humanely and not to be exposed to unnecessary discomfort, pain, or disruption.

By virtue of the social contract that the discipline has with society, psychologists have a higher duty of care to members of society than the general duty of care all members of society have to each other. However, psychologists are entitled to protect their own basic well-being (e.g., physical safety, family relationships) in their work as psychologists.

Ethical Standards

In adhering to the Principle of Responsible Caring, psychologists would:

General caring	II.1	Protect and promote the welfare of clients, research participants, employees, supervisees, students, trainees, colleagues, and others.
	II.2	Avoid doing harm to clients, research participants, employees, supervisees, students, trainees, colleagues, and others.
	II.3	Accept responsibility for the consequences of their actions.
	II.4	Refuse to advise, train, or supply information to anyone who, in the psychologist's judgment, will use the knowledge or skills to harm others.
	II.5	Make every reasonable effort to ensure that psychological knowledge is not misused, intentionally or unintentionally, to harm others.
Competence and self-knowledge	II.6	Offer or carry out (without supervision) only those activities for which they have established their competence to carry them out to the benefit of others.
	II.7	Not delegate activities to persons not competent to carry them out to the benefit of others.
	II.8	Take immediate steps to obtain consultation or to refer a client to a colleague or other appropriate professional, whichever is more likely to result in providing the client with competent service, if it becomes apparent that a client's problems are beyond their competence.
	II.9	Keep themselves up to date with a broad range of relevant knowledge, research methods, and techniques, and their impact on

persons and society, through the reading of relevant literature, peer consultation, and continuing education activities, in order that their service or research activities and conclusions will benefit and not harm others.

II.10 Evaluate how their own experiences, attitudes, culture, beliefs, values, social context, individual differences, specific training, and stresses influence their interactions with others, and integrate this awareness into all efforts to benefit and not harm others.

II.11 Seek appropriate help and/or discontinue scientific or professional activity for an appropriate period of time, if a physical or psychological condition reduces their ability to benefit and not harm others.

II.12 Engage in self-care activities that help to avoid conditions (e.g., burnout, addictions) that could result in impaired judgment and interfere with their ability to benefit and not harm others.

Risk/benefit analysis

II.13 Assess the individuals, families, groups, and communities involved in their activities adequately enough to ensure that they will be able to discern what will benefit and not harm the persons involved.

II.14 Be sufficiently sensitive to and knowledgeable about individual, group, community, and cultural differences and vulnerabilities to discern what will benefit and not harm persons involved in their activities.

II.15 Carry out pilot studies to determine the effects of all new procedures and techniques that might carry more than minimal risk, before considering their use on a broader scale.

II.16 Seek an independent and adequate ethical review of the balance of risks and potential benefits of all research and new interventions that involve procedures of unknown consequence, or where pain, discomfort, or harm are possible, before making a decision to proceed.

II.17 Not carry out any scientific or professional activity unless the probable benefit is proportionately greater than the risk involved.

Maximize benefit

II.18 Provide services that are coordinated over time and with other service providers, in order to avoid duplication or working at cross purposes.

II.19 Create and maintain records relating to their activities that are sufficient to support continuity and appropriate coordination of their activities with the activities of others.

II.20 Make themselves aware of the knowledge and skills of other disciplines (e.g., law, medicine, business administration) and advise the use of such knowledge and skills, where relevant to the benefit of others.

II.21 Strive to provide and/or obtain the best possible service for those needing and seeking psychological service. This may include, but is not limited to: selecting interventions that are relevant to the needs and characteristics of the client and that have reasonable theoretical or empirically-supported efficacy in light of those needs and characteristics; consulting with, or including in service delivery, persons relevant to the culture or belief systems of those served; advocating on behalf of the client; and, recommending professionals other than psychologists when appropriate.

II.22 Monitor and evaluate the effect of their activities, record their findings, and communicate new knowledge to relevant others.

II.23 Debrief research participants in such a way that the participants' knowledge is enhanced and the participants have a sense of contribution to knowledge. (Also see Standards III.26 and III.27.)

II.24 Perform their teaching duties on the basis of careful preparation, so that their instruction is current and scholarly.

II.25 Facilitate the professional and scientific development of their employees, supervisees, students, and trainees by ensuring that these persons understand the values and ethical prescriptions of the discipline, and by providing or arranging for adequate working conditions, timely evaluations, and constructive consultation and experience opportunities.

II.26 Encourage and assist students in publication of worthy student papers.

Minimize harm

II.27 Be acutely aware of the power relationship in therapy and, therefore, not encourage or engage in sexual intimacy with therapy clients, neither during therapy, nor for that period of time following therapy during which the power relationship reasonably could be expected to influence the client's personal decision making. (Also see Standard III.31.)

II.28 Not encourage or engage in sexual intimacy with students or trainees with whom the psychologist has an evaluative or other relationship of direct authority. (Also see Standard III.31.)

II.29 Be careful not to engage in activities in a way that could place incidentally involved persons at risk.

II.30 Be acutely aware of the need for discretion in the recording and communication of information, in order that the information not be misinterpreted or misused to the detriment of others. This includes, but is not limited to: not recording information that could lead to misinterpretation and misuse; avoiding conjecture; clearly labelling opinion; and, communicating information in language that can be understood clearly by the recipient of the information.

II.31 Give reasonable assistance to secure needed psychological services or activities, if personally unable to meet requests for needed psychological services or activities.

II.32 Provide a client, if appropriate and if desired by the client, with reasonable assistance to find a way to receive needed services in the event that third party payments are exhausted and the client cannot afford the fees involved.

II.33 Maintain appropriate contact, support, and responsibility for caring until a colleague or other professional begins service, if referring a client to a colleague or other professional.

II.34 Give reasonable notice and be reasonably assured that discontinuation will cause no harm to the client, before discontinuing services.

II.35 Screen appropriate research participants and select those least likely to be harmed, if more than minimal risk of harm to some research participants is possible.

II.36 Act to minimize the impact of their research activities on research participants' personalities, or on their physical or mental integrity.

Offset/correct harm

II.37 Terminate an activity when it is clear that the activity carries more than minimal risk of harm and is found to be more harmful than beneficial, or when the activity is no longer needed.

II.38 Refuse to help individuals, families, groups, or communities to carry out or submit to activities that, according to current knowledge, or legal or professional guidelines, would cause serious physical or psychological harm to themselves or others.

II.39 Do everything reasonably possible to stop or offset the consequences of actions by others when these actions are likely to cause serious physical harm or death. This may include reporting to appropriate authorities (e.g., the police), an intended victim, or a family member or other support person who can intervene, and would be done even when a confidential relationship is involved. (Also see Standard I.45.)

II.40 Act to stop or offset the consequences of seriously harmful activities being carried out by another psychologist or member of another discipline, when there is objective information about the activities and the harm, and when these activities have come to their attention outside of a confidential client relationship between themselves and the psychologist or member of another discipline. This may include reporting to the appropriate regulatory body, authority, or committee for action, depending on the psychologist's judgment about the person(s) or body(ies) best suited to stop or offset the harm, and depending upon regulatory requirements and definitions of misconduct.

II.41 Act also to stop or offset the consequences of harmful activities carried out by another psychologist or member of another discipline, when the harm is not serious or the activities appear to be primarily a lack of sensitivity, knowledge, or experience, and when the activities have come to their attention outside of a confidential client relationship between themselves and the psychologist or member of another discipline. This may include talking informally with the psychologist or member of the other discipline, obtaining objective information and, if possible and relevant, the assurance that the harm will discontinue and be corrected. If in a vulnerable position (e.g., employee, trainee) with respect to the other psychologist or member of the other discipline, it may include asking persons in less vulnerable positions to participate in the meeting(s).

II.42 Be open to the concerns of others about perceptions of harm that they as a psychologist might be causing, stop activities that are causing harm, and not punish or seek punishment for those who raise such concerns in good faith.

II.43 Not place an individual, group, family, or community needing service at a serious disadvantage by offering them no service in order to fulfill the conditions of a research design, when a standard service is available.

II.44 Debrief research participants in such a way that any harm caused can be discerned, and act to correct any resultant harm. (Also see Standards III.26 and III.27.)

Care of animals

II.45 Not use animals in their research unless there is a reasonable expectation that the research will increase understanding of the structures and processes underlying behaviour, or increase understanding of the particular animal species used in the study, or result eventually in benefits to the health and welfare of humans or other animals.

II.46 Use a procedure subjecting animals to pain, stress, or privation only if an alternative procedure is unavailable and the goal is justified by its prospective scientific, educational, or applied value.

II.47 Make every effort to minimize the discomfort, illness, and pain of animals. This would include performing surgical procedures only under appropriate anaesthesia, using techniques to avoid infection and minimize pain during and after surgery and, if disposing of experimental animals is carried out at the termination of the study, doing so in a humane way.

II.48 Use animals in classroom demonstrations only if the instructional objectives cannot be achieved through the use of video-tapes, films, or other methods, and if the type of demonstration is warranted by the anticipated instructional gain.

Extended responsibility

II.49 Encourage others, in a manner consistent with this *Code,* to care responsibly.

II.50 Assume overall responsibility for the scientific and professional activities of their assistants, employees, supervisees, students, and trainees with regard to the Principle of Responsible Caring, all of whom, however, incur similar obligations.

PRINCIPLE III: INTEGRITY IN RELATIONSHIPS

Values Statement

The relationships formed by psychologists in the course of their work embody explicit and implicit mutual expectations of integrity that are vital to the advancement of scientific knowledge and to the maintenance of public confidence in the discipline of psychology. These expectations include: accuracy and honesty; straightforwardness and openness; the maximization of objectivity and minimization of bias; and, avoidance of conflicts of interest. Psychologists have a responsibility to meet these expectations and to encourage reciprocity.

In addition to accuracy, honesty, and the obvious prohibitions of fraud or misrepresentation, meeting expectations of integrity is enhanced by self-knowledge and the use of critical analysis. Although it can be argued that science is value-free and impartial, scientists are not. Personal values and self-interest can affect the questions psychologists ask, how they ask those questions, what assumptions they make, their selection of methods, what they observe and what they fail to observe, and how they interpret their data.

Psychologists are not expected to be value-free or totally without self-interest in conducting their activities. However, they are expected to understand how their backgrounds, personal needs, and values interact with their activities, to be open and honest about the influence of such factors, and to be as objective and unbiased as possible under the circumstances.

The values of openness and straightforwardness exist within the context of Respect for the Dignity of Persons (Principle I) and Responsible Caring (Principle II). As such, there will be circumstances in which openness and straightforwardness will need to be tempered. Fully open and straightforward disclosure might not be needed or desired by others and, in some circumstances, might be a risk to their dignity or well-being, or considered culturally inappropriate. In such circumstances, however, psychologists have a responsibility to ensure that their decision not to be fully open or straightforward is justified by higher-order values and does not invalidate any informed consent procedures.

Of special concern to psychologists is the provision of incomplete disclosure when obtaining informed consent for research participation, or temporarily leading research participants to believe that a research project has a purpose other than its actual purpose. These actions sometimes occur in research where full disclosure would be likely to influence the responses of the research participants and thus invalidate the results. Although research that uses such techniques can lead to knowledge that is beneficial, such benefits must be weighed against the research participant's right to self-determination and the importance of public and individual trust in psychology. Psychologists have a serious obligation to avoid as much as possible the use of such research procedures. They also have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects from their use.

As public trust in the discipline of psychology includes trusting that psychologists will act in the best interests of members of the public, situations that present real or potential conflicts of interest are of concern to psychologists. Conflict-of-interest situations are those that can lead to distorted judgment and can motivate psychologists to act in ways that meet their own personal, political, financial, or business interests at the expense of the best interests of members of the public. Although avoidance of all conflicts of interest and potential exploitation of others is not possible, some are of such a high risk to protecting the interests of members of the public and to maintaining the trust of the public, that they are considered never acceptable (see Standard III.31). The risk level of other conflicts of interest (e.g., dual or multiple relationships) might be partially dependent on cultural factors and the specific type of professional relationship (e.g., long-term psychotherapy vs. community development activities). It is the responsibility of psychologists to avoid dual or multiple relationships and other conflicts of interest when appropriate and possible. When such situations cannot be avoided or are inappropriate to avoid, psychologists have a responsibility to declare that they have a conflict of interest, to seek advice, and to establish safeguards to ensure that the best interests of members of the public are protected.

Integrity in relationships implies that psychologists, as a matter of honesty, have a responsibility to maintain competence in any specialty area for which they declare competence, whether or not they are currently practising in that area. It also requires that psychologists, in as much as they present themselves as members and representatives of a specific discipline, have a responsibility to actively rely on and be guided by that discipline and its guidelines and requirements.

Ethical Standards

In adhering to the Principle of Integrity in Relationships, psychologists would:

Accuracy/honesty

III.1 Not knowingly participate in, condone, or be associated with dishonesty, fraud, or misrepresentation.

III.2 Accurately represent their own and their colleagues' credentials, qualifications, education, experience, competence, and affiliations, in all spoken, written, or printed communications, being careful not to use descriptions or information that could be misinterpreted (e.g., citing membership in a voluntary association of psychologists as a testament of competence).

III.3 Carefully protect their own and their colleagues' credentials from being misrepresented by others, and act quickly to correct any such misrepresentation.

III.4 Maintain competence in their declared area(s) of psychological competence, as well as in their current area(s) of activity. (Also see Standard II.9.)

III.5 Accurately represent their own and their colleagues' activities, functions, contributions, and likely or actual outcomes of their activities (including research results) in all spoken, written, or printed communication. This includes, but is not limited to: advertisements of services or products; course and workshop descriptions; academic grading requirements; and, research reports.

III.6 Ensure that their own and their colleagues' activities, functions, contributions, and likely or actual outcomes of their activities (including research results) are not misrepresented by others, and act quickly to correct any such misrepresentation.

III.7 Take credit only for the work and ideas that they have actually done or generated, and give credit for work done or ideas contributed by others (including students), in proportion to their contribution.

III.8 Acknowledge the limitations of their own and their colleagues' knowledge, methods, findings, interventions, and views.

III.9 Not suppress disconfirming evidence of their own and their colleagues' findings and views, acknowledging alternative hypotheses and explanations.

Objectivity/lack of bias

III.10 Evaluate how their personal experiences, attitudes, values, social context, individual differences, stresses, and specific training influence their activities and thinking, integrating this awareness into all attempts to be objective and unbiased in their research, service, and other activities.

III.11 Take care to communicate as completely and objectively as possible, and to clearly differentiate facts, opinions, theories, hypotheses, and ideas, when communicating knowledge, findings, and views.

III.12 Present instructional information accurately, avoiding bias in the selection and presentation of information, and publicly acknowledge any personal values or bias that influence the selection and presentation of information.

III.13 Act quickly to clarify any distortion by a sponsor, client, agency (e.g., news media), or other persons, of the findings of their research.

Straightforwardness/openness

III.14 Be clear and straightforward about all information needed to establish informed consent or any other valid written or unwritten agreement (for example: fees, including any limitations imposed by third-party payers; relevant business policies and practices; mutual concerns; mutual responsibilities; ethical responsibilities of psychologists; purpose and nature of the relationship, including research participation;

alternatives; likely experiences; possible conflicts; possible outcomes; and, expectations for processing, using, and sharing any information generated).

III.15 Provide suitable information about the results of assessments, evaluations, or research findings to the persons involved, if appropriate and if asked. This information would be communicated in understandable language.

III.16 Fully explain reasons for their actions to persons who have been affected by their actions, if appropriate and if asked.

III.17 Honour all promises and commitments included in any written or verbal agreement, unless serious and unexpected circumstances (e.g., illness) intervene. If such circumstances occur, then the psychologist would make a full and honest explanation to other parties involved.

III.18 Make clear whether they are acting as private citizens, as members of specific organizations or groups, or as representatives of the discipline of psychology, when making statements or when involved in public activities.

III.19 Carry out, present, and discuss research in a way that is consistent with a commitment to honest, open inquiry, and to clear communication of any research aims, sponsorship, social context, personal values, or financial interests that might affect or appear to affect the research.

III.20 Submit their research, in some accurate form and within the limits of confidentiality, to persons with expertise in the research area, for their comments and evaluations, prior to publication or the preparation of any final report.

III.21 Encourage and not interfere with the free and open exchange of psychological knowledge and theory between themselves, their students, colleagues, and the public.

III.22 Make no attempt to conceal the status of a trainee and, if a trainee is providing direct client service, ensure that the client is informed of that fact.

Avoidance of incomplete disclosure

III.23 Not engage in incomplete disclosure, or in temporarily leading research participants to believe that a research project or some aspect of it has a different purpose, if there are alternative procedures available or if the negative effects cannot be predicted or offset.

III.24 Not engage in incomplete disclosure, or in temporarily leading research participants to believe that a research project or some aspect of it has a different purpose, if it would interfere with the person's understanding of facts that clearly might influence a decision to give adequately informed consent (e.g., withholding information about the level of risk, discomfort, or inconvenience).

III.25 Use the minimum necessary incomplete disclosure or temporary leading of research participants to believe that a research project or some aspect of it has a different purpose, when such research procedures are used.

III.26 Debrief research participants as soon as possible after the participants' involvement, if there has been incomplete disclosure or temporary leading of research participants to believe that a research project or some aspect of it has a different purpose.

III.27 Provide research participants, during such debriefing, with a clarification of the nature of the study, seek to remove any misconceptions that might have arisen, and seek to re-establish any trust that might have been lost, assuring the participants that the research procedures were neither arbitrary nor capricious, but necessary for scientifically valid findings. (Also see Standards II.23 and II.44.)

III.28 Act to re-establish with research participants any trust that might have been lost due to the use of incomplete disclosure or temporarily leading research participants to believe that the research project or some aspect of it had a different purpose.

III.29 Give a research participant the option of removing his or her data, if the research participant expresses concern during the debriefing about the incomplete disclosure or the temporary leading of the research participant to believe that the research project or some aspect of it had a different purpose, and if removal of the data will not compromise the validity of the research design and hence diminish the ethical value of the participation of the other research participants.

III.30 Seek an independent and adequate ethical review of the risks to public or individual trust and of safeguards to protect such trust for any research that plans to provide incomplete disclosure or temporarily lead research participants to believe that the research project or some aspect of it has a different purpose, before making a decision to proceed.

Avoidance of conflict of interest

III.31 Not exploit any relationship established as a psychologist to further personal, political, or business interests at the expense of the best interests of their clients, research participants, students, employers, or others. This includes, but is not limited to: soliciting clients of one's employing agency for private practice; taking advantage of trust or dependency to encourage or engage in sexual intimacies (e.g., with clients not included in Standard II.27, with clients' partners or relatives, with students or trainees not included in Standard II.28, or with research participants); taking advantage of trust or dependency to frighten clients into receiving services; misappropriating students' ideas, research or work; using the resources of one's employing institution for purposes not agreed to; giving or receiving kickbacks or bonuses for referrals; seeking or accepting loans or investments from clients; and, prejudicing others against a colleague for reasons of personal gain.

III.32 Not offer rewards sufficient to motivate an individual or group to participate in an activity that has possible or known risks to themselves or others. (Also see Standards I.27, I.28, II.2, and II.49.)

III.33 Avoid dual or multiple relationships (e.g. with clients, research participants, employees, supervisees, students, or trainees) and other situations that might present a conflict of interest or that might reduce their ability to be objective and unbiased in their determinations of what might be in the best interests of others.

III.34 Manage dual or multiple relationships that are unavoidable due to cultural norms or other circumstances in such a manner that bias, lack of objectivity, and risk of exploitation are minimized. This might include obtaining ongoing supervision or consultation for the duration of the dual or multiple relationship, or involving a third party in obtaining consent (e.g., approaching a client or employee about becoming a research participant).

III.35 Inform all parties, if a real or potential conflict of interest arises, of the need to resolve the situation in a manner that is consistent with Respect for the Dignity of Persons (Principle I) and Responsible Caring (Principle II), and take all reasonable steps to resolve the issue in such a manner.

Reliance on the discipline

III.36 Familiarize themselves with their discipline's rules and regulations, and abide by them, unless abiding by them would be seriously detrimental to the rights or welfare of others as demonstrated in the Principles of Respect for the Dignity of Persons or Responsible Caring. (See Standards IV.17 and IV.18 for guidelines regarding the resolution of such conflicts.)

III.37 Familiarize themselves with and demonstrate a commitment to maintaining the standards of their discipline.

III.38 Seek consultation from colleagues and/or appropriate groups and committees, and give due regard to their advice in arriving at a responsible decision, if faced with difficult situations.

Extended responsibility

III.39 Encourage others, in a manner consistent with this *Code,* to relate with integrity.

III.40 Assume overall responsibility for the scientific and professional activities of their assistants, employees, supervisees, students, and trainees with regard to the Principle of Integrity in Relationships, all of whom, however, incur similar obligations.

PRINCIPLE IV: RESPONSIBILITY TO SOCIETY

Values Statement

Psychology functions as a discipline within the context of human society.[2] Psychologists, both in their work and as private citizens, have responsibilities to the societies in which they live and work, such as the neighbourhood or city, and to the welfare of all human beings in those societies.

Two of the legitimate expectations of psychology as a science and a profession are that it will increase knowledge and that it will conduct its affairs in such ways that it will promote the welfare of all human beings.

Freedom of enquiry and debate (including scientific and academic freedom) is a foundation of psychological education, science, and practice. In the context of society, the above expectations imply that psychologists will exercise this freedom through the use of activities and methods that are consistent with ethical requirements.

The above expectations also imply that psychologists will do whatever they can to ensure that psychological knowledge, when used in the development of social structures and policies, will be used for beneficial purposes, and that the discipline's own structures and policies will support those beneficial purposes. Within the context of this document, social structures and policies that have beneficial purposes are defined as those that more readily support and reflect respect for the dignity of persons, responsible caring, integrity in relationships, and responsibility to society. If psychological knowledge or structures are used against these purposes, psychologists have an ethical responsibility to try to draw attention to and correct the misuse. Although this is a collective responsibility, those psychologists having direct involvement in the structures of the discipline, in social development, or in the theoretical or research data base that is being used (e.g., through research, expert testimony, or policy advice) have the greatest responsibility to act. Other psychologists must decide for themselves the most appropriate and beneficial use of their time and talents to help meet this collective responsibility.

In carrying out their work, psychologists acknowledge that many social structures have evolved slowly over time in response to human need and are valued by the societies that have developed them. In such circumstances, psychologists convey respect for such social structures and avoid unwarranted or unnecessary disruption. Suggestions for and action toward changes or enhancement of such structures are carried out through processes that seek to achieve a consensus within those societies and/or through democratic means.

On the other hand, if structures or policies seriously ignore or oppose the principles of respect for the dignity of persons, responsible caring, integrity in relationships, or responsibility to society, psychologists involved have a responsibility to speak out in a manner consistent with the principles of this *Code*, and advocate for appropriate change to occur as quickly as possible.

In order to be responsible and accountable to society, and to contribute constructively to its ongoing development, psychologists need to be willing to work in partnership with others, be self-reflective, and be open to external suggestions and criticisms about the place of the discipline of psychology in society. They need to engage in even-tempered observation and interpretation of the effects of societal structures and policies, and their process of change, developing the ability of psychologists to increase the beneficial use of psychological knowledge and structures, and avoid their misuse. The discipline needs to be willing to set high standards for its members, to do what it can to assure that such standards are met, and to support its members in their attempts to maintain the standards. Once again, individual psychologists must decide for themselves the most appropriate and beneficial use of their time and talents in helping to meet these collective responsibilities.

Ethical Standards

In adhering to the Principle of Responsibility to Society, psychologists would:

Development of knowledge

IV.1 Contribute to the discipline of psychology and of society's understanding of itself and human beings generally, through free enquiry and the acquisition, transmission, and expression of knowledge and ideas, unless such activities conflict with other basic ethical requirements.

IV.2 Not interfere with, or condone interference with, free enquiry and the acquisition, transmission, and expression of knowledge and ideas that do not conflict with other basic ethical requirements.

IV.3 Keep informed of progress in their area(s) of psychological activity, take this progress into account in their work, and try to make their own contributions to this progress.

Beneficial activities

IV.4 Participate in and contribute to continuing education and the professional and scientific growth of self and colleagues.

IV.5 Assist in the development of those who enter the discipline of psychology by helping them to acquire a full understanding of their ethical responsibilities, and the needed competencies of their chosen area(s), including an understanding of critical analysis and of the variations, uses, and possible misuses of the scientific paradigm.

IV.6 Participate in the process of critical self-evaluation of the discipline's place in society, and in the development and implementation of structures and procedures that help the discipline to contribute to beneficial societal functioning and changes.

IV.7 Provide and/or contribute to a work environment that supports the respectful expression of ethical concern or dissent, and the constructive resolution of such concern or dissent.

IV.8 Engage in regular monitoring, assessment, and reporting (e.g., through peer review, and in programme reviews, case management reviews, and reports of one's own research) of their ethical practices and safeguards.

IV.9 Help develop, promote, and participate in accountability processes and procedures related to their work.

IV.10 Uphold the discipline's responsibility to society by promoting and maintaining the highest standards of the discipline.

IV.11 Protect the skills, knowledge, and interpretations of psychology from being misused, used incompetently, or made useless (e.g., loss of security of assessment techniques) by others.

IV.12 Contribute to the general welfare of society (e.g., improving accessibility of services, regardless of ability to pay) and/or to the general welfare of their discipline, by offering a portion of their time to work for which they receive little or no financial return.

IV.13 Uphold the discipline's responsibility to society by bringing incompetent or unethical behaviour, including misuses of psychological knowledge and techniques, to the attention of appropriate authorities, committees, or regulatory bodies, in a manner consistent with the ethical principles of this *Code,* if informal resolution or correction of the situation is not appropriate or possible.

IV.14 Enter only into agreements or contracts that allow them to act in accordance with the ethical principles and standards of this *Code.*

Respect for society

IV.15 Acquire an adequate knowledge of the culture, social structure, and customs of a community before beginning any major work there.

IV.16 Convey respect for and abide by prevailing community mores, social customs, and cultural expectations in their scientific and professional activities, provided that this does not contravene any of the ethical principles of this *Code.*

IV.17 Familiarize themselves with the laws and regulations of the societies in which they work, especially those that are related to their activities as psychologists, and abide by them. If those laws or regulations seriously conflict with the ethical principles contained herein, psychologists would do whatever they could to uphold the ethical principles. If upholding the ethical principles could result in serious personal consequences (e.g., jail or physical harm), decision for final action would be considered a matter of personal conscience.

IV.18 Consult with colleagues, if faced with an apparent conflict between abiding by a law or regulation and following an ethical principle, unless in an emergency, and seek consensus as to the most ethical course of action and the most responsible, knowledgeable, effective, and respectful way to carry it out.

Development of society

IV.19 Act to change those aspects of the discipline of psychology that detract from beneficial societal changes, where appropriate and possible.

IV.20 Be sensitive to the needs, current issues, and problems of society, when determining research questions to be asked, services to be developed, content to be taught, information to be collected, or appropriate interpretation of results or findings.

IV.21 Be especially careful to keep well informed of social issues through relevant reading, peer consultation, and continuing education, if their work is related to societal issues.

IV.22 Speak out, in a manner consistent with the four principles of this *Code*, if they possess expert knowledge that bears on important societal issues being studied or discussed.

IV.23 Provide thorough discussion of the limits of their data with respect to social policy, if their work touches on social policy and structure.

IV.24 Consult, if feasible and appropriate, with groups, organizations, or communities being studied, in order to increase the accuracy of interpretation of results and to minimize risk of misinterpretation or misuse.

IV.25 Make themselves aware of the current social and political climate and of previous and possible future societal misuses of psychological knowledge, and exercise due discretion in communicating psychological information (e.g., research results, theoretical knowledge), in order to discourage any further misuse.

IV.26 Exercise particular care when reporting the results of any work regarding vulnerable groups, ensuring that results are not likely to be misinterpreted or misused in the development of social policy, attitudes, and practices (e.g., encouraging manipulation of vulnerable persons or reinforcing discrimination against any specific population).

IV.27 Not contribute to nor engage in research or any other activity that contravenes international humanitarian law, such as the development of methods intended for use in the torture of persons, the development of prohibited weapons, or destruction of the environment.

IV.28 Provide the public with any psychological knowledge relevant to the public's informed participation in the shaping of social policies and structures, if they possess expert knowledge that bears on the social policies and structures.

IV.29 Speak out and/or act, in a manner consistent with the four principles of this *Code,* if the policies, practices, laws, or regulations of the social structure within which they work seriously ignore or contradict any of the principles of this *Code.*

Extended responsibility

IV.30 Encourage others, in a manner consistent with this *Code,* to exercise responsibility to society.

IV.31 Assume overall responsibility for the scientific and professional activities of their assistants, employees, supervisees, students, and trainees with regard to the Principle of Responsibility to Society, all of whom, however, incur similar obligations.

Notes

1. Adapted from: Canadian Psychological Association. (1985). *Guidelines for the elimination of sexual harassment.* Ottawa, Author.
2. *Society* is used here in the broad sense of a group of persons living as members of one or more human communities, rather than in the limited sense of state or government.

APPENDIX C

American Psychological Association Committee on Legal Issues

Strategies for Private Practitioners Coping with Subpoenas or Compelled Testimony for Client Records or Test Data

Psychologists have numerous ethical, professional, and legal obligations regarding the release of client records, test data, and other information in the legal context. The demands of the legal system sometimes conflict with psychologists' ethical obligations to maintain confidentiality of client records, to protect the integrity and security of test materials, and to avoid misuse of assessment techniques and data. This article identifies legal issues that may arise when private practitioners are faced with subpoenas or compelled court testimony for client records or test data and suggests strategies that might be considered in the event such a subpoena or demand is received.

Keywords: subpoenas, legal and ethical issues, responding to court order, release of client records, test disclosure

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Committee on Legal Issues, American Psychological Association. (2006). Strategies for private practitioners coping with subpoenas or compelled testimony for client records or test data. *Professional Psychology: Research and Practice, 37*(2), 215–222.

THIS DOCUMENT DOES NOT PROVIDE LEGAL ADVICE, nor is it intended to be or to substitute for the advice of an attorney. Relevant law varies substantially from state to state and context to context. Psychologists receiving a subpoena or other legal process that requires or is likely to require revelation of client records or test data, manuals, protocols, or other test information are encouraged to consult legal counsel, who can review the pertinent law and facts and provide appropriate legal assistance.

THIS DOCUMENT WAS INITIALLY PUBLISHED IN 1996. The current revision was deemed necessary in order to provide updated references to the most recent version of the Ethics Code as well as to laws that have come into effect since the first document was published. The Committee on Legal Issues and the Office of General Counsel wish to thank the following individuals who participated in this revision for their time and effort in drafting and producing this version of the document: Norman Abeles, Glenn A. Ally, Stephen Behnke, Marianne Ernesto, William E. Foote, Julia Ramos-Grenier, Lisa R. Grossman, Billie Hinnefeld, Daniel A. Krauss, Alan Nessman, Antonio E. Puente, and Mark Zelig.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to the Committee on Legal Issues Staff Liaison, Office of General Counsel, Sixth Floor, American Psychological Association, 750 First Street, NE, Washington, DC 20002–4242.

In response to a large number of inquiries by psychologists faced with subpoenas or compelled court testimony concerning client records or test data, manuals, protocols, and other test information, the American Psychological Association's Committee on Legal Issues prepared this article. It identifies legal issues that may arise from such subpoenas and similar legal demands, and it suggests strategies that might be considered in the event such a subpoena or demand is received. This document is not intended to establish any standards of care or conduct for practitioners nor does it establish American Psychological Association (APA) policy or guidelines. Rather, it provides some general information regarding strategies that may be available to psychologists in independent practice for responding to subpoenas or compelled court testimony concerning client records, test data, test manuals, test protocols, or other test information.

As a general principle of law, all citizens are required to provide information necessary for deciding issues before a court. From the perspective of the legal system, the more relevant information available to the trier of fact (i.e., judge or jury), the greater the likelihood of a fair decision being reached.

Statutes, rules of civil and criminal procedure, and rules of evidence have established the procedures for the transmittal of such information. In order to obtain this material, *subpoenas* (legal commands to appear to provide testimony) or *subpoenas duces tecum* (legal commands to appear and bring along specific documents) may be issued. Alternatively, the court may issue a *court order* to provide testimony or produce documents. A subpoena requesting testimony or documents, even if not signed by a judge, requires a timely response, but it may be modified or quashed (i.e., made void or invalid).

It is important to differentiate responding to a subpoena from disclosing confidential information. Unless the issuing attorney or court excuses the psychologist, it will be necessary to respond to a subpoena, that is, to be at a particular place at a particular time (with records, if the subpoena is a subpoena duces tecum). Responding to the subpoena, however, does not necessarily entail disclosing confidential information. In order to disclose confidential information, a psychologist will need to ensure that the conditions for disclosing confidential information, such as the client's consent or a judge's order or other legal mandate, are met, in addition to having a valid subpoena. Thus, although a subpoena requires a response, a subpoena alone will generally not be sufficient to warrant a disclosure of confidential information. However, once a court order for testimony or documents is issued and any attempt (made in a timely manner) to have the court vacate or modify its order has been unsuccessful, a psychologist may be held in contempt of court if he or she fails to comply.

The demands of the legal system sometimes conflict with the responsibility of psychologists to maintain the confidentiality of client records. This responsibility arises from tenets of good clinical practice, ethical standards, professional licensing laws, statutes, and other applicable laws. In many contexts, the client material generated in the course of a professional relationship may also fall under an evidentiary privilege, which protects such information from judicial scrutiny. Most state and federal jurisdictions recognize a psychotherapist–patient privilege that allows the client to prevent confidential material conveyed to a psychotherapist from being communicated to others in legal settings. In most jurisdictions, the privilege belongs to the client, not to the therapist. The psychologist has a responsibility to maintain confidentiality and to assert the psychotherapist–patient privilege unless the client has explicitly waived privilege, unless a legally recognized exception to privilege exists or unless the court orders the psychologist to turn over the client's information. Therapy notes, process notes, client information forms, billing records, and other such information usually may be turned over to the court with an appropriate release by the client or with a court order. Psychological test material presents a more complicated situation because inappropriate disclosure may seriously impair the security and threaten the validity of the test and its value as a measurement tool.

Psychologists have numerous ethical, professional, and legal obligations that touch on the release of client records, test data, and other information in the legal context. Many such obligations may favor disclosure, including, in particular, the general obligation of all citizens to give truthful and complete testimony in courts of law when subpoenaed to do so. But there are often conflicting duties and principles that favor withholding such information. These may include obligations to (a) clients or other individuals who receive treatment and/or are administered psychological tests (e.g., privileged or confidential communications that may include client responses to test items), (b) the public (e.g., to avoid public dissemination of test items, questions, protocols, or other test information that could adversely affect the integrity and continued validity of tests), (c) test publishers (e.g., contractual obligations between the psychologist and test publishers not to disclose test information; obligations under the copyright laws), and (d) other third parties (e.g., employers). Such obligations may, at times, conflict with one another. Under APA's "Ethical Principles of Psychologists and Code of Conduct" (APA, 2002), hereinafter referred to as the APA Ethics Code, psychologists facing a conflict between their ethical and legal responsibilities make known their commitment to the ethics code, take steps to resolve the conflict, and may fulfill their legal obligations if the conflict is unresolvable. For more on these obligations, see Appendix A [at the end of this appendix].

There are specific settings (e.g., educational, institutional, employment) in which the legal or ethical obligations of psychologists as they relate to disclosure of client records or test information present special problems. This article [appendix] does not purport to address disclosure issues in these special contexts, nor does it attempt to resolve dilemmas faced by psychologists in reconciling legal and ethical obligations.

STRATEGIES FOR DEALING WITH SUBPOENAS

Determine Whether the Request for Information Carries the Force of Law

It must first be determined whether a psychologist has, in fact, received a legally valid demand for disclosure of sensitive test data and client records, and consultation with a lawyer may be necessary to make this determination. If a demand is not legally enforceable for any reason, then the psychologist has no legal obligation to comply with it and may have no legal obligation to respond. A subpoena to produce documents generally must allow a sufficient period of time to respond to the demand and provide for some time within which the opposing side may move to quash such a demand. Without this allowed time period, the subpoena may not be valid. Even a demand that claims to be legally enforceable may not be. For example, the court issuing the subpoena may not have jurisdiction over the psychologist or his or her records (e.g., a subpoena issued in one state may not be legally binding on a psychologist residing and working in a different state). Or, the subpoena may not have been properly served to the psychologist (e.g., some states may require service in person or by certified mail or that a subpoena for such records be accompanied by a special court order). It is advisable that a psychologist consult with an attorney in making such a determination.[1] If the psychologist concludes that the demand is legally valid, then some formal response to the attorney or court will be required—either compliance with or opposition to the demand, in whole or in part. A psychologist's obligations in responding to a valid subpoena are not necessarily the same as those under a court order (see section titled "File a Motion to Quash the Subpoena or File a Protective Order" below). The next step, in most cases, may involve contacting the psychologist's client. However, the psychologist may wish to consider grounds for opposing or limiting production of the demanded information before contacting the client so that the client can more fully understand his or her options (see section titled "Possible Grounds for Opposing or Limiting Production of Client Records or Test Data" below).

Contact the Client

The client to whom requested records pertain often has a legally protected interest in preserving the confidentiality of the records. If, therefore, a psychologist receives a subpoena or advance notice that he or she may be required to divulge client records or test data, the psychologist, when appropriate, discusses the implications of the demand with the client (or his or her legal guardian). Also when appropriate and with the client's valid consent, the psychologist may consult with the client's attorney. It is important to recognize, however, that the client's attorney's interests and a psychologist's interests may diverge through the course of legal proceeding, and the psychologist may need to seek independent legal consultation and representation to make sure his or her interests are protected.

The discussion with the client will inform the client which information has been demanded, the purpose of the demand, the entities or individuals to whom the information is to be provided, and the possible scope of further disclosure by those entities or individuals. Following such a discussion, a legally competent client or the client's legal guardian may choose to consent to production of the data. It is safest to have such consent in writing, for clarity and if there is a need for documentation in the future. In some states, consent in writing may be required by law. The client's consent may not, however, resolve the potential confidentiality claims of third parties (such as test publishers). For more information, see APA Ethics Code, Ethical Standards, Section 4 (APA, 2002), and *Standards for Educational and Psychological Testing* (1999).

Negotiate with the Requester

If a client does not consent to release of the requested information, the psychologist (often through counsel) may seek to prevent disclosure through discussions with legal counsel for the requesting party. The psychologist's position in such discussions may be bolstered by legal arguments against disclosure, including the psychologist's duties under rules regarding psychotherapist–patient privilege. These rules often allow the psychologist to assert privilege on behalf of the client in the absence of a specific release or court order. (Some possible arguments are outlined in the section titled "Possible Grounds for Opposing or Limiting Production of Client Records or Test Data" below.) Such negotiations may explore whether there are ways to achieve the requesting party's objectives without divulging confidential information, for example, through disclosure of nonconfidential materials or submission of an affidavit by the psychologist disclosing nonconfidential information. Negotiation may also be used as a strategy to avoid compelled testimony in court or by deposition. In short, negotiation can be explored as a possible means of avoiding the wholesale release of confidential test or client information—release that may not be in the best interests of the client, the public, or the profession and that may not even be relevant to the issues before the court. Such an option could be explored in consultation with the psychologist's attorney or the client's attorney.

Seek Guidance from the Court

If, despite such discussions, the requesting party insists that confidential information or test data be produced, the safest course for the psychologist may be to seek a ruling from the court on whether disclosure is required. The simplest way of proceeding, and perhaps the least costly, may be for the psychologist (or his or her attorney) to write a letter to the court, with a copy to the attorneys for both parties, stating that the psychologist wishes to comply with the law but that he or she is ethically obligated not to produce the confidential records or test data or to testify about them unless compelled to do so by the court or with the consent of the client. In writing such a letter, the psychologist (or his or her lawyer) may request that the court consider the psychologist's obligations to adhere to federal requirements (e.g., the Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to protect the interests of the client, to protect the interests of third parties (e.g., test publishers or others), and to protect the interests of the public in preserving the integrity and continued validity of the tests themselves. This letter may help sensitize the court about the potential adverse effects of dissemination. The letter might also attempt to provide suggestions, such as the following, to the court on ways to minimize the adverse consequences of disclosure if the court is inclined to require production at all:

1. Suggest that the court direct the psychologist to provide test data only to another appropriately qualified psychologist designated by the court or by the party seeking such information.
2. Suggest that the court limit the use of client records or test data to prevent wide dissemination. For example, the court might order that the information be delivered to the court, be kept under seal, be used solely for the purposes of the litigation, and that all copies of the data be returned to the psychologist under seal after the litigation is terminated. The order might also provide that the requester must prevent or limit the disclosure of the information to third parties.
3. Suggest that the court limit the categories of information that must be produced. For example, client records may contain confidential information about a third party, such as a spouse, who may have independent interests in maintaining confidentiality, and such data may be of minimal or no relevance to the issues before the court. The court should limit its production order to exclude such information.
4. Suggest that the court determine for itself, through in camera proceedings (i.e., a nonpublic hearing or a review by the judge in chambers), whether the use of the client records or test data is relevant to the issues before the court or whether it might be insulated from disclosure, in whole or in part, by the therapist–client privilege or another privilege (e.g., attorney–client privilege).
5. Suggest that the court deny or limit the demand because it is unduly burdensome on the psychologist (see, e.g., Federal Rule of Civil Procedure 45[c][1–3]).
6. Suggest that the court shields from production "psychotherapy notes," if the psychologist keeps separate psychotherapy notes as defined by HIPAA privacy regulations. See rule excerpts in Appendix B [at the end of this appendix].

File a Motion to Quash the Subpoena or File a Protective Order

A *motion to quash* is a formal application made to a court or judge for purposes of having a subpoena vacated or declared invalid. Grounds may exist for asserting that the subpoena or request for testimony should be quashed, in whole or in part. For example, the information sought may be protected by the therapist–client privilege and therefore may not be subject to discovery, or it may not be relevant to the issues before the court (see section titled "Possible Grounds for Opposing or Limiting Production of Client Records or Test Data" below). This strategy may be used alone or in combination with a motion for a protective order.

A *motion for a protective order* seeks an order or decree from the court that protects against the untoward consequences of disclosing information. A protective order can be tailored to meet the legitimate interests of the client and of third parties such as test publishers and the public. The focus of this strategy first and foremost is to prevent or limit disclosure and the use of sensitive client and test information. The protective order—and the motion—may include any of the elements listed in the preceding section.

If, because of local procedure or other considerations, guidance cannot be sought through the informal means of a letter to the court, it may be necessary to file a motion seeking to be relieved of the obligations imposed by the demand for production of the confidential records. In many jurisdictions, the possible motions include a motion to quash the subpoena, in whole or in part, or a motion for a protective order. Filing such a motion may require the assistance of counsel, representing either the psychologist or the psychologist's client.

Courts are generally more receptive to a motion to quash or a motion for a protective order if it is filed by the client about whom information is sought (who would be defending his or her own interests) rather than by a psychologist who, in essence, would be seeking to protect the rights of the client or other third parties. The psychologist may wish to determine initially whether the client's lawyer is inclined to seek to quash a subpoena or to seek a protective order and, if so, may wish to provide assistance to the client's attorney in this regard. If the client has refused to consent to disclosure of the information, his or her attorney may be willing to take the lead in opposing the subpoena.

PSYCHOLOGIST'S TESTIMONY

If a psychologist is asked to disclose confidential information during questioning at a deposition, he or she may refuse to answer the question only if the information is privileged. If there is a reasonable basis for asserting a privilege, the psychologist may refuse to provide test data or client records until so ordered by the court. A psychologist who refuses to answer questions without a reasonable basis may be penalized by the court, including the obligation to pay the requesting parties' costs and fees in obtaining court enforcement of the subpoena. For these reasons, it is advisable that a psychologist be represented by his or her own counsel at the deposition. A lawyer may advise the psychologist, on the record, when a question seeks confidential information; such on-the-record advice will help protect the psychologist from the adverse legal consequences of erroneous disclosures or erroneous refusals to disclose. Similarly, if the request for confidential information arises for the first time during courtroom testimony, the psychologist may assert a privilege and refuse to answer unless directed to do so by the court. The law in this area is somewhat unsettled. Thus, it may be advisable for him or her to consult an attorney before testifying.

POSSIBLE GROUNDS FOR OPPOSING OR LIMITING PRODUCTION OF CLIENT RECORDS OR TEST DATA

The following options may or may not be available under the facts of a particular case and/or a particular jurisdiction for resisting a demand to produce confidential information, records, or test data (see Appendix C [at the end of this appendix]):

1. The court does not have jurisdiction over the psychologist, the client records, or the test data, or the psychologist did not receive a legally sufficient demand (e.g., improper service) for production of records or test data testimony.
2. The psychologist does not have custody or control of the records or test data that are sought, because, for example, they belong not to the psychologist but to his or her employer.
3. The therapist–client privilege insulates the records or test data from disclosure. The rationale for the privilege, recognized in many states, is that the openness necessary for effective therapy requires that clients have an expectation that all records of therapy, contents of therapeutic disclosures, and test data will remain confidential. Disclosure would be a serious invasion of the client's privacy. The psychologist is under an ethical obligation to protect the client's reasonable expectations of confidentiality. See APA Ethics Code, Ethical Standards, Section 4 (APA, 2002).[2]
4. The information sought is not relevant to the issues before the court, or the scope of the demand for information is overbroad in reaching information not relevant to the issues before the court, including irrelevant information pertaining to third parties such as a spouse.
5. Public dissemination of test information such as manuals, protocols, and so forth may harm the public interest because it may affect responses of future test populations. This effect could result in the loss of valuable assessment tools to the detriment of both the public and the profession of psychology.
6. Test publishers have an interest in the protection of test information, and the psychologist may have a contractual or other legal obligation

(e.g., copyright laws) not to disclose such information. Such contractual claims, coupled with concerns about test data devolving into the public domain, may justify issuance of a protective order against dissemination of a test instrument or protocols.[3]

7. Psychologists have an ethical obligation to protect the integrity and security of test information and data and to avoid misuse of assessment techniques and data. Psychologists are also ethically obligated to take reasonable steps to prevent others from misusing such information. See APA Ethics Code, Ethical Standards, Section 2 (APA, 2002).
8. Refer to ethical and legal obligations of psychologists as provided for under ethics codes; professional standards; state, federal, or local laws; or regulatory agencies.
9. Some court rules allow the party receiving the subpoena to object to the subpoena's demand, or ask that the demand be limited, on the basis that it imposes an undue burden on the recipient (see, e.g., Federal Rule of Civil Procedure 45[c][1–3]).

Notes

1. Fees for consultation with or representation by an attorney may be substantial. If consultation with an attorney becomes necessary to protect the interests and privileges of the client, then the practitioner may wish to clarify with his or her client who will be responsible for such legal fees.
2. A psychologist's obligation to maintain confidentiality may not apply under certain legally recognized exceptions to the therapist–patient privilege, including, but not limited to, situations such as the following: when child or elder abuse is involved, cases involving involuntary commitment evaluations, court-ordered evaluations, when clients raise their emotional condition as a basis for a legal claim or defense, or when the client presents an imminent danger to himself or herself or the community. Exceptions may depend on jurisdiction and the facts of a particular situation. Thus, the most prudent course of action may be for the psychologist to consult with an attorney.
3. Most test publishers have policies that address the disclosure of test data and materials. Very often, such policies can be found on a test publisher's Web site, along with other information such as terms of purchasing psychological tests, the publisher's position on legal aspects of disclosing test data and test materials, and contact information for the test publisher's privacy officer or general counsel. Reviewing a particular test publisher's Web site can be very helpful when psychologists are considering disclosing test data or test materials, especially when the disclosure potentially involves nonpsychologists. Psychologists should be aware that the information on test publisher's Web sites may or may not be consistent with APA policy, and APA takes no position on the accuracy of legal statements or claims found on such Web sites.

References

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57,* 1060–1073.

Definitions, 45 C.F.R. § 164.501 (2005).

Fed. R. Civ. P. 45(c).

Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104–191, 110 Stat. 1936.

Standards for educational and psychological testing. (1999). Washington, DC: American Psychological Association.

APPENDIX A: EXCERPTS FROM SECTIONS OF THE APA ETHICS CODE (2002)

Section 1. Resolving Ethical Issues

1.02 CONFLICTS BETWEEN ETHICS AND LAW, REGULATIONS, OR OTHER GOVERNING LEGAL AUTHORITY

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to the Ethics Code and take steps to resolve the conflict. If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing legal authority.

Section 2. Competence

2.01 BOUNDARIES OF COMPETENCE

(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure

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Note: From "Ethical Principles of Psychologists and Code of Conduct" by American Psychological Association, 2002, *American Psychologist, 57,* pp. 1063–1064, 1066 –1068, 1071–1072. Copyright 2002 by the American Psychological Association.

the competence of their services, or they make appropriate referrals, except as provided in *Standard 2.02, Providing Services in Emergencies.*

(c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

(d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.

(e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless 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.

(f) When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles.

Section 4. Privacy and Confidentiality

4.01 MAINTAINING CONFIDENTIALITY

Psychologists 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 professional or scientific relationship. (See also *Standard 2.05, Delegation of Work to Others.*)

4.02 DISCUSSING THE LIMITS OF CONFIDENTIALITY

(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also *Standard 3.10, Informed Consent.*)

(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

(c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.

4.04 MINIMIZING INTRUSIONS ON PRIVACY

(a) Psychologists include in written and oral reports and consultations, only information germane to the purpose for which the communication is made.

(b) Psychologists discuss confidential information obtained in their work only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

4.05 DISCLOSURES

(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.

(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (See also *Standard 6.04e, Fees and Financial Arrangements.*)

Section 6. Record Keeping and Fees

6.01 DOCUMENTATION OF PROFESSIONAL AND SCIENTIFIC WORK AND MAINTENANCE OF RECORDS

Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law. (See also *Standard 4.01, Maintaining Confidentiality.*)

6.02 MAINTENANCE, DISSEMINATION, AND DISPOSAL OF CONFIDENTIAL RECORDS OF PROFESSIONAL AND SCIENTIFIC WORK

(a) Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium. (See also *Standards 4.01, Maintaining Confidentiality,* and *6.01, Documentation of Professional and Scientific Work and Maintenance of Records.*)

(b) If confidential information concerning recipients of psychological services is entered into databases or systems of records available to persons whose access has not been consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers.

(c) Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice. (See also *Standards 3.12, Interruption of Psychological Services,* and *10.09, Interruption of Therapy.*)

Section 9. Assessment

9.01 BASES FOR ASSESSMENTS

(a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings. (See also *Standard 2.04, Bases for Scientific and Professional Judgments.*)

(b) Except as noted in 9.01c, psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations. (See also *Standards 2.01, Boundaries of Competence,* and *9.06, Interpreting Assessment Results.*)

(c) When psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations.

9.02 USE OF ASSESSMENTS

(a) Psychologists administer, adapt, score, interpret, or use assessment techniques, interviews, tests, or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.

(b) Psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation.

(c) Psychologists use assessment methods that are appropriate to an individual's language preference and competence, unless the use of an alternative language is relevant to the assessment issues.

9.04 RELEASE OF TEST DATA

(a) The term *test data* refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of *test data.* Pursuant to a client/patient release, psychologists provide test data to the client/ patient or other persons identified in the release. Psychologists may refrain from releasing test data to protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law. (See also *Standard 9.11, Maintaining Test Security.*)

(b) In the absence of a client/patient release, psychologists provide test data only as required by law or court order.

9.06 INTERPRETING ASSESSMENT RESULTS

When interpreting assessment results, including automated interpretations, psychologists take into account the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences, that might affect psychologists' judgments or reduce the accuracy of their interpretations. They indicate any significant limitations of their interpretations. (See also *Standards 2.01b* and *c, Boundaries of Competence,* and *3.01, Unfair Discrimination.*)

9.07 ASSESSMENT BY UNQUALIFIED PERSONS

Psychologists do not promote the use of psychological assessment techniques by unqualified persons, except when such use is conducted for training purposes with appropriate supervision. (See also *Standard 2.05, Delegation of Work to Others.*)

9.09 TEST SCORING AND INTERPRETATION SERVICES

(a) Psychologists who offer assessment or scoring services to other professionals accurately describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use.

(b) Psychologists select scoring and interpretation services (including automated services) on the basis of evidence of the validity of the program and procedures as well as on other appropriate considerations. (See also *Standard 2.01b* and *c, Boundaries of Competence.*)

(c) Psychologists retain responsibility for the appropriate application, interpretation, and use of assessment instruments, whether they score and interpret such tests themselves or use automated or other services.

9.11 MAINTAINING TEST SECURITY

The term *test materials* refers to manuals, instruments, protocols, and test questions or stimuli and does not include *test data* as defined in *Standard 9.04, Release of Test Data.* Psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligations, and in a manner that permits adherence to this Ethics Code.

APPENDIX B: FEDERAL RULES AND REGULATIONS

Excerpt from Code of Federal Regulations,

TITLE 45–PUBLIC WELFARE

SUBTITLE A–DEPARTMENT OF HEALTH AND HUMAN SERVICES

PART 164–SECURITY AND PRIVACY–TABLE OF CONTENTS

Subpart E–Privacy of Individually Identifiable Health Information

Section 164.501 Definitions.

As used in this subpart, the following terms have the following meanings: . . .

Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date . . .

EXCERPT FROM FEDERAL RULES OF CIVIL PROCEDURE

VI. TRIALS

RULE 45. SUBPOENA

. . . (c) Protection of Persons Subject to Subpoenas.

(1) A party or an attorney responsible for the issuance and service of a subpoena shall take reasonable steps to avoid imposing undue burden or expense on a person subject to that subpoena. The court on behalf of which the subpoena was issued shall enforce this duty and impose upon the party or attorney in breach of this duty an appropriate sanction, which may include, but is not limited to, lost earnings and a reasonable attorney's fee.

(2) (A) A person commanded to produce and permit inspection and copying of designated books, papers, documents or tangible things, or inspection of premises need not appear in person at the place of production or inspection unless commanded to appear for deposition, hearing or trial.

(B) Subject to paragraph (d)(2) of this rule, a person commanded to produce and permit inspection and copying may, within 14 days after service of the subpoena or before the time specified for compliance if such time is less than 14 days after service, serve upon the party or attorney designated in the subpoena written objection to inspection or copying of any or all of the designated materials or of the premises. If objection is made, the party serving the subpoena shall not be entitled to inspect and copy the materials or inspect the premises except pursuant to an order of the court by which the subpoena was issued. If objection has been made, the party serving the subpoena may, upon notice to the person commanded to produce, move at any time for an order to compel the production. Such an order to compel production shall protect any person who is not a party or an officer of a party from significant expense resulting from the inspection and copying commanded.

(3) (A) On timely motion, the court by which a subpoena was issued shall quash or modify the subpoena if it

(i) fails to allow reasonable time for compliance;

(ii) requires a person who is not a party or an officer of a party to travel to a place more than 100 miles from the place where that person resides, is employed or regularly transacts business in person, except that, subject to the provisions of clause (c)(3)(B)(iii) of this rule, such a person may in order to attend trial be commanded to travel from any such place within the state in which the trial is held, or

(iii) requires disclosure of privileged or other protected matter and no exception or waiver applies, or

(iv) subjects a person to undue burden.

(B) If a subpoena

(i) requires disclosure of a trade secret or other confidential research, development, or commercial information, or

(ii) requires disclosure of an unretained expert's opinion or information not describing specific events or occurrences in dispute and resulting from the expert's study made not at the request of any party, or

(iii) requires a person who is not a party or an officer of a party to incur substantial expense to travel more than 100 miles to attend trial, the court may, to protect a person subject to or affected by the subpoena, quash or modify the subpoena or, if the party in whose behalf the subpoena is issued shows a substantial need for the testimony or material that cannot be otherwise met without undue hardship and assures that the person to whom the subpoena is addressed will be reasonably compensated, the court may order appearance or production only upon specified conditions. . . .

APPENDIX C: DISCLOSURE ISSUES DIAGRAM

The following steps may be taken, as appropriate:

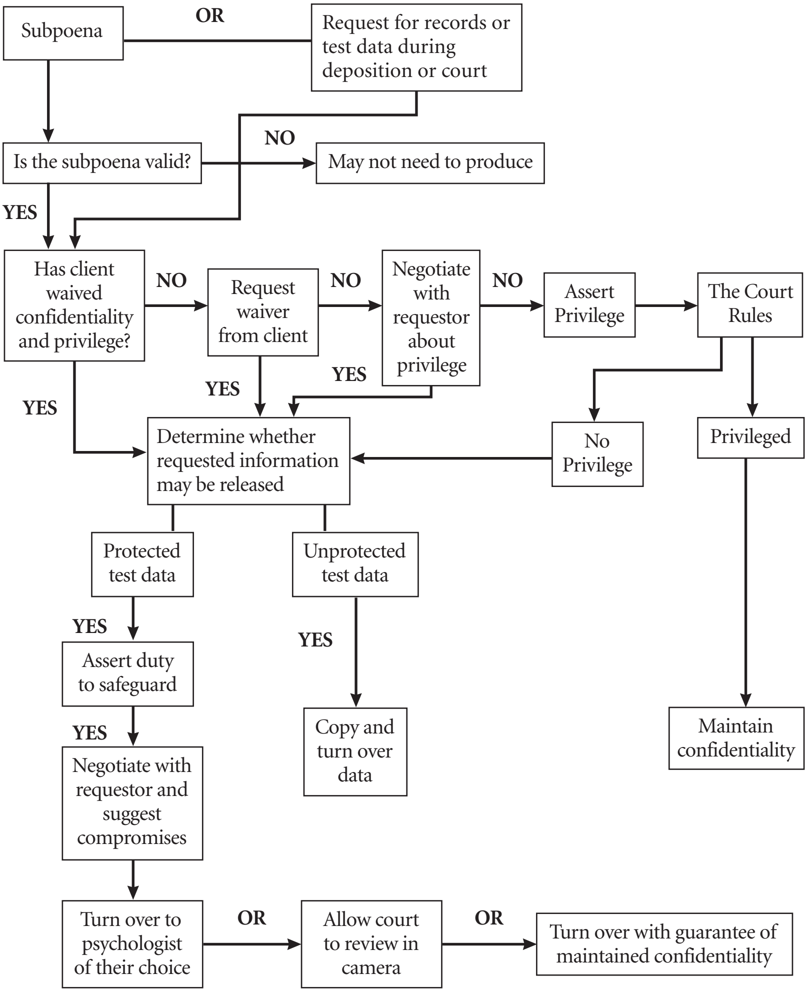
Disclosure Issues Diagram
The following steps may be taken, as appropriate:

Figure C1.

APPENDIX D

American Psychological Association Statement on Services by Telephone, Teleconferencing, and Internet

AUTHORS' NOTE: According to Steve Behnke, "The Ethics Committee voted that statements issued under a version of the ethics code are valid only as long as that version is in effect. So with the adoption of the 2002 version, the APA Statement on Services by Telephone, Teleconferencing, and Internet, issued on November 5, 1997, is no longer considered in force. This is not to say it's not a good and valuable statement, and the Ethics Committee may well update it to reflect the current code—it's just to say that with the passing of the code under which it was adopted, it is no longer in force" (personal communication, Steve Behnke, June 4, 2006). We include it in this book because it identifies issues that are helpful for therapists and counselors to consider when thinking through services using telephones, the Internet, and other electronic media.

From APA Statement on Services by Telephone, Teleconferencing, and Internet, by the American Psychological Association, 1997, Washington, DC: American Psychological Association. Copyright 1997 by the APA. Retrieved September 23, 2004, from PsychNET Website: http://www.apa.org/ethics/stmnt01.html.

The American Psychological Association's Ethics Committee issued the following statement on November 5, 1997, based on its 1995 statement on the same topic.

The Ethics Committee can only address the relevance of and enforce the "Ethical Principles of Psychologists and Code of Conduct" and cannot say whether there may be other APA Guidelines that might provide guidance. The Ethics Code is not specific with regard to telephone therapy or teleconferencing or any electronically provided services as such and has no rules prohibiting such services. Complaints regarding such matters would be addressed on a case by case basis.

Delivery of services by such media as telephone, teleconferencing and internet is a rapidly evolving area. This will be the subject of APA task forces and will be considered in future revision of the Ethics Code. Until such time as a more definitive judgment is available, the Ethics Committee recommends that psychologists follow Standard 1.04c, Boundaries of Competence, which indicates that "in those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect patients, clients, students, research participants, and others from harm." Other relevant standards include Assessment (Standards 2.01–2.10), Therapy (4.01–4.09, especially 4.01 Structuring the Relationship and 4.02 Informed Consent to Therapy), and Confidentiality (5.01–5.11). Within the General Standards section, standards with particular relevance are 1.03, Professional and Scientific Relationship; 1.04 (a, b, and c), Boundaries of Competence; 1.06, Basis for Scientific and Professional Judgments; 1.07a, Describing the Nature and Results of Psychological Services; 1.14, Avoiding Harm; and 1.25, Fees and Financial Arrangements. Standards under Advertising, particularly 3.01–3.03 are also relevant.

Psychologists considering such services must review the characteristics of the services, the service delivery method, and the provisions for confidentiality. Psychologists must then consider the relevant ethical standards and other requirements, such as licensure board rules.

APPENDIX E

Patients' Mental Health Rights

The following "Bill of Rights" was developed by several participating groups, including: American Association for Marriage and Family Therapy; American Counseling Association; the American Family Therapy Academy; American Nurses Association; American Psychiatric Association; American Psychiatric Nurses Association; American Psychological Association; Clinical Social Work Federation; and National Association of Social Workers. (The participating and support groups are listed at the end, as on the Web site.)

YOUR MENTAL HEALTH RIGHTS

Right to Know

BENEFITS

Individuals have the right to be provided information from the purchasing entity (such as the employer or union or public purchaser) and the insurance/third party payer describing the nature and extent of their mental health and

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American Psychological Association. (1997). Mental Health Patient's Bill of Rights. Retrieved from http://www.apa.org/topics/rights/, September 26, 2006. Also available (Bill of Rights, brochures, posters) through (800) 374-2721.

substance abuse treatment benefits. This information should include details on procedures to obtain access to services, on utilization management procedures, and on appeal rights. The information should be presented clearly in writing with language that the individual can understand.

PROFESSIONAL EXPERTISE

Individuals have the right to receive full information from the potential treating professional about that professional's knowledge, skills, preparation, experience, and credentials. Individuals have the right to be informed about the options available for treatment interventions and the effectiveness of the recommended treatment.

CONTRACTUAL LIMITATIONS

Individuals have the right to be informed by the treating professional of any arrangements, restrictions, and/or covenants established between the third party payer and the treating professional that could interfere with or influence treatment recommendations. Individuals have the right to be informed of the nature of information that may be disclosed for the purposes of paying benefits.

APPEALS AND GRIEVANCES

Individuals have the right to receive information about the methods they can use to submit complaints or grievances regarding provision of care by the treating professional to that profession's regulatory board and to the professional association. Individuals have the right to be provided information about the procedures they can use to appeal benefit utilization decisions to the third party payer systems, to the employer or purchasing entity, and to external regulatory entities.

Confidentiality

Individuals have the right to be guaranteed the protection of the confidentiality of their relationship with their mental health and substance abuse professional, except when laws or ethics dictate otherwise. Any disclosure to another party will be time limited and made with the full written, informed consent of the individuals.

Individuals shall not be required to disclose confidential, privileged or other information other than diagnosis, prognosis, type of treatment, time and length of treatment, and cost.

Entities receiving information for the purposes of benefits determination, public agencies receiving information for health care planning, or any other organization with legitimate right to information will maintain clinical information in confidence with the same rigor and be subject to the same penalties for violation as is the direct provider of care.

Information technology will be used for transmission, storage or data management only with methodologies that remove individual identifying information and assure the protection of the individual's privacy. Information should not be transferred, sold, or otherwise utilized.

Choice

Individuals have the right to choose any duly licensed/certified professional for mental health and substance abuse services. Individuals have the right to receive full information regarding the education and training of professionals, treatment options (including risks and benefits), and cost implications to make an informed choice regarding the selection of care deemed appropriate by individual and professional.

Determination of Treatment

Recommendations regarding mental health and substance abuse treatment shall be made only by a duly licensed/certified professional in conjunction with the individual and his or her family as appropriate. Treatment decisions should not be made by third party payers. The individual has the right to make final decisions regarding treatment.

Parity

Individuals have the right to receive benefits for mental health and substance abuse treatment on the same basis as they do for any other illnesses, with the same provisions, co-payments, lifetime benefits, and catastrophic coverage in both insurance and self-funded, self-insured health plans.

Nondiscrimination

Individuals who use mental health and substance abuse benefits shall not be penalized when seeking other health insurance or disability, life, or any other insurance benefit.

Benefit of Usage

The individual is entitled to the entire scope of the benefits within the benefit plan that will address his or her clinical needs.

Benefit Design

Whenever both federal and state law and/or regulations are applicable, the professional and all payers shall use whichever affords the individual the greatest level of protection and access.

Treatment Review

To assure that treatment review processes are fair and valid, individuals have the right to be guaranteed that any review of their mental health and substance abuse treatment shall involve a professional having the training, credentials, and licensure required to provide the treatment in the jurisdiction in which it will be provided. The reviewer should have no financial interest in the decision and is subject to the section on confidentiality.

Accountability

Treating professionals may be held accountable and liable to individuals for any injury caused by gross incompetence or negligence on the part of the professional. The treating professional has the obligation to advocate for and document necessity of care and to advise the individual of options if payment authorization is denied. Payers and other third parties may be held accountable and liable to individuals for any injury caused by gross incompetence or negligence or by their clinically unjustified decisions. Participating and Support Groups

Participating Groups

American Association for Marriage and Family Therapy
American Counseling Association
American Family Therapy Academy
American Nurses Association
American Psychiatric Association
American Psychiatric Nurses Association
American Psychological Association
Clinical Social Work Federation
National Association of Social Workers

Support Groups

American Group Psychotherapy Association
American Psychoanalytic Association

National Association of Alcoholism and Drug Abuse Counselors
National Depressive and Manic Depressive Association
National Mental Health Association
Therapeutic Communities of America

APPENDIX F

Ethical Guidelines for Professional Care in a Managed Care Environment

The following Guidelines were published by the National Academies of Practice (NAP), an interdisciplinary association of professionals including Dentistry, Medicine, Nursing, Optometry, Osteopathic Medicine, Podiatric Medicine, Psychology, Social Work and Veterinary Medicine. Each academy was represented on the team which developed the guidelines, including Alden N. Haffner, OD Ph.D. (Chair), Daniel M. Laskin, DDS, MS, Tracy Gordy, MD, Roberta Conti, Ph.D., RN, Stephen Urban, DO, Larry Harkless, DPM, Norma Simon, Ed.D., Jean L. Athey, MA, Ph.D., David Phillips, DSW, Alex Ardans, DVM. The Guidelines were approved by mail ballot of the Council of the National Academies of Practice and affirmed by President Ron Fair, O. D. on 2 June 1997. They were distributed to the membership on August 14, 1997.

National Academies of Practice. (1997). *Ethical guidelines for professional care in a managed care environment.* Washington, DC: Author. Reprinted with permission.

NATIONAL ACADEMIES OF PRACTICE

AN INTERDISCIPLINARY ASSOCIATION OF PROFESSIONALS

ETHICAL GUIDELINES FOR PROFESSIONAL CARE IN A MANAGED CARE ENVIRONMENT

Preamble

Ethical guidelines of the National Academies of Practice regarding professional care and services are founded on an ideology of patient advocacy. Moreover, preserving the patient's welfare must be the principal objective in resolving ethical dilemmas or challenges that arise from patient care delivery systems. Many health care professionals recognize that managed care was created with the intent to offer an excellent opportunity to advance quality standards of practice and care while reducing unnecessary and wasteful health care. A further purpose was to achieve a more balanced and socially responsive approach to the achievement of desirable health outcomes in our communities through the use of prudent interdisciplinary resources.

During the last decade, reimbursement arrangements in the health care enterprise have increasingly changed from fee-for-service to some type of externally managed care. However, virtually all managed care plans tend to shift financial risk from payers to health professionals. This transfer of financial risk has the potential to invite ethical conflicts by way of creating a tension between economic availability and clinical care considerations bearing on patient care, patient rights and advancing the knowledge base of the health care professions. The purpose of the ethical guidelines is to set forth the positions of the National Academies of Practice on certain of these pertinent issues.

I. Professional Commitment to Patient Needs Must Remain the Prime Concern

Patient-focused care has the potential to be threatened by economic pressures to abbreviate the utilization and scope of professional services. While mindful of economy and efficiency in health care services, an ethically based patient-practitioner relationship should admit to unreasonable diminution of the professional's commitment to the patient's need and care consistent with accepted standards of clinical care.

It is the position of the National Academies of Practice that it is unethical to compromise a patient's needs and quality care concerns to satisfy financial objectives. The patient's right to appropriate care must not be diluted by economic pressures. The benefits offered by all health care providers should:

- Provide access by the patient to appropriate professional services;
- Meet with patient satisfaction;
- Avoid contamination by an overly rigid adherence to clinical guidelines such that the practitioner's decision making is hampered;
- Provide delivery by uniquely trained personnel, such as medical specialists and other professionals trained in delivering psychosocial services, when the complexity of the patient's condition requires the knowledge base and expertise beyond those of the primary care provider.

The rationale for these positions derives from a patient or consumer-focused value, that has remained constant in the historical evolution of Western ethics, is reiterated in contemporary health professional codes of ethics and can be found in current regulatory statements such as the Patient Rights Standards of the Joint Commission on the Accreditation of Healthcare Organizations. Health professionals must refrain from subordinating the patient's welfare to economic mandates thereby potentially creating an incursion on the patient's rights. The fiduciary role of the provider must be balanced with the patient's needs.

II. Informational Disclosure

Questions frequently arise over whether the practitioner has an ethical obligation to present reasonably considered clinical options for care and services regardless of those economic restrictions or contractual prohibitions, such as "gag rules," that may be dictated by the patient's insurance or managed health care plan.

It is the position of the National Academies of Practice that all reasonable clinical options for care and services, consistent with sound and accepted clinical standards, should be presented to the patient and that the practitioner should not be deterred through gag rules or otherwise constrained to present only those options for care and services that are covered by the patient's policy or plan.

The rationale for this position inheres in the patient's right of informed consent as a service consumer. This right entitles the patient access to information whose scope may exceed that allowed by the health insurance policy of health care plan. The patient's rights of informed consent also repudiates attempts to restrict patient-provider discussions to the plan coverage.

III. Teaching and Research in Patient Care

A clinical environment that includes teaching and research functions traditionally has represented a hallmark of health care delivery. Teaching and research functions are quintessential ingredients in the advancement of knowledge about the patient's needs and the deployment of sophisticated services. With pressures to produce utilization efficiencies and fiscal economies, managed care arrangements may conflict with teaching and research functions. The values of teaching and research, which are enduring in the advancement of science, must not be lost.

It is the position of the National Academies of Practice that demands for increased economy and efficiency in the health care environment should not be allowed to conflict with teaching and research functions. Such demands risk retarding the advancement of knowledge and training in the health sciences and are of consequential importance.

The rationale for this position inheres in the ongoing necessity of scientific research to realize patient-centered achievements. These beneficial goals require an unremitting effort not only to train but to advance the knowledge base of health care professionals.

IV. Confidentiality

The confidentiality of patient data in clinical encounters is a primary concern. Although utilization review and quality assurance are customary and appropriate functions in every health care environment, these activities should not breach the confidentiality of patient data. Safeguards must be adopted when persons engaged in utilization and quality assurance reviews have access to patient files.

It is the position of the National Academies of Practice that utilization studies and quality assurance reviews are appropriate functions in an efficient and effective health care system. However, safeguards must be adopted, codified and implemented to protect the privacy and confidentiality of patient data and the practitioner's clinical material. Confidential information can be disclosed only with the patient's consent except in instances where withholding that information poses unreasonable and foreseeable harm to the patient or identifiable others.

The rationale for this position is founded on the patient's autonomous right to control sensitive personal information. It is further based upon an historical recognition in the Oath of Hippocrates and corroborated throughout the centuries, of the enduring value or preserving confidentiality in order to enhance mutual trust and respect in the patient-provider relationship.

V. Prevention

While direct care based upon episodes of illness, disease, or disability is always appropriate, concerns about preventive services as an integral part of clinical care should be of utmost concern to all practitioners.

It is the position of the National Academies of Practice that every health care enterprise should acknowledge the critical importance of the teaching and inculcation of prevention as well as the need for competently delivered patient care services.

The rationale for this position derives from the ethical principle of beneficence, which recognizes the desirability of preventing illness and disease and promoting health among all persons and communities. The principle of autonomy argues for the informed patient's right to initiate preventive and wellness measures. This right is dependent upon the patient having access to relevant health information and strategies which are essential ingredients of patient care and services.

APPENDIX G

Ethics Codes, Professional Standards, and Practice Guidelines for Assessment, Therapy, Counseling, and Forensic Practice

This appendix lists ethics codes, professional standards, and practice guidelines developed by professional organizations (for example, of psychologists, psychiatrists, social workers, and marriage and family counselors). The codes and guidelines are in the area of assessment, therapy, counseling, and forensics.

The list was compiled by Ken Pope and reprints a page from his Web site (*Articles, Research, and Resources in Psychology,* at http://kspope.com). That site provides links to each of these codes, standards, and guidelines, as well as to other resources.

American Academy of Child and Adolescent Psychiatry: Code of Ethics

American Academy of Forensic Psychology: Specialty Guidelines

American Academy of Psychiatry and Law: Ethical Guidelines for the Practice of Forensic Psychiatry

American Association for Marriage and Family Therapy Code of Ethics

American Association of Christian Counselors: Code of Ethics

American Association of Pastoral Counselors: Code of Ethics

American Association of Sex Educators, Counselors and Therapists: Code of Ethics

American Association of Spinal Cord Injury Psychologists and Social Workers: Standards for Psychologists and Social Workers in SCI Rehabilitation

American Bar Association and American Psychological Association: Assessment of Older Adults with Diminished Capacity—A Handbook for Lawyers

American Bar Association, American Psychological Association, and National College of Probate Judges: Judicial Determination of Capacity of Older Adults in Guardianship Proceedings

American Board of Examiners in Clinical Social Work: Code of Ethics

American Board of Forensic Psychology: Specialty Guidelines

American College Personnel Association: Statement of Ethical Principles and Standards

American Counseling Association: Code of Ethics and Standards of Practice

American Group Psychotherapy Association: Guidelines for Ethics

American Hospital Association: Billing and Collection Practices

American Medical Association: Principles of Medical Ethics

American Mental Health Counselors Association: Code of Ethics

American Music Therapy Association: Code of Ethics

American Nursing Association: Code of Ethics for Nurses

American Psychiatric Association: The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry

American Psychiatric Nurses Association: Position Papers

American Psychoanalytic Association: Principles and Standards of Ethics for Psychoanalysts

American Psychological Association: Disaster Response Network Member Guidelines

American Psychological Association: Ethical Principles of Psychologists and Code of Conduct [prior code: December 1, 1992–May 31, 2003]

American Psychological Association: Ethical Principles of Psychologists and Code of Conduct [current code: effective as of June 1, 2003; see Appendix A]

American Psychological Association: Guidelines for Child Custody Evaluations in Divorce Proceedings

American Psychological Association: Guidelines for Ethical Conduct in the Care and Use of Animals

American Psychological Association: Guidelines for the Evaluation of Dementia and Age-Related Cognitive Decline

American Psychological Association: APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations

American Psychological Association: Guidelines for Psychological Evaluations in Child Protection Matters

American Psychological Association: Guidelines for Psychological Practice with Older Adults

American Psychological Association: Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients

American Psychological Association: Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists

American Psychological Association: Professional, Ethical, and Legal Issues Concerning Interpersonal Violence, Maltreatment, and Related Trauma

American Psychological Association: Record Keeping Guidelines

American Psychological Association: Report from APA Working Group on Assisted Suicide and End-of-Life Decisions

American Psychological Association: Resolution on Appropriate Therapeutic Responses to Sexual Orientation

American Psychological Association: Rights and Responsibilities of Test Takers: Guidelines and Expectations

American Psychological Association: Statement on Services by Telephone, Teleconferencing, and Internet [see Appendix D]

American School Counselor Association: Ethical Standards for School Counselors

American Society of Clinical Hypnosis: Code of Ethics

Association for Comprehensive Energy Psychology: Code of Ethics

Association for Specialists in Group Work Best Practice Guidelines: Best Practice Guidelines

Association for Specialists in Group Work: Principles for Diversity-Competent Group Workers

Association for Specialists in Group Work: Professional Standards for the Training of Group Workers

Association for the Treatment of Sexual Abusers: Professional Code of Ethics

Association of Clinical Pastoral Education: Standards and Ethics Manual

Association of Professional Chaplains: Code of Ethics

Association of State and Provincial Psychology Boards: Code of Conduct

Association of State and Provincial Psychology Boards: Guidelines for Prescriptive Authority

Association of State and Provincial Psychology Boards: Supervision Guidelines

Australian Association of Social Workers: Code of Ethics

Australian Psychological Society: Code of Ethics

British Association for Counselling and Psychotherapy: Ethical Framework for Good Practice in Counselling and Psychotherapy

British Association of Social Workers: Code of Ethics for Social Work

British Columbia Association of Clinical Counsellors: Code of Ethical Conduct and Standards of Clinical Practice for Registered Clinical Counsellors

British Psychological Society: Ethics, Rules, Charter, Code of Conduct

California Association for Counseling and Development: Code of Ethics and Standards of Practice

California Association of Marriage and Family Therapists: Ethical Standards

California Society for Clinical Social Work: Ethical Standards of the Clinical Social Work Federation

Canadian Counselling Association: Code of Ethics

Canadian Medical Association: Code of Ethics

Canadian Psychiatric Association: The CMA Code of Ethics Annotated for Psychiatrists

Canadian Psychoanalytic Society: Principles of Ethics for Psychoanalysis

Canadian Psychological Association: Canadian Code of Ethics for Psychologists (3rd edition) [see Appendix B]

Canadian Psychological Association: Ethical Guidelines for Psychologists Providing Psychological Services via Electronic Media

Canadian Psychological Association: Guidelines for Professional Practice for School Psychologists

Canadian Psychological Association: Practice Guidelines for Providers of Psychological Services

Canadian Traumatic Stress Network [Reseau canadien du stress traumatique]: Ethical Principles

Catholic Church: Ethical and Religious Directives for Catholic Health Care Services

Christian Association for Psychological Studies: Ethics Statement

Clinical Social Work Federation: Code of Ethics

Commission on Rehabilitation Counselor Certification: Code of Professional Ethics

Employee Assistance Professionals Association: EAPA Code of Ethics

European Association for Body-Psychotherapy: Ethical Guidelines and Code

European Federation of Psychologists' Associations: Charter of Professional Ethics for Psychologists

Feminist Therapy Institute: Code of Ethics

Harcourt Assessments: HIPAA Guidelines

Harry Benjamin International Gender Dysphoria Association: Standards of Care for Gender Identity Disorders

Health on the Net Foundation: Code of Conduct for Medical and Health Web Sites

International Federation of Social Workers: Ethics of Social Work—Statement of Principles

International Society for the Study of Dissociation: Guidelines for the Evaluation and Treatment of Dissociative Symptoms in Children and Adolescents

International Society for the Study of Dissociation: Guidelines for Treating Dissociative Identity Disorder (Multiple Personality Disorder) in Adults

Irish Association for Counseling and Therapy: Code of Ethics and Practice

Irish Association of Social Workers: Code of Ethics

Joint Committee on Testing Practices: Code of Fair Testing Practices in Education

Louisiana State Board of Social Work Examiners: Guidelines for Child Custody Evaluations

Mental Health Patient's Bill of Rights [see Appendix E]

Multi-Health Systems: PIPEDA & HIPAA Test Disclosure Privacy Guidelines

National Academies of Practice: Ethical Guidelines for Professional Care and Services in a Managed Health Care Environment [see Appendix F]

National Academy of Neuropsychology: Independent and Court-Ordered Forensic Neuropsychological Examinations

National Academy of Neuropsychology: Presence of Third-Party Observers During Neuropsychological Testing

National Academy of Neuropsychology: Use of Neuropsychology Test Technicians in Clinical Practice

National Association of School Psychologists: Professional Conduct Manual—Principles for Professional Ethics

National Association of Social Workers: Code of Ethics

National Board for Certified Counselors: Code of Ethics

National Board for Certified Counselors: The Practice of Internet Counseling

National Career Development Association: Ethical Standards

National Council for Community Behavioral Healthcare: Values and Principles for Behavioral Healthcare Delivery

National Council for Hypnotherapy: Code of Ethics and Conduct

National Registry of Certified Group Psychotherapists: Guidelines for Ethics

National Student Nurses Association: Code of Professional Conduct

New Zealand Psychological Society: Code of Ethics

Pearson Assessments: HIPAA Guidelines

Psychological Society of Ireland: Code of Professional Ethics

Sidran: Rights and Responsibilities in Psychotherapy (informed consent form to be used with therapy patients)

Society for Research in Child Development: Ethical Standards for Research with Children

World Medical Association: Ethics Policies

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Ken Pope, Ph.D., ABPP, received graduate degrees from Harvard and Yale universities and has been in independent practice as a licensed psychologist since the mid-1980s. A diplomate in clinical psychology, he has authored or coauthored over a hundred articles and chapters in peer-reviewed scientific and professional journals and books. He was elected a charter fellow of the Association for Psychological Science (APS) and a fellow of American Psychological Association (APA) Divisions 1, 2, 12, 29, 35, 41, 42, 44, and 51.

Based on his research in the 1970s on therapist-patient sex, he cofounded the University of California, Los Angeles (UCLA), Post-Therapy Support Program, the first center offering services, conducting research, and providing university-based training for graduate students and therapists seeking to work with people who had been sexually exploited by therapists. Ken taught courses in psychological and neuropsychological assessment, abnormal psychology, and professional standards of care at UCLA, where he served as a psychotherapy supervisor. He chaired the Ethics Committees of the APA and the American Board of Professional Psychology.

In the early 1980s, he was the director of clinical programs for a consortium of community mental health centers and hospitals. He worked with the community, the hospitals, and the centers to find ways to meet community needs in accordance with its own cultures and ecology. By the end of his work in those areas, their programs included home-bound services (in which therapists and others went to the homes of people whose chronic or terminal illnesses or disabilities prevented them from traveling); legal services for people who were poor or homeless; Manos de Esperanza, serving people whose primary language was Spanish; a twenty-four-hour crisis service; peer-support services; and group homes so that people who were mentally disabled could live independently.

His publications include ten articles in *American Psychologist* and eleven books; among them are *What Therapists Don't Talk About* *and Why: Understanding Taboos That Hurt Us and Our Clients* (2nd ed.), with Janet Sonne and Beverly Greene; *The MMPI, MMPI-2, and MMPI-A in Court: A Practical Guide for Expert Witnesses and Attorneys* (3rd ed.), with James Butcher and Joyce Seelen; *How to Survive and Thrive as a Therapist: Information, Ideas, and Resources for Psychologists in Practice,* with Melba Vasquez; *Sexual Involvement with Patients: Patient Assessment, Subsequent Therapy, Forensics; The Stream of Consciousness: Scientific Investigations into the Flow of Human Experience,* with Jerome Singer; and *The Law and Mental Health Professionals: California,* with Brandt Caudill.

One of his main interests is the family of special-needs dogs and cats who live in his home and whose photos and stories can be seen at http://kenpope.com. He also maintains three other Web sites: *Articles, Research, and Resources in Psychology,* at http://kspope.com; *Accessibility and Disability Information and Resources in Psychology Training and Practice,* at http://kpope.com; and *Resources for Companion Animals, Assistance Animals, and Special-Needs Animals,* at http://catanddoghelp.com.

Ken provides a free psychology news service for more than a thousand subscribers (anyone is welcome to join the list). Each day he e-mails three to six messages, including excerpts from just published and in press articles in scientific and professional journals and from psychology-related articles in that morning's newspapers, job announcements, requests for information and resources from list members, and other information.

He has received the Belle Mayer Bromberg Award for Literature; the Frances Mosseker Award for Fiction; the APA Division 42 Presidential Citation "In Recognition of His Voluntary Contributions, His Generosity of Time, the Sharing of His Caring Spirit [and] His Personal Resources"; the APA Division 44 Citation of Appreciation; the APA Division 12 Award for Distinguished Professional Contributions to Clinical Psychology; and the APA Award for Distinguished Contributions to Public Service, which includes the following citation:

> For rigorous empirical research, landmark articles and books, courageous leadership, fostering the careers of others, and making services available to those with no means to pay. His works include 9 books and over 100 other publications on topics ranging from treating victims of torture to psychometrics to memory to ethics. His pioneering research has increased our understanding of therapist-patient sex, es-

> pecially in the areas of effects on patients, tendencies to deny or discount risks, factors enabling known perpetrators to continue or resume not only practicing but also abusing patients, and approaches to prevention. As the title—"What Therapists Don't Talk About and Why"—of his acceptance talk for the Division 12 Award for Distinguished Professional Contributions to Clinical Psychology suggests, Pope's research frequently addresses concerns that are relatively neglected because they tend to cause anxiety, such as therapists' feelings of anger, hate, fear, or sexual attraction toward patients, or therapists' own histories of sexual and physical abuse. He frequently declines compensation for his work to advance psychology in the public interest. This is evident in his recent book, *Sexual Involvement with Therapists: Patient Assessment, Subsequent Therapy, Forensics,* published by the American Psychological Association. Pope waived all royalties for the volume in order that it might be sold at reduced price and be more readily available and useful. His integrity, good will, humor, and tireless work in the public interest represent the finest ideals of our profession [*American Psychologist,* 1995, pp. 241–243].

Melba J. T. Vasquez received her Ph.D. degree in counseling psychology from the University of Texas at Austin, and is a psychologist in full-time independent practice in Austin. From 1978 to 1991 she served as a university counseling center psychologist, first at Colorado State University and then at University of Texas at Austin. She also served as internship training director at both institutions.

She has served in various leadership capacities of the American Psychological Association, including on the APA Ethics Committee, and on the APA Ethics Committee Task Forces for Revisions of the Ethical Principles of Psychologist and Code of Conduct for both the 1992 and the 2002 versions. She was elected to serve as a member-at-large on the APA Board of Directors, 2007–2009. She has served on various APA boards and committees, including as the first chair of the board for the Advancement of Psychology in the Public Interest, chair of the board of Professional Affairs, member of Committee for the Advancement of Professional Practice, and member of the Policy and Planning Board. She is a past president of APA Divisions 35 (Society for the Psychology of Women) and 17 (Society of Counseling Psychology) and of the Texas Psychological Association. Vasquez has been involved in the planning and implementation of several key conferences, including the 1997 Supply and Demand Conference and 2002

Competencies Conference. She is a cofounder, with Rosie Bingham, Lisa Porche-Burke, and Derald Wing Sue, of the National Multicultural Conference and Summit, which is now an ongoing biannual conference. Other leadership activities include service as Council of Representative from Division 42, Psychologists in Independent Practice (2004–2006), and from Division 17, Society of Counseling Psychology (1994–1997), and as a cofounder and the first Council Representative from Division 45, Society for the Psychological Study of Ethnic Minority Issues (1989–1992). She has served as chair of the Ethnic Minority Caucus and of the Women's Caucus of Council.

She has published over sixty journal articles and book chapters in the areas of ethics, ethnic minority psychology, psychology of women, supervision and training, and counseling and psychotherapy. Her interests in diverse groups, including women and people of color, have been particular foci of her writings. She has taught graduate courses and has provided workshops and presentations in those areas as well. Ken Pope and she are also coauthors of *How to Survive and Thrive as a Therapist: Information, Ideas and Resources for Psychologists in Practice* (2005). She is interested in the integration of science and practice and for the promotion of psychological knowledge that contributes to human welfare.

Vasquez is an American Psychological Association Fellow of Divisions 1, 17, 35, 42, 45, and 49 and a member of Divisions 9, 31, and 44. She holds the Diplomate from the American Board of Professional Psychology. She is listed with the National Register and has received numerous awards, including:

- Honorary doctorate degree, Phillips Graduate Institute, May, 2005
- James M. Jones Lifetime Achievement Award, American Psychological Association, 2004
- Psychologist of the Year, Texas Psychological Association, November 2003
- Foremother Award in Appreciation for Contributions to the Section for the Advancement of Women, and Counseling Psychology of Women, Society of Counseling Psychology Division 17, American Psychological Association, 2003
- Eminent Women: 25th Annual Symposium on Historical and Personal Perspectives, American Psychological Association, 2003

- Senior Career Award for Distinguished Contributions to Psychology in the Public Interest, American Psychological Association, 2002
- Janet E. Helms Award for Mentoring and Scholarship, Winter Roundtable on Cross-Cultural Psychology and Education, Columbia University, 2002
- Vision to Action Award, Austin Women's Psychotherapy Project, Kaleidoscope of Women's Lives Conference, 2002
- John Black Award for Outstanding Achievement in the Practice of Counseling Psychology, Division 17, Counseling Psychology, American Psychological Association, 2000
- Distinguished Leader for Women in Psychology Award, Committee of Women in Psychology, American Psychological Association, 2000
- Award for Extraordinary Contributions in the Professional Practice of Counseling Psychology, Academy of Counseling Psychology of the American Board of Professional Psychology, 2000
- Outstanding Contribution to Public Service Award, Texas Psychological Association, 1999
- Distinguished Career Contributions to Service Award, Division 45 of the American Psychological Association, Society for the Psychological Study of Ethnic Minority Issues, 1999

The 2002 Award for Distinguished Senior Career Contributions to the Public Interest cited the following:

> For her scholarship, teaching, service delivery, and professional leadership activities, which reflect commitment to issues of empowerment, justice, and equality for all members of society, Melba J. T. Vasquez has been involved in promoting the increase of ethnic minority and gender representation in all aspects of psychology. She has demonstrated her commitment to ensuring that psychology attends to the needs of the diverse population reflected in American society. Through her work in the areas of ethnic minority psychology, psychology of women, professional ethics, and teaching and training, her activism, passion, and commitment are particularly evident [*American Psychologist, 57,* 878–888].

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