FOURTH EDITION

PRACTICAL ETHICS FOR PSYCHOLOGISTS

A POSITIVE APPROACH



SAMUEL J. KNAPP • RANDY FINGERHUT

To all those who want to practice ethically and to have a framework for addressing the many complex ethics issues and dilemmas that arise in the practice of psychology, this book is for you. *Practical Ethics for Psychologists* lives up to the promise of its title and really does provide very practical and user-friendly guidance for addressing and responding to the ethics issues common to the practice of psychology today, with each issue illustrated by realistic and relatable case examples. Every psychologist and psychologist-in-training should purchase and regularly read and use this book.

—Jeffrey E. Barnett, PsyD, ABPP,
Professor of Psychology, Loyola University, Maryland

"Practical" and "positive" are but two of the adjectives that apply to the newly published fourth edition. "Insightful," "in-depth," and indeed "indispensable" further describe this critically important resource.

—Eric Y. Drogin, JD, PhD, ABPP, Harvard Medical School;
Past Chair, Committee on Professional Practice and Standards,
American Psychological Association

To keep psychologists current with the changes and challenges in the field, the fourth edition of this valuable book includes a focus on culture and diversity, ethical issues regarding new health care technologies, and the necessity of self-care. The authors encourage psychologists to go beyond just following the rules to avoid punishment and strive to achieve their highest ethical aspirations. Through vignettes the reader can see how ethical principles apply to everyday situations and can expand their ethical decision-making skills. Students as well as professionals will benefit from the many practical examples of situations often faced by psychologists.

—Linda K. Knauss, PhD, ABPP, Professor of Psychology,
Widener University, Institute for Graduate Clinical Psychology

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"This book should be on the bookshelf of every practicing psychologist. It is chockful of timely, current, practical, and common sense advice on how to practice psychology consistently with both the law and ethics. It is truly, once again, a winner!"

—Jeffrey N. Younggren, PhD, ABPP, Clinical Professor, Department of Psychiatry and Behavioral Sciences, University of New Mexico, Albuquerque, NM;
Associate Editor, *Professional Psychology: Research and Practice*; COL(r), MS;
Risk Management Consultant, The Trust

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AMERICAN PSYCHOLOGICAL ASSOCIATION

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To Janemarie Heesen Knapp

—SAMUEL KNAPP

To Pamela Fingerhut

—RANDY FINGERHUT

IMPORTANT NOTICE

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PREFACE TO THE FOURTH EDITION

We view ourselves as coparticipants (with many other scholars in psychology) in a tradition that tries to integrate overarching ethical values into the practice of psychology. We have been pleased with the reception received by our efforts to do so in the first three editions of *Practical Ethics for Psychologists: A Positive Approach.*

Although we retain the basic format and perspective of the previous editions in the fourth edition, we believe that changes in the ethical issues and our understanding of ethical issues warrant a revised edition. Since the publication of the third edition, psychologists have become more attuned to the importance of culture and diversity in understanding human behavior and in the ethical delivery of health care. Effective psychologists need to be critically conscious of the lived experiences of those with whom they work and consider their role as psychologist–citizens in addressing long-standing social inequalities. Additionally, psychologists need to understand how they can integrate new health care technologies into their work in an ethical manner that keeps the focus on patient well-being. Finally, there is more awareness of the impact of emotional problems on professional competence and the necessity of self-care in maintaining ethical practices. We believe that these additions make the fourth edition more relevant to the challenges faced by contemporary psychologists, as well as students and trainees in psychology.

ACKNOWLEDGMENTS

We, the authors of this book, have embedded ourselves in a network of conscientious psychologists and advocates who have displayed a long-time commitment to the full integration of ethical issues into the practice of psychology. In a sense, this book has become a community project.

We first want to thank Dr. Leon VandeCreek, an author on the first three editions, who established our work's foundations and who has made many contributions to ethics education for psychologists in general. We hope to be worthy to carry on the tradition of his work.

We thank Anne Marie Frakes and the Pennsylvania Psychological Association for allowing us to adapt several articles that had previously appeared in the *Pennsylvania Psychologist*.

We express appreciation to the American Psychological Association (APA) Practice Organization, which trained Samuel Knapp and other state directors of professional affairs on the Health Insurance Portability and Accountability Act Privacy Rule.

We also express appreciation to the reviewers of the first edition, including Drs. Lindsay Childress-Beatty, Stanley Jones, Stephen Behnke, as well as to Mr. Alan Nessman of APA for his contribution to the first and subsequent editions.

We owe a special debt to the late Patricia Bricklin, the late Dianne Salter, and the late Joseph French all of whom did much to stimulate our understanding of ethical issues. We thank Drs. Mitchell Handelsman and Michael Gottlieb who, among many contributions, developed the acculturation model for training students, collaborated on expanding the implications of positive ethics, and refined concepts related to patient-centered decision making.

Drs. Jana Martin, Eric Harris, Jeff Younggren, and Bruce Bennett of the Trust have done so much to integrate an ethics perspective into risk management. Dr. Linda Knauss assisted in the development of the five-step decision-making model. Dr. Peter Keller helped us appreciate the importance of ethical climates and cultures. Dr. John Lemoncelli shared with us his perspective on religiously informed psychotherapy. Dr. Jeff Sternlieb continues to educate us on the importance of self-care and self-reflection. Samuel Knapp owes additional debts to Drs. Vince Bellwoar, Constance Fischer, Steven Cohen, Molly Cowan, the enthusiastic John Gavazzi, Jade Logan, Bruce Mapes, Don McAleer, John "Jay" Mills, Eve Orlow, Arnold Sheinvold, Max Schmidheiser, Brett Schur, Jeanne Slattery, Richard Small, Allan Tjeltveit, Edward Zuckerman, attorney Rachael Baturin, and attorney psychologist Alan Tepper, who provided him with ethically informed legal perspectives. Mr. Thomas DeWall mentored us in ethically informed political advocacy. Randy Fingerhut and Samuel Knapp both express deep appreciation for the supportive and educational role that the Ethics Committee of the Pennsylvania Psychological Association has played in their professional development.

Dr. Fingerhut would like to thank his colleagues at La Salle University for supporting his professional development and his students, whom he has had the honor of teaching and learning from over the years.

Practical Ethics for Psychologists

1

The Legal Floor and Positive Ethics

Ethics refers to values, how we ought to behave, and what constitutes proper conduct. Practical or applied ethics refers to the application of ethics to specialized areas or professions, such as psychology (Beauchamp & Childress, 2019). The word *ethics* could either refer to the legal or mandatory floor adopted by the profession, or to the aspirational ceiling of voluntary efforts to live out high moral ideals. The floor approach focuses almost exclusively on the laws or standards designed to protect the public from harmful actions by psychologists (i.e., state and federal laws regulating the practice of psychology, the regulations of state licensing boards, and the enforceable standards of the American Psychological Association's (APA's; 2017a) *Ethical Principles of Psychologists and Code of Conduct* [APA Ethics Code]). However, psychologists can also view ethics as a voluntary effort to "do the right thing" or "to do one's best" by following one's deeply held moral principles. This approach is reflected in the aspirational principles of the APA Ethics Code and in writings on positive or active ethics (Handelsman et al., 2009). Although psychologists may be motivated by different religious or philosophical sources, most ethical systems reflect a common morality or a shared set of core aspirational beliefs.

The floor approach reflects an incomplete view of ethics. Most psychologists want to do more than just avoid being punished; they want to help others and to excel in their profession. A technically legal action may differ from a morally sensitive one. Conscientious psychologists not only ensure that they meet minimal standards of competence, but they also strive to do their best to

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help others. For example, ethical standards forbid psychologists from discriminating unfairly, especially against persons who belong to groups that have historically experienced discrimination. However, most psychologists also ask themselves how they can be affirmative of these individuals. Although psychologists want to meet the "letter of the law" with regard to informed consent, they also want to meet its spirit and ensure that their patients participate in treatment decisions as fully as possible. The term *positive ethics* is used to emphasize the importance of overarching ethical theories in determining proper behavior and to move psychologists and others away from thinking of ethics as nothing more than compliance with laws, regulations, enforceable standards, or disciplinary actions.

The mandatory and aspirational aims of ethics interact with one another. Psychologists can better fulfill their minimum professional responsibilities if they understand and can apply the moral principles that underlie the disciplinary codes. In addition, psychologists can better fulfill their highest ideals if they understand and follow the disciplinary codes that establish minimum standards of conduct.

Disciplinary codes are necessary but not sufficient in guiding psychologists with their day-to-day professional decisions. Those who are familiar with ethics codes recognize their strengths as well as their limitations in facilitating ethical decision making. Psychologists often face dilemmas where no ethical standard clearly applies to their resolution. This is why ethics professors commonly respond to questions regarding ethical practice with "It depends." In these instances, psychologists must rely on an ethical decision-making model informed by an integration of both professional values and their personal ethical code.

The purpose of this book is to help psychologists—including students and psychologists in training—clarify what they value, consider their obligations, and determine what constitutes proper professional conduct. We wrote this book to help psychologists reach a higher level of service by attending to the practical ethical issues that arise while they engage in professional activities.

We hope to achieve this goal by reviewing the standards of practice as reflected by the APA Ethics Code and relevant state and federal laws. Furthermore, we present three models: (a) the ethics acculturation model (Handelsman et al., 2005), (b) the five-step decision-making model, and (c) the quality enhancement model (Knapp et al. 2013) that readers can use to resolve ethical dilemmas. Most important, we believe in the importance of overarching ethical principles, and we try to demonstrate how psychologists can incorporate these values in their day-to-day work.

THE REGULATION OF PSYCHOLOGY

Psychology is both a scientific discipline and a profession. In everyday usage, the word *profession* refers broadly to any occupation, and the term *professional* is sometimes used for a member of any occupation who practices conscientiously.

However, in the academic sense, the word *profession* applies only to occupations whose members have mastered a body of specialized knowledge, must use judgment in applying that knowledge, commit themselves to the public welfare, and agree to adhere to specific standards of conduct.

According to these criteria, attorneys belong to a profession because they must acquire extensive legal training to enter the field, use judgment in advising their clients, serve the interests of justice, and agree to follow the rules of the court and their profession. Legal clerks, however, do not need extensive education, apply only predetermined or routine knowledge, and are not, at least by these criteria, members of a profession. Accountants are professionals; bookkeepers are not. Veterinarians are professionals; veterinary assistants are not. Physicians are professionals; medical clerks are not.

In addition to advanced training, professionals have a fiduciary relationship (or a relationship of trust) with concurrent responsibilities to promote the public welfare and avoid or minimize conflicts of interests with their clients or patients. For psychologists, agreed upon standards of conduct delineate these obligations and guide them. It is not a coincidence that APA first published a code of ethics for psychologists in 1953, or soon after the movement for licensing psychology as an independent profession began to gain momentum.

Psychologists, like all health care professionals, are regulated by other controls, both from inside and outside the profession. Some of these controls are designed to prevent psychologists from harming their patients or violating the ethics code or other standards (*before-the-fact* controls). Other controls are designed to discipline psychologists after they have harmed patients or violated the ethics code or other standards (*after-the-fact* controls). The demarcation between the before-the-fact and the after-the-fact controls is not absolute. For example, merely knowing that after-the-fact controls exist can act as a before-the-fact control (Knapp & VandeCreek, 2003).

In addition to being a profession, psychology is also an academic and research discipline whose members teach and conduct research. Academic and research psychologists do not have the same set of controls as professional psychologists; however, they are subject to external controls of their own, such as grant-funding agencies and/or the institutional review boards (IRBs) of academic institutions.

Before-the-Fact (Preventive) Controls

Before-the-fact controls attempt to prevent misconduct or harm to the public. They include requirements of training programs, licensing boards, and mandatory continuing education (CE). All things being equal, before-the-fact controls are preferable because they have the potential to prevent harm to the public (Knapp & VandeCreek, 2003).

Theoretically, training programs only accept graduate students who have adequate academic credentials and make progress in graduate school, including acceptable performance in practica and internships. Presumably, training

programs screen out applicants who have not met competency benchmarks or do not demonstrate the character necessary to become competent psychologists.

Licensing boards require applicants to obtain the appropriate education, receive supervision, show acceptable moral character, and pass an examination on the content of psychology (some states[1] require an additional oral or written examination on state law). Furthermore, licensing boards also require licensees to acquire CE credits as a condition of licensure renewal (many require ethics as part of those CE requirements). Of course, conscientious psychologists may voluntarily take additional steps to improve their competence beyond the minimum required by the licensing board.

After-the-Fact (Punitive) Controls

After-the-fact controls are activated when professionals have harmed the public or violated a standard of the profession. They include disciplinary actions by licensing boards and ethics committees, various civil and criminal statutes that empower lawsuits against psychologists, and if applicable, institutional oversight (Knapp & VandeCreek, 2003).

Licensing boards may discipline their licensees who have violated the licensing law or its regulations. Typically, licensing boards adopt the APA Ethics Code entirely or modify it in their regulations. Offending psychologists can receive letters of reprimand or censure. Both letters of reprimand and censure involve public notice of misconduct, but generally a letter of censure represents more severe misconduct. If the offense is especially egregious, the licensing board may suspend or revoke the license of the offending psychologist. In addition, licensing boards may fine licensees or require them to take additional CE courses, receive supervision, receive psychotherapy, or take other steps to ensure their competence.

Complaints before a licensing board fall under the category of administrative law. Because such complaints do not fall within the purview of criminal law (i.e., psychologists cannot be imprisoned as a result of prosecution before a licensing board), the guaranteed civil liberty protections found in criminal court do not apply to proceedings before licensing boards. For example, licensees do not have a constitutional right to be represented by counsel (although it may be wise for them to do so), to confront their accusers, or to have a speedy trial. Investigators may accept (and sometimes appear to encourage) self-incriminating statements. The standard of proof may *be clear and convincing* or *preponderance of evidence*, both of which are lower than the standard of *beyond a reasonable doubt* required in criminal cases. Some states may, through statutes, regulations, or case law, grant some protections in administrative law cases, such as the right to have an attorney present, but they have no constitutional obligations to do so.

[1]This could also include territories, the District of Columbia and the Commonwealth of Puerto Rico.

Professional organizations can also provide after-the-fact controls. The APA Ethics Code has been adopted as binding for its members by APA and most of its state or territorial affiliates. The Ethics Committee of APA (or its state or territorial affiliates) may discipline its members if they violate the APA Ethics Code (although currently few state or territorial psychological associations have ethics committees authorized to discipline members). However, associations only have authority over their own members. The associations may send offending members letters of reprimand or censure or, if the offense is especially severe, suspend or expel them from the association. Although associations cannot fine a member, they can, as a condition of membership, require the psychologist to take additional CE courses, receive supervision, or take other steps to ensure their competence.

Malpractice courts act as another after-the-fact control. The four criteria for malpractice complaints all begin with the letter d: *duty* (a professional duty has been established), *deviation* (the professional deviated from acceptable standards of conduct), *damage* (the patient or third party was harmed), and *direct* (there was a direct relationship between the deviation from professional standards and the damage to the patient or third party; Simon, 1992). Plaintiffs in a malpractice suit must prove that the accused psychologist harmed them. In contrast, complainants before an ethics committee or a licensing board only need to prove that the accused psychologist violated the ethics code, licensing law, or board regulation. Malpractice courts, unlike ethics committees or licensing boards, may grant monetary awards to patients.

A variety of criminal laws also apply to psychologists. These include laws that prohibit insurance fraud, penalize psychologists for failing to report suspected child abuse, and in some states, prohibit sexual contact between patients and psychotherapists. The confidentiality standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) function as a before-the-fact control to the extent that they require psychologists to include privacy protections in their practices; they also function as an after-the-fact control to the extent that they can levy sanctions against psychologists who violate its provisions.

Finally, employers such as hospitals, schools, or public mental health centers regulate their employees, including psychologists. Often these institutions require their psychologist employees to adhere to the APA Ethics Code or licensing board regulations. In Chapter 12 we describe a decision-making process in those situations when institutional rules may conflict with the APA Ethics Code.

These various disciplinary mechanisms interact with each other in complex ways. For example, a plaintiff may use the finding that a psychologist violated the licensing law as a crucial piece of evidence in a malpractice case. The mere fact that a licensee violated the APA Ethics Code or the licensing law or its regulations may be sufficient to prove one of the important d's in a malpractice case: deviation from acceptable standards of care.

Academic and research psychologists also have before-the-fact and after-the-fact controls, although they may differ somewhat from those of their

professional colleagues. The before-the-fact controls for academic and research psychologists include training programs and IRBs, which review research protocols to ensure that researchers protect patient well-being. After-the-fact controls include ethics committees, institutional employers, and funding agencies, which can withhold support because of researcher misconduct (Knapp & VandeCreek, 2003).

The effectiveness and fairness of these mechanisms are sources of controversy. Some have claimed that licensing boards are overly aggressive in prosecuting licensees (Williams, 2000), whereas others have claimed that they exercise considerable restraint (Van Horne, 2004).

Unfortunately, no standardized set of data identifies the most common infractions of psychologists. Data can be obtained from a variety of sources, such as licensing board complaints through the data bank of the Association of State and Provincial Psychology Boards (2021), complaints before the APA Ethics Office, and information from malpractice carriers. Data from malpractice carriers are proprietary, but sometimes they disclose general trends concerning complaints. These sources, however, do not categorize complaints in the same manner. Because of the incompleteness of these multiple sources of data, it is impossible to create a definitive ranking of the areas in which psychologists are most likely to be disciplined. Nonetheless, an "eyeball" analysis across many sources of disciplinary data show that the common sources of complaints are multiple relationships (sexual and nonsexual), alleged incompetence in diagnoses or treatment, disputes arising out of child custody evaluations, fee disputes, and premature termination or abandonment. Other complaints include inadequate supervision, breach of confidentiality, inadequate record keeping, impairment, and failure to acquire required CE credits for licensure renewal. Also, academic or research psychologists tend to have complaints more relevant to their area of work, such as disputes about authorship, plagiarism, informed consent to research, and conflicts of interest from funding sources.

Similarly, it is impossible to compile the exact number of psychologists who have been disciplined by a licensing board or ethics committee, found liable by a malpractice court, or convicted of violating a criminal statute related to the practice of psychology. Nonetheless, across all these disciplinary bodies, the likelihood that a psychologist will be disciplined by any of them is small. Previous survey research has found that 11% of psychologists had responded to a licensing board complaint sometime in their career (Schoenfeld et al., 2001), but states vary widely in the frequency with which they discipline psychologists. The APA Ethics Office disciplines few psychologists (e.g., APA, 2016a). Montgomery et al. (1999) reported that 6% of the psychologists in their survey had been sued for malpractice. Nonetheless, many of these disciplinary venues overlap. For example, a crime in the practice of psychology may be grounds for a disciplinary complaint, or if it involved harm to a patient in the context of a professional relationship, it could also be grounds for a malpractice suit. Some complainants seek redress against psychologists in a variety of venues, such as a licensing board complaint, ethics complaint, and a malpractice lawsuit for the same act of alleged misconduct.

Although disciplinary complaints against psychologists are relatively rare, they are high-impact events. Even professionals who have violated no rule may have to spend thousands of dollars and hundreds of hours defending themselves. Professionals who have prided themselves on the quality of their services risk great public humiliation as a result of a charge against them, even if the complaint is eventually dismissed. Psychologists who have had to respond to these complaints often feel depressed, angry, and anxious (Montgomery et al., 1999; Schoenfeld et al., 2001).

POSITIVE (ACTIVE) ETHICS

Many psychologists construe ethics primarily or exclusively in terms of the laws regulating psychology, the enforceable ethics codes, and the adjudicatory procedures of disciplinary bodies (Handelsman et al., 2009). Although regulatory bodies discipline relatively few psychologists, the study of ethics, defined in terms of punishment, often provokes anxiety. According to this floor approach, ethics represents a fixed entity of prohibitions or commandments that must be followed.

This limited view of ethics minimizes the spirit or underlying philosophy behind these commandments, deprecates the significance of the subtle ways in which patients can be harmed, ignores the positive contributions of ethics, and fails to consider the ways in which ethics can uplift the many psychologists who try to function effectively. Furthermore, it presents ethics in an unnecessarily unpleasant manner. In reality, disciplinary codes represent only the ethical floor, or minimum standards, to which psychologists should adhere.

As stated by Handelsman et al. (2002):

> The current notions of professional ethics focus too heavily on avoiding or punishing misconduct rather than promoting the highest ethical conduct. . . . Similar to the pathology perspective, the prevailing models of ethics often are too rule-bound or defensive. (p. 732)

Psychologists can also view ethics as a way to help them to fulfill their highest potential as psychologists. It can mean relying on an underlying philosophical system to help psychologists think through complex ethical dilemmas. Ethics should focus not only on how a few psychologists harm patients but also on how all psychologists can do better at helping them. This view of ethics is called positive or active ethics. The concept of positive ethics is consistent with the encouragement of bioethicists Beauchamp and Childress (2019) to focus on moral excellence and not just the minimal obligations found in the disciplinary codes of the health care professions. A positive or active ethics perspective is similar to the General (i.e., aspirational) Principles found in the APA Ethics Code, in that positive ethics encourages psychologists to live up to their highest ethical standards. However, positive ethics differs from aspirational ethics in that it encourages psychologists to integrate personal ideals into their professional lives. Additionally, it recognizes that the ethical foundations of psychologists

may differ from the principle-based ethics found in the aspirational section of the APA Ethics Code.

Positive ethics requires a fundamental philosophical underpinning, although it does not specify what that philosophical underpinning should be. It could be virtue ethics, communitarian ethics, deontological (Kantian) ethics, utilitarianism, principle-based ethics, or another philosophical system. We briefly review these ethical systems in Chapter 2. Often positive ethics is based on or influenced by religious convictions or personal upbringing. The goal is for psychologists to consider their vision of the good life and "formulate ways of translating these visions into action" (Prilleltensky, 1997, p. 518).

This development of positive ethics parallels the development of positive psychology as a scientific endeavor. Positive psychology attempts to shift the goals of psychology from an almost exclusive focus on pathology and healing, to a science that helps "to articulate a vision of the good life" (Seligman & Csikszentmihalyi, 2000, p. 5). Positive psychology focuses on positive individual traits (e.g., competence, courage, interpersonal skills) as well as how institutions can promote civic virtues (e.g., responsibility, altruism, civility).

Similarly, a goal of positive ethics is to shift the emphasis of professional psychologists away from an almost exclusive focus on wrongdoing and disciplinary actions toward an articulated vision of high ethical standards. Positive ethics can focus on individual conduct (whether articulated as virtues such as generosity or ethical principles such as beneficence) as well as on how institutions can promote high standards. The floor approach focuses on how disciplinary bodies react to misconduct. Positive or active ethics also considers how individual psychologists can help institutions promote individual and social well-being (Keller et al., 2012).

This is not to say that instruction in the legal floor has no place in ethics education. Ethical psychologists know the codes and laws that govern the practice of psychology. It is also important for psychologists to appreciate good risk management principles. Risk management programs identify ways that patients can be harmed (or at least perceive themselves to be harmed) and how psychologists can protect themselves from unfounded or frivolous complaints. Risk management principles or recommendations go beyond or expand on the minimum standards of conduct. Although they are not enforceable as legal standards of conduct, good risk management programs are anchored in overarching ethical principles. The best risk management principle is to deliver and document good services, and psychologists should reconsider any purported risk management principle that appears to harm a patient or violate an overarching ethical principle (Knapp et al., 2013). However, education about disciplinary codes, risk management principles, and disciplinary boards and their procedures are not sufficient for ethics education in and of themselves.

A complete education in ethics requires psychologists to consider how they can maximize their adherence to moral principles. Typically, psychologists can follow good risk management principles, follow the letter of the law, and follow good ethical values. But ethical psychologists go beyond the minimal

standards found in the APA Ethics Code. They try to uphold the moral principles that form the foundation of the APA Ethics Code and demonstrate sensitivity to the personal or environmental factors that could facilitate or hinder an effort for ethical excellence.

This means, for example, taking special effort to ensure that patients understand the treatment process rather than just trying to get their signatures on an informed consent form. It means taking a special effort to ensure that the debriefing of research participants is truly helpful as opposed to a formality. It means that psychologists who hold positions of privilege because of their race or gender, will consider implicit biases that could keep them from displaying moral excellence.

Precursors of Positive Ethics

It could be argued that we are creating a straw man with our characterization of the floor approach. In reality, we know of no leading scholar in the field of ethics who adopts that approach. Nonetheless, many individual psychologists may at least implicitly equate professional ethics with the floor approach. In addition, all psychologists (including us) may allow a floor mode of thinking to drift into their conception of ethics. As we describe later in the section on the psychological underpinnings of positive ethics, we all might have innate psychological propensities that make it easy to adopt a floor approach.

Furthermore, the term positive ethics only labels similar perspectives already articulated by other scholars in the field of professional ethics. For example, L. S. Brown (1994) commented that many psychotherapists have mistakenly conceived of ethics as "a concrete wall hemming us in, forbidding us from human connections" (p. 276). R. F. Kitchener and Kitchener (2012) noted the limitations of the APA Ethics Code and urged psychologists to rely on overarching moral theories to help them make important decisions. We could give many more examples.

Throughout this book, we identify several instances in which a positive approach would alter the manner in which psychologists conceptualize their relationships to patients and others. However, we make no pretense of having the last word on positive ethics. Instead, we hope that others will identify additional ways that psychologists can implement a positive approach and improve upon the suggestions contained in this book. These continual revisions will help ensure that positive ethics does not get frozen into its own set of rigidly held formulas or beliefs.

Psychologists can enhance the clarity of their moral vision by studying the literature on philosophical ethics and accounts from persons who have traditionally been marginalized in society. Although feminists represent diverse philosophical perspectives, they share common ground in identifying how societal structures contain power dynamics that tend to disenfranchise women and other groups. Attending to these perspectives may help psychologists see ways in which they may unknowingly minimize the perspectives of others.

Similarly, psychologists from traditionally underrepresented cultures have identified ways that psychologists from the dominant culture have failed to appreciate the unique life situations of patients from other cultures and ethnicities, and, as a result, have provided less than optimal treatment. In addition to learning the perspectives of persons from diverse cultures, it is also important to incorporate the perspectives of the recipients of services as well. Much can be learned from reading their first-hand accounts and listening to their concerns. The most important step is to include all impacted persons in the dialogue.

Psychological Underpinnings of Positive Ethics

The propensity for a floor approach may have roots in innate psychological processes. The floor approach to ethics may be reinforced by the human tendency to give disproportionate weight to negative events compared with positive events with a similar impact. This general predisposition, called *loss aversion* (Kahneman, 2011), may motivate individuals to expend more energy avoiding punishment than focusing on the opportunity to benefit others by doing the right thing. Accordingly, it appears that the inhibitory influences on morality have more influence than the proactive influences.

Additional research suggests that the floor and positive approaches to ethics reflect an inherent psychological mechanism, and not just a convenient way to describe different perspectives on ethics. For example, Carver (2006) has postulated the presence of two systems that either activate approach behaviors or avoidant behaviors.[2] These avoidant/approach processes might apply to moral behavior as well. Janoff-Bulman et al. (2009) stated:

> There are two systems of moral regulation as well—a proscriptive system sensitive to negative outcomes (i.e., anti-goals, threats, punishments, and other undesirable end states) and based on behavioral inhibition, and a prescriptive system sensitive to positive outcomes (i.e., goals, rewards, incentives and other desirable end-states) and based in behavioral activation. (p. 522)

According to Janoff-Bulman et al. (2009), avoiding prohibited acts and evading punishment reflect *prospective morality*, which includes obligatory, concrete, detailed, and clearly defined standards with the goal of evading punishment. Prohibited acts are found within the enforceable standards of the APA Ethics Code.

Acting to promote the well-being of others corresponds more closely to *prescriptive morality*, which includes more discretionary and abstract standards with the goal of achieving benefits. These may be seen as reflected in the General (aspirational) Principles of the APA Ethics Code.

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[2]Reiss (2012), among others, contended that motivation has more facets than dual motivational theories claim. We do not weigh into this argument; we only suggest that any motivational theory should rest on more than just avoidance of punishment.

Benefits of Positive Ethics

A positive approach to ethics can sensitize psychologists to the ethical implications of the decisions they face in their daily practices (Knapp et al., 2018). For example, they may have to decide whether to accept a particular patient, how to balance the apparently competing needs of family members and patients, or how much to support their patients' desires for freedom from or dependence on their families (Tjeltveit, 1999).

Positive ethics also may help psychologists to appreciate the values that form the basis of the APA and other Ethics Codes. Many rules, such as those prohibiting sexual contact with patients, respecting patient confidentiality, and avoiding harmful multiple relationships, are designed to avoid harming patients. Psychologists may be more willing to appreciate and support these rules if they understand their underlying moral basis.

If they are not burdened by excessive fear of being disciplined or shamed, psychologists may be more willing to discuss their ethical concerns openly with colleagues and seek consultation when appropriate. That way ethics gets discussed in the open rather than as part of an *ethics underground* where psychologists only whisper their most troubling ethical issues with a few colleagues whom they trust to keep their secrets. Ideally an ethics code will address the real-life concerns of psychologists in a manner that reflects their values.

Positive ethics will also assist psychologists in their ethical decision making, especially when it requires balancing the competing ethical demands in a given situation. Although some ethical rules for psychologists are absolute (e.g., do not have sex with patients, do not gossip about patients, do not falsify insurance forms), psychologists encounter many gray areas in which they need to exercise substantial judgment. These ethical dilemmas can be stressful for psychologists who sincerely want to do the right thing but can find no clear-cut answer in the APA Ethics Code. Psychologists who are more aware of the moral principles that underlie the APA Ethics Code should become better at identifying ethical issues, thinking through their implications, and following the optimal course of action.

Finally, the ethical imperative to promote general well-being may encourage psychologists to do more than just promote the well-being of their individual patients, students, or participants in their research programs. Instead, psychologists who adopt a positive approach may be more willing to help other psychologists become better practitioners, teachers, or researchers and promote institutional policies that are more sensitive to moral issues. Along those same lines, many psychologists recognize their important role as citizens in a wider community, and they aspire to address systemic social problems such as racism, poverty, heterosexualism, or other factors that impede human well-being. By working through their professional organizations in psychology or through other collaborative efforts, psychologists can collectively apply scientific information or a scientific perspective to social problems.

OVERVIEW OF THIS BOOK

We start this book by reviewing foundational ethical theories and their relationship to ethics codes (and specifically to the APA Ethics Code) and to ethical decision making. Then we apply these overarching principles and relevant standards of the APA Ethics Code to the areas of competence (Chapter 5), informed consent (Chapter 6), boundaries (Chapter 7), confidentiality (Chapter 8), life-endangering patients (Chapter 9), assessment (Chapter 10), forensic psychology (Chapter 11), special topics in psychotherapy (Chapter 12), and business issues (Chapter 13). We also discuss principles and standards related to psychologists as educators (Chapter 14), supervisors (Chapter 15), and researchers (Chapter 16). We have emphasized social justice issues throughout the book as appropriate and describe the special obligations incumbent on psychologists as citizens of the wider world.

As described in these chapters, the APA Ethics Code does not always provide direction for psychologists, who must then rely upon overarching ethical principles to guide their conduct.

Consequently, within these chapters, we describe three models for psychologists to use that will help them act in accordance with their ethical beliefs. First, in Chapter 2, we present the ethics acculturation model, which helps psychologists understand the professional roles that they must follow. Second, in Chapter 4, we present an ethical decision-making model to use when the ethical obligations of psychologists are unclear or when overarching ethical principles appear to conflict. Finally, in Chapter 9, we offer the quality enhancement model (adapted from the risk management model of Knapp et al., 2013), which helps when psychologists encounter difficult patients or patients with a high risk of failing at treatment.

2

Foundations of Ethical Behavior

People become psychologists for many reasons. A career choice, like many other choices, is probably overdetermined. Certainly, psychologists want employment that is interesting, pays enough, and has good working conditions. Nonetheless, another major reason for choosing any career is the opportunity to live out important ethical ideals (Martin, 2000). As such, most psychologists want a profession that allows them to live out their values. They want to integrate their personal commitments into their professional lives.

Like others, psychologists have asked themselves, "What is the good life?" "How should we live?" "What are our obligations to others?" and "What principles should guide our lives?" Although few psychologists have taken up a comprehensive study of philosophical ethics, most have deliberated conscientiously on their personal ethical positions. Our values are often influenced by our religious or cultural backgrounds, guided by parents and other caregivers, and altered through personal experiences. These values can become central to our self-concept.

We can enrich our efforts to clarify our personal and professional values by looking at recent studies from the science of morality, the long and rich traditions of philosophical ethics, and current efforts to re-evaluate long standing assumptions that have created and continue to support social inequality. First, we selectively review findings from the science of morality, which sheds light on what actually influences how we make our decisions. Then, we look at

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philosophical traditions and their influence on our personal and professional values. Finally, we consider how to integrate personal and professional values. Chapter 3 reviews the ethical foundations of social justice in more detail.

THE SCIENCE OF MORALITY

Studies from the science of morality help elucidate factors that influence our decisions, for better or worse. From these studies we learn that (a) ethical knowledge does not always result in ethical behavior, (b) our mental architecture is not naturally suited to making impartial decisions, and (c) emotions may influence our decisions in ways outside of our conscious awareness.

Several analogue studies and surveys have found that graduate students of psychology and practicing psychologists reported differences between what they should do and what they would do when applying ethical principles of conduct in their professional lives (e.g., Bernard & Jara, 1986; Venkatesh & Lovibond, 2020). Personal factors, such as a relationship with one of the parties in the dilemma, influenced the willingness to do what "should" be done, especially if the dilemma was ambiguous.

In one scenario in the study by Bernard and Jara, participants were told that a fellow graduate student's alcohol abuse is negatively affecting his clinical competency. Participants were asked to apply the applicable standard from the American Psychological Association's (APA's; 2017a) *Ethical Principles of Psychologists and Code of Conduct* (APA Ethics Code) to determine what they should do and then to identify what they would do if they were friends with this graduate student. However, only 45% of participants said they would do exactly what they should do and 55% said they would do less. From this and other experiments and surveys, one may conclude that simply knowing the rules of ethics is necessary but not sufficient for ensuring ethical practice. A conclusion is that meaningful discussion of ethics within the practice of psychology must consider how contextual factors and value systems influence behavior. Next, we review three lines of research from the science of morality (moral foundations theory; moral dumbfounding, and emotional reactions to hypothetical trolley dilemmas) that may help explain why psychologists (and other moral agents) sometimes find it hard to act consistently with their values.

Moral Foundations Theory

One body of research on intuitive morality concerns Haidt's moral foundations theory (Graham & Haidt, 2012), which identified five central value systems that influence human behavior:

- **Care:** Humans are motivated to care for others and avoid actions that would cause harm or suffering.
- **Fairness:** Humans value reciprocity and cooperation in their relationships. This value is best exemplified in the Golden Rule—"Do unto others as you wish they would do unto you."

- **Loyalty:** Humans are loyal to groups with which they associate. They sacrifice their own interests for the benefit of their families, communities, and countries.
- **Authority:** Humans respect and abide by the wishes of higher status individuals (e.g., parents, government officials, spiritual leaders, police).
- **Sanctity:** Humans value purity, cleanliness, and chastity in their behavior. This value is most associated with religious practices (e.g., Kosher laws) but can also be seen in secular practices (e.g., veganism).

Haidt theorized that humans are born with an innate sense of morality that becomes fine-tuned through their interactions with their environment. Moral learning occurs within a cultural context. All cultures subscribe to the five moral foundations to some degree, but the proportion of value on each foundation may vary from culture to culture. For example, collectivist cultures may value loyalty and authority more than individualist cultures. Those who follow orthodox religions may value sanctity more than those who do not.

One can see the relevance of the moral foundations approach to actual behavior. Haidt did not argue that moral agents should use these five factors in making their ethical decisions; he argued that they actually do use these five factors. These findings suggest some insights as to why psychologists failed to do what they should by turning in a colleague who appeared to be impaired from the abuse of alcohol. Perhaps these psychologists were overly influenced by notions of loyalty to a friend.

The Role of Rational and Intuitive Thinking Models: Moral Dumbfounding

Furthermore, Haidt (2001) stated that our moral decision making tends to be intuitive rather than reasoned. When faced with a moral dilemma, individuals instinctively judge the situation as "good" or "bad" and then use their reasoning to justify their already-made judgments. As an example, consider this moral dilemma that Haidt used in one of his studies:

Julie and Mark are brother and sister. They are traveling together in France on summer vacation from college. One night they are staying alone in a cabin near the beach. They decide that it would be interesting and fun if they tried making love. At the very least it would be a new experience for each of them. Julie was already taking birth control pills, but Mark uses a condom too, just to be safe. They both enjoy making love, but they decide not to do it again. They keep that night as a special secret, which makes them feel even closer to each other. What do you think about that? Was it OK for them to make love? (Haidt, 2001, p. 814)

Most individuals who read this vignette judged Julie and Mark's behavior as immoral. However, when asked to explain the reasoning behind their judgment, participants had difficulty finding a rational explanation to support their decision. Is their incestuous behavior wrong because they might produce

a baby with birth defects? No, the vignette explained that Julie and Mark used birth control. Is their behavior wrong because it may cause stigma within their community? No, the vignette explained that Julie and Mark will not tell anyone that they made love. Is their behavior wrong because it will cause a rift within their familial relationship? No, the vignette explained that Julie and Mark felt even closer to each other. Haidt coined the term *moral dumbfounding* to describe the experience that occurs when individuals are unable to justify their moral judgments through reasoning. When pushed to find a rational explanation for this vignette, many participants simply concluded that, "I do not know why, but it's just wrong!"

Haidt further opined that we have two interacting systems for evaluating moral issues. System 1 (the dumbfounding system) operates automatically and instinctively. System 2, on the other hand, is slower to act, requires effort to activate, and is deliberative (see Kahneman, 2011, for a more detailed description of System 1 and System 2 thinking). While not all researchers concur with the conclusions that Haidt drew from his studies (Royzman et al., 2015), we nonetheless find that his conception of two systems of moral evaluations can help psychologists to consider how they respond to the situations they encounter. Perhaps some of the psychologists responding to the dilemmas presented by Bernard and Jara were relying more on System 1 thinking in formulating their responses.

Emotions and Decision Making

Emerging evidence suggests that emotions play an influential role in decision making. This can be seen in a classic set of experiments designed by philosophers Foot and Thomson (see the review in Edmonds, 2014). Foot and Thomson presented participants with two moral dilemmas. In the first dilemma, a runaway trolley is heading down a track towards five people. Participants can save the five people from death if they hit a switch that will divert the train towards another track, where it will kill only one person. Participants were asked whether they would kill one person to save five. Most participants said that they would. In the second dilemma, a runaway trolley is still heading down the track towards five people. In this version, however, participants can save the five people from death if they push a large stranger off of a footbridge onto the track below, thus stopping the train and saving five lives, although the large stranger would die. Participants were asked whether they would push the large man to his death in order to save five. Most participants said that they would not. What might explain the discrepancy of participants' responses to the two dilemmas? Logic would dictate that participants would apply the same cost–benefit analysis to both dilemmas. However, something gives participants a pause when they have to be personally involved in killing a person, even a stranger, although it would result in saving five lives.

J. D. Greene et al. (2001) examined this discrepancy further. They asked nine participants to respond to 60 dilemmas while undergoing fMRI brain scanning.

The dilemmas were characterized as either nonmoral, moral-impersonal, or moral-personal. fMRI results found that areas of the brain associated with emotions were more active when participants engaged in the moral-personal dilemmas compared with nonmoral and moral-impersonal dilemmas. Additionally, areas associated with working memory that are typically less active during emotional processing, were less active during the moral-personal dilemmas when compared to the other two conditions. These results suggest that moral reasoning activates portions of the brain dealing with emotions. Moral dilemmas are not just abstract problems to be solved rationally. Instead, they can involve very deep and intense emotions.

Edmonds (2014) has acknowledged the debates over whether the trolley dilemmas are too artificial or removed from real-life events. Nonetheless, the studies show that making ethical decisions activates areas of the brain dealing with emotions. Such decisions can require considerable cognitive and emotional effort, which suggests that figuring out the right thing to do sometimes requires hard work. Still, from these and other studies we may conclude that moral agents, including psychologists, respond to ethical dilemmas by relying on implicit values, which can be activated spontaneously and without forethought, and which can generate much emotional turmoil.

FORMAL PHILOSOPHICAL SYSTEMS

The second source of guidance comes from the long rich tradition of philosophical ethics. Formal philosophical systems have a place in the discussion about ethics because they can enhance the ability to identify and clarify ethical issues, ground or justify ethical positions, or help psychologists make good decisions in situations in which their ethical obligations are not clear (Tjeltveit, 1999). Tjeltveit (1999) claimed that psychologists who desire to reach high standards of conduct need to understand their values and moral traditions. Psychologists who have a clear sense of what they believe and why they believe it can make better ethical decisions. A well-trained psychologist can empathize with their clients' suffering and can call on deeply held ethical schemas even during periods of considerable personal turmoil.

We briefly review five philosophical systems (virtue ethics, communitarian ethics, utilitarianism, deontological ethics, and principle-based ethics) that appear particularly helpful to psychologists. Although philosophers have considered these systems in detail, they have more than theoretical or historical importance. Many of the terms and assumptions of these ethical systems have seeped into common culture and influence how people interpret everyday ethical situations. Although all ethical systems have their weaknesses, these systems have endured because of their coherence and usefulness in addressing ethical problems. This brief review can only touch the surface of these major philosophical traditions because each tradition has numerous subthemes, variations, and branches.

These philosophical systems have important differences, but the differences should not be overemphasized. The systems often start in different places on an issue but end up in a similar location. They may appear highly dissimilar on the surface, but they lead to similar conclusions on most of the ethical issues that psychologists face. That is to say, they are consistent with the common morality. Only on the more technical or specific issues do they lead to differences in conduct.

We do not include *self-interest* as one of the philosophical systems reviewed here because it has never attracted a substantial following among philosophers or even in the public in general. Respect for legitimate self-interest is an integral part of all of the philosophical systems reviewed. Certainly, pursuing one's enlightened self-interest, if conducted appropriately, usually contributes to the overall social welfare. Furthermore, self-interest as an overarching and comprehensive philosophical perspective lacks internal consistency. Persons who believe in self-interest as a comprehensive philosophy believe that the primary ethical obligation of all individuals is to promote their own welfare. However, to promote their own welfare to the fullest, they would have to argue that others should be altruistic toward them. In other words, they must argue against their own philosophical system to promote it.

Feminism has had a substantial influence on important current ethical issues, although it is often applied in the context of other ethical systems (Norlock, 2019). Adherents of feminism can be found among those who advocate virtue ethics or other philosophical systems. Feminism's influence is especially important when considering issues dealing with fairness and abuse of power (e.g., Brabeck, 2000). Consequently, we do not discuss feminism as a separate ethical system but refer to feminist influences on ethical thinking as appropriate throughout this book. In the discussion that follows, we show an inclination toward principle-based efforts, but we rely on perspectives from other ethical theories when they appear useful.

Virtue Ethics

Whereas most ethical theories focus on a dominant principle of moral behavior, virtue ethics focuses on individual character. *Virtues* are character traits that have moral value. Aristotle was the first major Western philosopher to emphasize virtues in the conceptualization of morality, although a virtue-oriented approach to ethics is found in the writings of non-Western philosophers as well, such as Master Kong-Fut-zi (Confucius) and Méng Ke (Mencius).

According to virtue ethics, an ethical professional has the right mixture of motives, knowledge, and character. Adherents of virtue ethics may disagree about which virtues are essential and how to define them, but Meara et al. (1996) included the following: (a) prudence (demonstrating planned, appropriate forethought, and good judgment), (b) integrity (adherence to an internally consistent code of conduct), (c) respectfulness (considering others worthy of high regard or special attention), and (d) benevolence (acting to help

others). Feminists have expanded on these virtues. For example, Kitchener (2000) noted that respectfulness from a feminist perspective requires listening to the perspectives of other persons, especially those who come from populations that have traditionally been underrepresented or oppressed.

Other non-Western religions or philosophies have identified similar virtues. For example, a review by Dahlsgaard et al. (2005) found that the major religions or philosophies of the world (Athenian philosophy, Buddhism, Christianity, Confucianism, Hinduism, Islam, and Judaism) all focus on the importance of courage, justice, humanity (love and kindness), temperance, wisdom, and transcendence (appreciation of the universe through hope and gratitude).

Proponents of virtue ethics claim that ethics codes can never cover all the situations that psychologists may encounter. Instead, ethics codes require psychologists and other moral agents to use their judgment in implementing moral principles in novel or ambiguous situations. Indeed, it would not be appropriate to try to replace the judgment of virtuous psychologists with an exhaustive list of rules calculated to predict every possible situation. Such a system of rules, even if it could be comprehensive, would risk becoming so complex that it would be unmanageable and miss nuances of the individual situation that can undercut goals.

Furthermore, it could be claimed that other systems of ethics risk turning ethical dilemmas into intellectual puzzles that are solved through the application of specific rules. On the other hand, virtue ethics forces individuals to see ethical dilemmas as human activities that sometimes involve strong and competing motives and emotions.

On the whole, virtue ethicists argue that it is better to emphasize character building in psychologists than to just try to enforce conformity to rules. The virtuous psychologist chooses the virtuous act because it is the right thing to do, not because of any anticipation of personal gain. Over time, psychologists who act virtuously will cultivate a steady state of character whereby virtuous actions become more automatic and eventually become nurtured habits.

Critics of virtue ethics are not opposed to virtues such as benevolence and integrity but believe that virtues may not be the optimal formulation for an ethical theory. Although they may claim that the virtues listed previously strongly resemble the ethical principles articulated by others (e.g., benevolence corresponds to beneficence, respectfulness corresponds to respect for patient autonomy), they see no merit in framing these concepts in terms of personality traits as opposed to more abstract ethical principles (Bersoff, 1996). Furthermore, the virtue ethics perspective does not naturally lead to an ethical decision-making formula as do other systems of ethics.

Communitarian Ethics

Adherents of communitarian ethics can represent a range of differing political, economic, or ideological perspectives, but generally they focus on the importance of close relationships and the common good. They represent a reaction

against extreme individualism. Communitarians believe that people function best when they are well integrated into social networks. Historically those networks have been geographically localized, although today people with common interests can connect remotely through electronic communications. Psychologists who work together on common projects or who share similar values may constitute one of those close social networks. One communitarian, Amitai Etzioni, refers to this as a "thicker social order" (1996, p. 10). In addition, the common goals of communitarians focus more on social goods, or the well-being of the community and less on individual well-being. While individual rights and personal autonomy are important, they should not, according to communitarians, be overemphasized, and moral agents should not pursue self-interest or self-actualization at the cost of public well-being.

Communitarian approaches have been influential in psychology. As discussed later in Chapter 5, communitarian psychologists would strive to embed themselves in a social network that both supports and challenges them. They may, for example, have frequent contact with each other, work on shared projects, give each other feedback and support, and focus on ways that they can further their shared values. The shared values include the improvement of public health, which could be accomplished by improving one's own level of competence but could also be achieved by helping others within their social network to improve their levels of competence as well. Psychologists who foster their social networks tend to have lower rates of burnout, more satisfying careers, and better patient outcomes (see the discussion of self-care in Chapter 5).

Deontological Ethics

Immanuel Kant (1724–1804) is the leading figure in the history of deontological (i.e., duty-based) ethics. The primary goal of ethical behavior according to Kant is for individuals to fulfill their duties. Happiness is only a fortuitous by-product of doing one's duty. Being happy is not necessarily immoral; it is possible to be happy while doing one's duty. However, happiness is not an end in and of itself. Moral[1] actions do not occur out of spontaneous emotions but out of an intention to fulfill one's responsibilities. "An action done from duty must wholly exclude the influence of inclination" (Kant, 1785/1988, p. 25).

While all religions and philosophies recognize the high importance of some ethical principles, Kant's early writings were unique in that he made no exceptions for following these rules. Despite this limitation, Kant did make enduring contributions in his consideration of moral motivations, the importance of the categorical imperative (a version of the Golden Rule), and his influence on the origin of other ethical theories, including principle-based ethics.

[1]Ethicists disagree on how to distinguish morals and ethics. In this book we use moral or morality to refer to universal standards of conduct and ethics or ethical to refer to standards of conduct specific to a health care profession, although many times the words can be interchangeable.

According to Kant (1785/1988), people can do the right thing for the wrong reasons. The consequences of an action are irrelevant for determining the morality of an action. For example, three psychologists may reduce the fee for an uninsured self-pay patient who is unable to afford the full cost of psychotherapy. The first psychologist may believe that she has a duty to provide some services to those who otherwise cannot afford them. The second psychologist would rather fill up his empty time slot with a partial-payment patient than to leave it empty. The third psychologist may be moved by the plight of a patient and act out of a spontaneous moment of sympathy. According to Kant, the first psychologist would be acting ethically, whereas the second and third would not. Although all performed the same outward act, they are not morally equal. The first is fulfilling an obligation to help others, the second is promoting their self-interest, and the third is responding to a spontaneous emotion.

Kant (1785/1988) distinguished between *hypothetical (conditional) imperatives* and *categorical (universal) imperatives.* The hypothetical imperative can be expressed in the form of an *if–then* statement. A hypothetical or conditional imperative tells one to act in a certain way if one wants to achieve a certain result. An example of the hypothetical imperative might be, "If I want to become licensed as a psychologist, then I need to pass the licensing examination." The categorical imperative applies to all persons even if there is no *if*. The categorical imperative commands an individual to act a certain way at all times. Obedience to a categorical imperative is a duty, whereas obedience to a hypothetical imperative is only a matter of prudence.

Kant (1785/1988) established several versions of the categorical imperative, and the two most familiar ones are repeated here. Kant's first formulation of the categorical imperative was to "act only on that maxim whereby thou canst at the same time will that it should become a universal law" (p. 49). Kant's second formulation was to "act as to treat humanity, whether in thine own person or in that of any other, in every case as an end withal, never as means only" (p. 58).

These formulations have a not coincidental similarity to the Golden Rule of Christianity. Although Kant was influenced by the Christian tradition, similar golden rules have been found in Judaism ("love your neighbor as yourself," Leviticus 19:18; Good News Translation, 2003), Buddhism ("That which one desireth not for oneself, do not do unto others," cited in Ballou, 1976, p. 157), Confucianism ("What you do not want done to yourself, do not do to others," cited in Ballou, 1976, p. 489), Islam ("No one of you is a believer until he loves for his brother what he loves for himself," cited in Ballou, 1976, p. 476), and other religions.

The categorical imperative does not state that one cannot use other people as a means; it states that one cannot use other people *only* as a means. For example, psychologists can charge patients for health care services. In that sense, psychologists are using them as a means to promote their self-interest. However, such actions are moral if the patients get health care services in exchange for the money. Similarly, research psychologists can enroll participants

in their study. In that sense, research psychologists are using them for their own purposes. However, the relationships between researcher and participant would be considered ethical if the participants get something in return, such as course credit, insight into the research process, or payment.

The categorical imperative can have profound implications for the professional behavior of a psychologist, insofar as it emphasizes the importance of focusing on the intrinsic worth of individuals. The categorical imperative breaks down the us/them dichotomy. It requires psychologists to consider how they may have inadvertently adopted implicit prejudices that could diminish the fairness with which they treat others. Self-awareness therefore becomes a prerequisite to living an ethical life. As stated by Lao-Tze, "He who knows others is wise; He who knows himself is enlightened" (cited in Ballou, 1976, p. 548).

Utilitarianism

Although seeds of utilitarianism can be found in the writings of some early philosophers, such as Mencius, utilitarianism is best known to Western audiences through the English social reformer Jeremy Bentham (1748–1832) and was best articulated by John Stuart Mill (1806–1873). According to utilitarianism, the consequences (i.e., the sum of happiness and unhappiness) to everyone involved determine the moral value of an act. According to Mill (1987), "The creed which accepts as the foundation of morals, Utility or the Greatest Happiness Principle, holds that actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness" (p. 278). Utilitarianism, therefore, is concerned with maximizing benefits for all relevant parties.

The three essential features of utilitarianism theory are that it is *consequential, hedonistic,* and *universal* (Knapp, 1999). It is consequential in that the litmus test of morality depends on the consequences or outcomes of behavior. This contrasts with deontological theory, in which the intentions of the actor are important, but the consequences are incidental to the morality of the action. Utilitarianism is hedonistic in that happiness, pleasure, or well-being is the goal of behaviors. It is universal in that the happiness, pleasure, or well-being of others (generalized benevolence) is just as important as the happiness of the individual in determining the morality of an action.

Principle-Based (Prima Facie) Ethics

Principle-based or prima facie ethics has been especially influential in American health care (e.g., Beauchamp & Childress, 2019). In this book, we rely heavily on principle-based ethics to analyze and understand the ethical obligations and aspirations of psychologists and to formulate responses to ethical dilemmas.

Sir William David Ross (1877–1971) developed principle-based ethics. Ross wanted an ethical theory that could address the shortcomings of both deontological and utilitarian theories (Knapp & VandeCreek, 2004). The major

characteristic of ethical behavior in deontological ethics is that the actors are attempting to fulfill their duties. The outcomes of the action are not important, but the intentions of the actor are. Deontological theory is absolute in that it allows no exceptions to its categorical imperatives. However, Ross argued that sometimes the most moral action requires breaking absolute rules. For example, if we apply Ross's perspective to health care, at times it may be more moral for a psychologist to slant or withhold information from a patient if doing so upholds another important moral principle, such as protecting the patient or others from great harm.

According to utilitarianism, actors attempt to maximize the benefits to all affected persons and should not give special consideration for the impact of behavior on personalized relationships such as family bonds or friendships. Utilitarianism judges ethical behavior according to the standard of utility: the greatest good for the greatest number. However, at times moral agents have obligations to specific individuals (e.g., family members, close friends) that transcend their obligations to society in general. For example, according to Ross, the obligations that psychologists have to family members may require them to restrict the amount of their pro bono services, even though psychologists could assist more people and improve the overall good of the community.

According to Ross (1930/1998), the best ethical theory rests on several moral principles referred to as *prima facie duties,* meaning an obligation that holds unless it is overridden by a superior obligation. These duties are sometimes referred to as *ethical intuitions.* They may be seen in the prereflective immediate reactions of individuals when they see an injustice. For example, most individuals would not think twice or engage in the steps of moral decision making when they see a gross injustice. Ross identified several prima facie duties, such as fidelity, gratitude, justice, beneficence, self-improvement, and nonmaleficence, but acknowledged that there may be others as well.

According to Beauchamp and Childress (2019), five moral principles are especially important in the field of biomedical ethics (beneficence, nonmaleficence, respect for patient autonomy, justice, and respect for patient relationships). Respect for patient relationships includes the concept of *fidelity* identified by Kitchener (1984) and Bersoff and Koeppl (1993). We suggest that *public responsibility* (or *general* or *public beneficence*) is a sixth moral principle applicable to psychologists.[2]

Beneficence means working to help others. "Morality requires that we treat people autonomously and refrain from harming them, but morality also requires that we contribute to their welfare" (Beauchamp & Childress, 2019, p. 197). Psychologists have a positive obligation to help patients by conscientiously implementing appropriate services for them.

[2]You may notice some overlap between prima facie principles and two of the five moral foundations of Haidt (care and fairness). The fact that Haidt's moral foundations do not correspond exactly to the six essential moral principles of principle-based ethics as applied to health care is not a concern. Principle-based ethics reflects normative ethics (what factors people should consider when they act), while Haidt is investigating descriptive ethics (what factors people really do consider when they act).

"Nonmaleficence obligates us to abstain from causing harm to others" (Beauchamp & Childress, 2019, p. 155). Although many psychologists remember this moral principle through the phrase *primum non nocere* ("First, do no harm"), Ross did not suggest that this moral principle always overrides other moral principles. Given the right set of circumstances, another moral principle could take priority over nonmaleficence.

Respect for autonomy means respecting the freedom of others to do as they choose, as long as they do not infringe on the rights of others. To respect a patient's autonomy is to "acknowledge their right to hold views, to make choices, and to take actions based on their values and beliefs" (Beauchamp & Childress, 2019, p. 104). Under this principle, psychologists should treat patients as autonomous and independent agents who can participate as full partners in determining their treatment goals and expressing preferences for treatment methods.

Different theorists conceptualize justice differently. However, from the perspective of principle-based ethics as described by Beauchamp and Childress (2019), justice has two major aspects to it. *Formal (procedural) justice* refers to equal treatment either before the law or by others. *Distributive justice* refers to the equitable distribution of resources. Procedural justice and distributive justice are not orthogonal, as psychologists who treat others fairly make it easier for them to access available resources.

Procedural justice is a prima facie obligation within the professional activities of psychologists. That is, psychologists have an obligation to treat all individuals fairly. For example, psychologists should refrain from discriminating against persons because of race, religion, national background, sexual orientation, disability, or any other basis proscribed by law (Knapp & VandeCreek, 2004). Distributive justice is a discretionary obligation in that no law or standard requires psychologists to donate time or resources to promote the well-being of those who do not have equal access to resources. However, distributive justice takes on substantial significance as a justification for a social justice perspective or a perspective that shows concern for health inequity and other social inequalities. Chapter 3 covers social justice in more detail.

According to the principle of fidelity, psychologists should be faithful to their obligations (Kitchener, 1984). Psychologists show fidelity when they protect patient confidentiality and avoid harmful conflicts of interest.

Responsibility to the public at large, citizenship, or general (public) beneficence is a sixth moral virtue. General beneficence corresponds closely to "responsibility to society," one of the principles identified in the Canadian Psychological Association's (2017) *Code of Ethics for Psychologists.* For example, psychologists may have a responsibility to act to protect the public when one of their patients presents an imminent danger to harm an identifiable third party (see Chapter 9). In another example, psychologists have a responsibility to protect future consumers of psychological services by protecting the integrity of psychological tests.

Furthermore, moral agents should generally follow these moral principles. Nonetheless, at times it may be impossible to follow one moral principle without violating another. One moral principle may override another moral principle in some situations. According to Ross (1930/1998):

> When I am in a situation . . . in which more than one of these prima facie duties is incumbent on me, what I have to do is to study the situation as fully as I can until I form the considered opinion (it is never more) that in the circumstances one of them is more incumbent than any other. (p. 268)

Beauchamp and Childress (2019) identified six conditions that must be met before infringing on a moral principle. First, "good reasons are offered to act on the overriding norm rather than on the infringed norm." Second, "the moral objective justifying the infringement has a realistic prospect of achievement." Third, "no morally preferable alternatives are available." Fourth, "the lowest level of infringement, commensurate with achieving the primary goal of the action, has been selected." Also, "all negative effects of the infringement have been minimized." Finally, "all affected parties have been treated impartially" (p. 23).

For example, professional psychologists respect patient autonomy by acknowledging patient control over the direction and major events of psychotherapy. However, under rare circumstances, such as when a patient presents an imminent danger of self-harm, psychologists have to consider whether to temporarily invoke the principle of beneficence (e.g., break confidentiality and notify a family member of the serious suicidal threat) to override the principle of respect for patient autonomy.

Using the six conditions identified by Beauchamp and Childress (2019) with a suicidal patient, for example, psychologists would ask themselves, "Is protecting the life of the patient more important than ensuring their autonomy?" "Will breaking confidentiality have a realistic chance of protecting the life of the patient?" "Is there any other alternative to breaking confidentiality?" "Can I infringe on confidentiality as little as possible to ensure the safety of the patient?" and "Can I minimize the harm caused by the breach of confidentiality?" Finally, psychologists should ask themselves if their decision is influenced by any morally irrelevant information. Morally irrelevant information might include minor inconveniences to the psychologist in implementing measures to protect the patient.

Even though beneficence may trump respect for patient autonomy, the psychologist can minimize the infringement of autonomy and involve the patient as much as possible in selecting the intervention designed to reduce the likelihood of self-harm (Knapp & VandeCreek, 2007a). For example, if the desired intervention requires notifying the spouse of the patient, then the psychologist can ask the patient, "How should we go about informing your spouse? Do you want to be present when I share the information about your needs?" If the psychologist speaks to the spouse directly, then the psychologist should give only

the minimal amount of information necessary to achieve the goal. Chapter 4 covers ethical decision making in more detail.

INTEGRATING PERSONAL AND PROFESSIONAL ETHICS

One of the advantages of relying on overarching ethical theories is that they help specify what moral agents, such as psychologists, can do as they strive to reach their highest ethical ideals. The ethical systems reviewed here can promote standards of conduct higher than the minimum found in the disciplinary codes of the profession and consistent with the goals of positive ethics (Knapp & VandeCreek, 2003). Consequently, the question that should be asked is not, "What must I do to fulfill the minimum requirements of the APA Ethics Code?" Instead, it should be, "What must I do to fulfill my ethical ideals?" If psychologists strive to become moral maximalists instead of moral minimalists, they will still follow the disciplinary codes, but only as the beginning of their ethical responsibilities. According to Beauchamp and Childress (2019), concentrating only on minimal obligations "dilutes the moral life. . . If we expect only the moral minimum of obligations, we may lose an ennobling sense of moral excellence" (p. 50).

Psychologists base their lives on ethical theories, implicitly or explicitly, such as those reviewed here, and do not approach the practice of psychology in a moral vacuum. They have a background of personal beliefs that they bring to their professional duties.

Generally speaking, the moral foundations of one's personal ethics should be consistent with the moral foundations of one's professional ethics. Psychologists will show more commitment to their professional ethics if they can connect the moral standards underlying professional ethics with their personal ethics.

However, the manner in which psychologists implement ethics in their personal lives differs from how they implement ethics in their professional lives. For example, beneficent behavior among friends may involve mutual self-disclosure, the exchange of gifts, touching, exchanging favors, and the possibility that a sexual relationship may develop given the willingness or availability of the other person. In contrast, beneficent behaviors between psychologists and patients involve primarily one-way self-disclosure, restrictions on gift giving and touching, and no sexual relationship. Friends may loan each other money or set up dating relationships. Psychologists do neither of these with their patients.

One of the goals of psychology training programs is to help students understand how moral principles are actualized or implemented differently in their personal and professional lives. Psychology students bring a set of habits or perceptions of how to implement their personal value system without understanding how those same behaviors could harm patients or themselves when implemented within the unique role of a psychologist.

Handelsman et al. (2005) and Anderson and Handelsman (2021) described this socialization process in terms similar to those used by Berry and Kim (1988) in describing acculturation. Just as recent immigrants bring their distinct cultural background into the United States, psychology students bring their distinct value systems into psychology. Just as recent immigrants vary in the extent and speed to which they acculturate themselves to the United States, students vary in the extent and the speed to which they acculturate themselves to the unique ethical demands found in psychology.

Acculturation is a complex process, and immigrants typically fall along a continuum of acculturation. They may be acculturated in some parts of their lives but not in others. It is also a process that may continue throughout their lifetimes.

The model by Handelsman et al. (2005) is a metaphor that helps explain how to integrate personal and professional ethics. Psychology students who are not acculturated to the roles of their future profession may be more willing to act as a friend would with patients and loan money, give advice, self-disclose personal information, and give or receive gifts. Students who are well acculturated to the roles of the profession would be less likely to cross those boundaries.

This does not mean that psychologists lose the capacity to feel compassion. However, psychologists express their compassion in friendships differently from how they express it in a professional relationship. Psychologists know that in the long run they can best promote the welfare of their patients by adhering to certain norms of behavior.

In the acculturation process, the students (or psychologists) can be described as being high or low in their degree of identification with their personal value system and high or low in their degree of identification with the value system of psychology. This classification is shown in Table 2.1.

Students who are low on personal ethics but high on professional ethics may attempt to follow the letter of the code but fail to understand the meaning behind it. They are at risk of developing an overly legalistic stance. Handelsman et al. (2005) would identify these students as relying on an *assimilated strategy.*

TABLE 2.1. Ethics Viewed From an Acculturation Model

Professional ethics	Personal ethics	
	High	**Low**
High	Integrated	Assimilated
	Professionally informed; guided by personal compassion; highly effective psychologist	Adopted professional standards but lacks compassion; may become rigid and legalistic
Low	Separated	Marginalized
	Personal compassion not restrained by professional ethics; may get overinvolved (runaway compassion)	Low professional and personal standards; risks becoming exploitative

From the standpoint of Haidt's moral foundations theory, they may have a disproportionate allegiance to authority.

Students who are low on personal ethics and low on professional ethics present the greatest risk of harming others. They are at risk of being motivated primarily by self-interest and not by concern for their patients. Furthermore, they lack an appreciation of professional ethics. Handelsman et al. (2005) would identify these students as relying on a *marginalized strategy.*

Students who are high in personal ethics but low on professional ethics have strong personal values. However, they fail to see how the unique roles of psychologists direct the implementation of those values. They risk allowing spontaneous impulses of compassion to override good professional judgment. Handelsman et al. (2005) would identify these students as relying on a *separated strategy.* From the perspective of Haidt's moral foundations theory, these students may give a high priority to fairness or caring but fail to alter its expression to account for the uniqueness of the professional relationship.

Finally, students who are high on personal ethics and high on professional ethics understand how to implement their personal values in the context of a professional role. Handelsman et al. (2005) would identify them as relying on an *integrated strategy.* Research has found that more experienced students were more likely to integrate personal and professional constructs when engaging in an ethical decision-making task compared with less experienced students who relied more on personal constructs (Jenkin et al., 2021).

The description of a professional using an integrated strategy corresponds closely to Jordan and Meara's (1990) description of a virtuous professional. According to Jordan and Meara, professional training introduces a new context for defining and developing virtues.

> People socialize one another into a professional culture that they continually construct and shape and from which they seek inspiration and support. As time passes, certain shared assumptions and values are "taken for granted" and form the character of the profession and are part of the individual characters of the professionals. (Jordan & Meara, 1990, p. 110)

Here is an example of how psychologists using assimilated, marginalized, separated, and integrated strategies might respond to a clinical situation.

CASE EXAMPLE: SHOULD THIS QUESTION HAVE BEEN ANTICIPATED?

A patient requested psychological services for her marital problems and saw that the psychologist was wearing a wedding ring. She asked the psychologist if he had ever been divorced.

A psychologist using a marginalized strategy (low personal ethics and low professional ethics) might say whatever was convenient without concern for the patient or the consequences to treatment. That psychologist might say, for example, "Sure. I have been married for seven years. Let me show you a picture of my wife," or other similar comments that would draw the attention away from the patient.

A psychologist using an assimilated strategy (low personal ethics and high professional ethics) would be at risk of taking a rigid stance and stating, "I am sorry, but that is not directly relevant to your problem, and I do not have to answer it."

A psychologist using a separated strategy (high personal ethics and low professional ethics) would risk reacting spontaneously and stating, "No, I have never been divorced" in the same manner that they would respond to any ordinary social inquiry about their marital status. The psychologist has followed the general social convention of disclosing this information without considering its impact on the treatment relationship.

A psychologist using the integrated strategy (high personal ethics and high professional ethics) would seek a way to respond in a manner that promotes the effectiveness of treatment. Some psychologists using an integrated strategy may give a very limited disclosure as to whether or not they were ever divorced (others may decline to respond at all). However, all psychologists who use the integrated strategy would focus on the meaning of the question for the patient. They would know that these inquiries sometimes reflect a desire of the patient to know if the psychologist has the skills to deal with their problems or has the ability to understand their experiences. At other times, patients may wish to divert the conversation away from the unpleasant issues that they face. A psychologist using the integrated strategy would respond in a way that helps address the potential needs of the patient.

Psychology instructors can promote integrated strategies by taking a positive approach to ethics. Ideally, instructors create a supportive environment in which students reflect on their implicit ethical assumptions. Instructors will be able to identify the adaptive strategy of the students and move them closer to integration. Just as clinical supervisors are more effective when they know their supervisees, ethics educators can be more effective when they understand how their instructions fit within the values and skills of their students.

3

Social Justice

Psychologists do many things to improve public well-being and to help people address their life problems and live better lives. They may treat patients who have mental or physical illnesses, help develop effective educational programs, improve organizational behavior, help individuals select appropriate careers, teach, or conduct socially useful research. One of the biggest problems facing society is the unequal access to good-paying jobs, health care, good schools, and the other opportunities that help promote a good life. So, those who work to improve public well-being need to understand issues of social justice.

Social justice refers to the application of the principles of justice throughout all of society including procedural justice (i.e., the fair treatment of all persons), distributive justice (i.e., the fair distribution of resources across society), and interactional justice (i.e., fairness in social relationships; Abraham et al., 2022). Adopting a social justice orientation involves being sensitive to those who have less access to social goods including those from groups that have been historically marginalized. For example, psychologists who apply procedural justice would treat a patient who is a recent immigrant to the United States with the same high quality of service as they would a native-born patient. Psychologists who adhere to the principle of distributive justice might offer low-cost services to persons who would otherwise be unable to afford them. Psychologists who utilize interactional justice would ensure that all their research participants feel safe to ask questions about their experiments and are treated respectfully.

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Some ways of promoting social justice are obligatory for psychologists because they are embedded in the American Psychological Association's (APA's; 2017a) *Ethical Principles of Psychologists and Code of Conduct* (APA Ethics Code), whereas other ways to promote social justice are discretionary. The APA Ethics Code, for example, in Standard 2.01b, Boundaries of Competence, mandates:

> 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.

Also, Standard 3.01, Unfair Discrimination, mandates that "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." Both Standards 2.01, Boundaries of Competence, and 3.01, Unfair Discrimination, are based on the overarching ethical principles of Beneficence and Nonmaleficence (Principle A) and Justice (Principle D).

However, other activities related to social justice are discretionary and are not mandated by the APA Ethics Code but are nonetheless vital. Nothing in the APA Ethics Code, for example, compels psychologists to vote, volunteer for community organizations that serve the poor, or conduct research on issues dealing with environmental justice. However, an aspirational social justice perspective urges psychologists to go beyond the minimum required in the APA Ethics Code and proactively promote social justice, especially as this applies to groups that have been historically marginalized. This requires sensitivity to issues of social advantage, an awareness of past and current systemic injustices against marginalized groups, and a willingness to self-reflect and consider the ways that one may inadvertently contribute to social inequalities.

One can ground a social justice perspective on many ethical theories. According to principle-based ethics, moral agents can ground their ethical behavior on "the mere fact that there are other beings in the world whose condition we can make better" (Ross, 1930/1998, p. 269). According to utilitarianism, ethical actions should be based on what is best for everyone—meaning that everyone—including those who are most marginalized in society, should have their concerns and well-being addressed. According to virtue ethics, virtuous persons act with concern for others, including those who are disadvantaged. Finally, the categorical imperative in the deontological perspective requires moral agents to treat everyone, including those who are different from themselves or less advantaged, as they would want to be treated themselves.

The needs of society are huge, and one could become exhausted attempting to address them all. Therefore, it is reasonable to ask what, if any, limits should one place on the obligation to promote social justice. One response comes from

the philosopher Peter Singer, who has written about obligations to others in the context of reducing world hunger, but his analysis applies to other social justice efforts as well. According to Singer, we should sacrifice and donate our fair share of time or money to others until such sacrifices would compromise something of comparable ethical importance, although he never defined what is of comparable ethical importance (Beauchamp & Childress, 2019). Therefore, this obligation to donate time, resources or services to others has limits. For example, one could conclude that psychologists should not work such long hours that their children would lose the benefit of having a responsible parent, that they fail to provide for their retirement, that they lose the ability to offer quality services to existing patients, or that they exhaust themselves physically or emotionally (Beauchamp & Childress, 2019; Nadal, 2017).

THE HISTORY OF PSYCHOLOGY AND SOCIAL JUSTICE

As a profession and a scientific discipline, psychology has had a mixed history in terms of social justice. Psychology as a separate discipline did not emerge until the end of the 19th century. Those early psychologists, who were almost always White men, had largely adopted the racist, nativist, and sexist worldview of their contemporaries. These views were reflected in the interpretations of early research, which supported the White supremacy attitudes of the time. For example, Blackford (1916) advocated for the belief in the moral superiority of White people. She claimed, "Wherever there is stable government, it is either in the hands or under the influence of blondes—white men" (p. 50).

Other psychologists used results from intelligence tests to argue for the intellectual superiority of White people and, as late as 1962, had such articles published in *American Psychologist* (e.g., Garrett, 1962). Garrett later testified in Congress against civil rights legislation (Cummings Center for the History of Psychology, 2021). Similar researchers would look at differences in intelligence test scores of recent immigrants (who were mostly from Southern or Eastern Europe) and native-born White Americans (who were more likely to have ancestry from Northern Europe) and assume any difference was due to an inherent genetic superiority of Northern Europeans. An exception was the pioneering Black psychologist Charles Thompson (1928), who developed a "large amount of excellent organized data" (Fernberger, 1929, p. 666) to refute the racist ideology of the time.

Several early presidents of the APA were leaders in the eugenics movement (Cummings Center for the History of Psychology, 2021). Eugenics incorporates the belief that biological factors account for almost all the difference in performance on intelligence tests among groups. Eugenicists used their theory to support segregation, laws opposing interracial marriages, and sterilization (Cummings Center for the History of Psychology, 2021). Also, during its early years, psychology programs routinely prohibited or discouraged women and/or persons of color from applying to their programs. Overall, the profession and discipline of psychology has a history of unfair discrimination.

Psychology as a profession and a discipline began to change noticeably as the consciousness of the nation began to change during the civil rights movement in the 1960s. On the one hand, formal systems that prioritized social advantages continued to exclude many women and persons of color, and informal systems of bias often made many women and persons of color feel unwelcome in the profession. On the other hand, persistent psychologists gradually changed the culture of the organization and profession. APA finally elected its first Black president (Dr. Kenneth Clark) in 1971 and had had only two women presidents in its history until 1972, when Dr. Anne Anastasia was elected (Vasquez, 2012).

As part of a long arc that we hoped was bending toward justice, psychologists increasingly commented on issues of public interest with a social justice perspective. Some psychologists were, in the terminology of Dr. Martin Luther King Jr. *creatively maladjusted*.[1] During the 1950s, Dr. Evelyn Hooker published research criticizing the dominant belief that homosexuality was a mental disorder. During the McCarthy era in the early 1950s, homosexuality was considered a serious crime and was the subject of many harmful myths and stereotypes. Her research was a major factor in leading the American Psychiatric Association to remove homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders*. Dr. Mamie Clark, assisted by her husband Dr. Kenneth Clark, studied the impact of racism on the self-perception of Black children. Their research was cited in the U.S. Supreme Court case *Brown v. Board of Education*, which overturned the separate but equal doctrine used to justify segregation. Dr. Carol Gilligan studied the moral development of girls and showed the impact of societal expectations on girls' moral development, challenging the dominant theories of moral development based primarily on work with boys and men. These "creatively maladjusted" psychologists were poking holes in oppressive ideologies that marginalized large groups of people.

Commissions or workgroups of APA began to publish summaries of scientifically sound research on public issues such as a report showing that elective abortions of unwanted pregnancies do not routinely cause mental health problems; that interventions to change the sexual orientations of people do not succeed—and often create psychological harm; and that same-sex couples can raise healthy and well-cared-for children (Vasquez, 2012). Each of these commissions addressed important issues of the day. Those opposed to abortion often falsely claimed that abortions early in life caused long term psychological problems later. Those who opposed same-sex attraction argued, without evidence, that sexual orientation was a choice without any biological basis to it and that same-sex attraction could be unlearned. Opponents of same-sex marriage also argued, without evidence, that persons who had sexual attraction to members of the same sex were incapable of being caring parents.

[1] "If we are to be people of goodwill . . . we must never adjust ourselves to racial discrimination . . . religious bigotry . . . to economic conditions that take the necessities from the many to give luxuries to the few . . . and the self-defeating effects of physical violence" (Martin Luther King Jr. 1967, cited in Beer, 2017, p. 14).

APA-accredited programs in psychology must now teach about diversity, and graduate schools now have more students of color than ever before. APA formally apologized for its past participation in racist activities and has proposed an action plan to address racism within the organization (APA, 2021a). Still, more effort is needed to build upon these positive steps, and individual psychologists need to consider what they are doing to promote social justice.

PROMOTING SOCIAL JUSTICE

The shifting culture within organized psychology needs to be accompanied by actions by individual psychologists to promote social justice. Psychologists can give their time and skills to promote social justice by ensuring sensitivity to diversity issues in their roles as health care professionals, educators, consultants, or researchers. They can offer preventive services to vulnerable populations or share their expertise and time to guide public policies to improve the well-being of society both in health care and non–health care areas. They can teach about topics related to social justice, conduct research related to issues of concern for traditionally marginalized people, join local organizations serving marginalized communities, and so on.

In addition, psychologists can be involved in preventive services. They could, for example, participate in programs designed to benefit those who are at risk of developing mental health disorders because of the life conditions to which they have been exposed. Within our profession, psychologists can continue to advocate for a more diverse psychology workforce and for curricula that train psychologists in cultural competence, cultural humility, and the importance of health equity.

But other social justice activities require institutional support, which sometimes may be lacking. Thus, psychologists may sometimes need to challenge unfair policies by causing what John Lewis called *good trouble* (Labode, 2020). But good trouble (as opposed to just "trouble") requires self-reflection and deliberation. The challenge must come out of a sense of concern for others, not out of ego or self-righteousness. Often the issues of concern represent flagrant abuses of others. At other times, the issues are more nuanced. The most effective advocates are responsible rebels. Good troublemakers take their time to learn about the issues, which may require that they listen to others (even those who may appear to oppose their views) and strive to understand their perspectives. Good troublemakers are in it for the long run, understanding that substantial change can sometimes take time. And in striving for these goals, good troublemakers know the importance of developing allies, making friends, and protecting their emotional health. Good troublemakers accomplish more as a team than as individuals. Chapter 12 describes how psychologists can use a decision-making process when institutional policies appear to conflict with ethical principles.

In every venue where psychologists contribute to society, whether it is in education, research, organizational development, or health care, issues of social

justice may become salient. Next, we discuss equity in health care as an example of one area of importance to health care psychologists where issues of social justice are especially relevant. Then, we discuss how psychologists can promote a social justice perspective through direct service and working to promote changes in public policies.

HEALTH EQUITY AS AN EXAMPLE OF SOCIAL JUSTICE ADVOCACY

Populations that have been historically marginalized tend to have poorer health, caused by exposure to conditions that harm health and the lack of access to high quality health care. However, psychologists working from a social justice perspective want to promote health equity or the equal opportunity to have good health (Kelly, 2022). This means access not only to good health care but also to the positive social conditions that determine good health.

Social Determinants of Health

Social determinants of health refer to the conditions under which people live and work, including, but not limited to, their education or income level; access to safe housing, good food, and safe neighborhoods; and the quality of their social networks, including exposure to any racial, gender, or ableist discrimination. Social determinants are downstream (i.e., more removed) from illnesses but nonetheless determine the likelihood of becoming ill and the outcomes of those illnesses.

Economically marginalized Americans are exposed to more harmful living conditions and have an increased risk of chronic physical diseases and poorer mental health (Diez Roux & Mair, 2010). Physicians may prescribe antibiotics to treat infections, but physicians have no medication that could reverse the malnutrition responsible for weakening immune systems and making patients more susceptible to infections (Galea et al., 2011). A psychologist may treat a patient for anxiety but has no treatment that could remove the realistic fear of violence caused by living in an unsafe neighborhood.

These social determinants do not cause illnesses, but they are among several factors, including genetic predispositions or lifestyles, which may create the conditions leading to poorer health (Kinner & Borschmann, 2020). According to Woolf (2019), "Health care alone cannot improve population health" (p. 196).

Deaths of Despair

The COVID-19 pandemic brought the social determinants of health into bright focus. Persons working in lower paying service professions, such as grocery store clerks and delivery persons, had more exposure to COVID-19 and higher rates of infection and death (Do & Frank, 2021; Yancy, 2020). Also, the COVID-19 pandemic appears to have increased the risk of *deaths of despair,* which include deaths from drug overdoses, suicides, and cirrhosis (and other alcohol-related

chronic liver diseases). These deaths are often linked to depression and demoralization (Case & Deaton, 2015). The increase in deaths of despair over the last 10 years is a major factor in the recent decline in the life expectancy among Americans.

The decline in life expectancy (especially among males 25–64) within the United States started even before the COVID-19 pandemic. Evans et al. (2020) estimated that 150,000 Americans died deaths of despair in 2018, although Kramer (2020) claimed that figure is too low. Deaths of despair were higher in those 20% of the American counties that have experienced economic insecurity and reductions in income and material resources (E. Knapp et al., 2019). Nonetheless, affluent counties also saw an increase in the number of deaths of despair albeit at a smaller rate.

Deaths of despair have increased the most among White Americans. Nonetheless, Black Americans and Native Americans still have higher all-cause mortality than Whites. For many years, public health efforts had reduced the health disparities gap between White and non-White Americans, but this trend reversed itself in the past decade, especially for young children of color. Public health efforts need to address the increase in deaths among middle aged White people, but this should not detract from continuing efforts to address the disparity in all-cause mortality across racial groups (Gennuso et al., 2019).

The link between socioeconomic status (SES) and deaths of despair illustrates the role of SES as a determinant of health. The link between lower SES and health is called the *SES gradient* (Adler, 2009), which Marmot et al. (1984) documented in the Whitehall Study. This study found that as the employment level of English civil servants decreased, their mortality rates increased. Similarly, within the United States, those with higher incomes lived the longest. At the extreme end, are those who experience *social death*, a condition where people have lost their social roles and other significant components of their identity. Perhaps they lost their social identity through incarceration or homelessness, which massively disrupted their lives and social connections (Salhi & Osborne, 2021).

Racism is a social determinant of health. It harms mental and physical health regardless of education (Paradies et al., 2015) and impacts the quality of health care services. Even when Black Americans have the same access to health care as White Americans, they may receive unequal health care treatment. In part this may be due to health care professionals' implicit biases (FitzGerald & Hurst, 2017) or an inability to overcome a lack of trust among Black Americans who for centuries had received unequal health care treatment.

More than 120 years ago, sociologist and activist W. E. B. DuBois (1903/1994) stated that the color line is the essential problem of the 20th century. Years later, in 1967, Dr. Martin Luther King Jr. addressed the APA and stated that "White America needs to understand that it is poisoned in its soul by racism" (King, 1967, cited in Beer, 2017, p. 5) and that White Americans underestimated the impact of racism and "the amount of bigotry the white majority was disguising" (King, 1967, cited in Beer, 2017, p. 6).

These comments have relevance today. Commentators may debate whether, or how much, progress has been made in race relationships in the United States. Nonetheless, more needs to be done. Any effective work for social justice needs to include an antiracist attitude. Kendi (2019) defined antiracism as acknowledging that problems derive from unequal power structures rather than racial groups themselves and advocating for policies that promote racial equality.

METHODS FOR PROMOTING HEALTH EQUITY

Psychologists can promote health equity by helping marginalized persons receive better health care, by working to prevent the development of disorders, and by advocating for systemic changes. Understanding the social determinants of health can help psychologists to deliver better health care. Chapter 5 covers steps that psychologists can take to improve the quality of their services to those who have experienced poverty, racism, or other forms of unfair treatment.

Direct Service

One way psychologists can promote health equity directly is by delivering preventive services to those who have a high risk of developing health problems. For example, psychologists can implement educational or support programs for those who are at a high risk of developing a psychological disorder such as persons who are or have recently been in prison, refugees, or victims of crimes. Socialization groups could be held for older adults at risk of loneliness and social isolation. Prospective couples could receive premarital or relationship counseling. Parents could receive instructions on child development, and so on.

One example of a preventive intervention is the use of *lethal means safety counseling* with veterans. Lethal means counseling is an intervention that attempts to place a barrier between a patient and their preferred means of suicide. It could involve, for example, temporarily removing firearms or potentially lethal medications from a house. American veterans die from suicide at a rate higher than the population in general and are more likely to use firearms as their method of suicide. However, lethal means counseling and distribution of cable locks can lead to substantial changes in how members of the armed services store lethal weapons (Anestis et al., 2021).

Regrettably, the economics of health care in the United States tends to reimburse for direct services to patients, but rarely reimburses for prevention programs. As a result, sometimes psychologists may have to offer these interventions for little or no remuneration or seek creative ways to receive funding for these programs.

Advocacy

Finally, psychologists can advocate for social policies that help mitigate the social determinants of poor mental health or which address difficulties in accessing

health care. Even modest improvements in access to resources, such as easier access to food stamps or increases in the minimum wage can substantially improve the quality of the lives and health of low-income persons. For example, increases in the minimum wage or increased access to food stamps is associated with a decrease in suicide rates (e.g., Gertner et al., 2019). Raising the minimum wage and other social policies can be complex issues that involve multiple economic and local factors. We are not suggesting that anyone who opposed a particular measure to increase the minimum wage is necessarily unethical. But we are saying that all psychologists should consider the public health impact of such policy changes.

Such changes require political advocacy. Many people, including some psychologists, do not trust the American political process and can point to its many shortcomings and abuses. However, the best way to correct these abuses is to participate in the political process itself—not to avoid it. Those of us who have a background in advocacy realize that many elected officials want to promote the public welfare (Knapp & DeWall, 2003). Although the current political system has very serious flaws, avoiding that system means that psychologists give up their ability to influence public policy.

Also, democracies thrive when citizens (including psychologists) support the process by voting and participating in other political activities. Despite their limitations, democracies tend to have citizens with longer life expectancies and report greater personal well-being compared with those in authoritarian countries where political imprisonment, governmental corruption, and social traumas are more common (Layard, 2005).

Local, state, and federal policy makers determine the rules under which health care professionals and insurance companies practice, and how schools, hospitals, prisons, and other institutions are run. Sometimes these rules further the public well-being; far too often they fail to adequately consider the psychological well-being of the public. To promote the overarching principles of social justice and public beneficence, psychologists see advocacy as a logical extension of their commitment to health equity.

Psychologists can further advocacy efforts by retaining membership in their state psychological associations and APA, which fund advocacy efforts, contributing to psychology's political action committees, voting, or meeting with or sending emails to legislators. Ideally, the public welfare will guide the advocacy efforts of psychologists, recognizing that the public consists of individual constituencies, such as consumers and employers, and government agencies, such as schools, hospitals, and prisons.

As a profession involved in health care, it is sometimes hard to separate public interest from enlightened self-interest. Promoting equal treatment for mental health in health insurance policies definitely benefits our patients, but it also benefits psychologists who deliver mental health care. Other advocacy efforts involve goals unrelated to the financial interests of psychologists (e.g., the humane treatment or diversion of persons with mental illness from prisons, or programs that prevent youth violence). Also, sometimes advocacy may

involve promotion of ideas that appear contrary to the short-term financial interests of some psychologists. For example, psychologists should promote digital interventions as a first response to certain problems if the evidence suggests their effectiveness—even if it means reduced demand for direct services from psychologists.

Psychologists can and should make public statements in areas where they have special knowledge or expertise. According to the APA Ethics Code, psychologists with competence in areas may take stands on public issues as long as they are grounded on scientific basis and do not otherwise violate ethical standards (APA Ethics Code 2017a, Standard 5.04, Media Presentations). As an example, APA's statement on firearm ownership was based on a review of outcome literature, which found some firearm safety measures to be well supported and others that currently lacked sufficient empirical support to justify widespread adoption (APA, 2013b).

Psychologists should guard against allowing their personal biases to skew their interpretation of data. Advocacy efforts should strive for accuracy and acknowledge any limitations of data used in its support. Advocates risk having their enthusiasm outrun their evidence. No one is an expert on everything, and psychologists should resist the pressure to comment on areas where they lack specialized expertise.

Providing information is often best done in coordination with those who have familiarity with the political system and can help psychologists to craft their messages. Data are often more memorable if combined with a personal real-life story. For example, one rule of thumb is that psychologists should convey an image or story for every fact that they convey.

Working with coalitions increases the strength of the message and likelihood of success, although it may require compromise. Advocacy experts within professional associations need to decide when to compromise and when to hold fast on a position. It may mean listening to opponents in good faith and accepting compromise when needed. Very few people ever get exactly what they want in advocacy and advocacy efforts can sometimes take years (or decades) before they succeed. I (Samuel J. Knapp) attended my first meeting on promoting mental health parity in 1987, although it was not until 2008 that the federal parity law was enacted and even then, it had exceptions and loopholes. But the net effect was a substantial increase in the number of persons who had access to mental health services.

4

Applying Ethical Theories to Ethics Codes and Ethical Decision Making

The minimum standards of professional conduct are found in the American Psychological Association's (APA's; 2017a) *Ethical Principles of Psychologists and Code of Conduct* (APA Ethics Code), licensing laws and regulations, standards of malpractice courts, and other laws. For psychologists to understand the intent or spirit of the APA Ethics Code, it is important for them to understand the moral principles on which the standards of the Code are based. We begin with a review of the APA Ethics Code from the standpoint of principle-based ethics.

OVERVIEW OF ETHICS CODES

Adherence to an ethics code is one of the defining characteristics of a profession. Codes should protect the public by establishing minimum standards of conduct, but they can have other functions as well. In part, they are a public relations document that can assure the public that psychologists will adhere to certain agreed-on minimum standards of behavior, a statement of the overarching goals and values of the profession that can encourage practitioners to strive toward higher levels of behavior, and an educational tool that sensitizes practitioners to ethical issues (Knapp et al., 2020).

Of course, no ethics code exists in a legal or social vacuum. In reality, federal laws (e.g., the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 [HIPAA]; U.S. Department of Health and Human Services,

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2002), previous negotiations with the Federal Trade Commission, case law, and other factors influenced the final wording of the APA Ethics Code. Nonetheless, an attempt was made to base the Code on moral principles and to focus on public welfare. The APA Ethics Code largely succeeded in reaching that ideal (Knapp & VandeCreek, 2004).

As noted in Chapter 1, APA uses its Ethics Code as the standard of enforcement. Most states or boards of psychology have adopted the APA Ethics Code or a variant of it in their regulations. Other licensing boards have adopted the Association of State and Provincial Psychology Boards' (2021) *Code of Conduct*. Other countries with well-developed psychological communities have their own ethics codes.

The International Union of Psychological Sciences developed a universal ethics code that attempted to create an international consensus on what it means to be a psychologist (Pettifor, 2004). The Code was written broadly to reflect the different concerns of different countries. Nonetheless, Gauthier et al. (2010) identified five common principles across other ethics codes: respect for rights and dignity of others; caring for others; competence; integrity; and professional, scientific, and social responsibility. This international code and the discussions that surrounded its development helped promote awareness about the appropriate role that culture plays in the development or interpretation of ethics codes.

Overview of the APA Ethics Code

The APA Ethics Code (2017a) contains three major parts: the Introduction and Applicability section, the aspirational Preamble and General Principles, and the enforceable Ethical Standards. The Introduction and Applicability section describes the purposes of the APA Ethics Code and how and to whom it applies. Among other things, it explains that the APA Ethics Code has three parts, that it obligates APA members to adhere to the APA Ethics Code, and that it applies only to the work-related roles of psychologists. The APA Ethics Code does not govern purely private or personal conduct (Knapp et al., 2020).

The aspirational principles encourage psychologists to strive for the ethical ceiling. In addition, psychologists can use these aspirational principles to assist themselves in ethical decision making. However, psychologists would not be disciplined for failing to uphold aspirational principles.

The aspirational principles are roughly modeled on principle-based ethics. However, principle-based ethicists do not dictate a single way to define or categorize the prima facie principles. Ethics codes may categorize these principles slightly differently, but these differences have more to do with wording and emphasis than with substance.

The third part of the APA Ethics Code contains the enforceable standards.[1] Psychologists who do not comply with these standards risk disciplinary

[1]Unless specified differently, the word *standard* in this chapter refers to an enforceable standard of the APA Ethics Code.

sanctions by the APA Ethics Committee or by other organizations, such as licensing boards, to the extent that they adopt the APA Ethics Code.

Before 1992, the APA Ethics Code combined aspirational principles and enforceable standards together. The 2002 Code separated the aspirational and enforceable standards to help psychologists better identify what behaviors could result in a disciplinary action. Nonetheless, it is impossible to completely separate them on a day-to-day basis. Psychologists attempting to provide the highest level of services should also ensure that they fulfill the minimum standards of the profession.

The standards of the APA Ethics Code differ from guidelines that inform psychologists about conduct in certain practice areas (e.g., child custody evaluations, services to linguistic or cultural minorities). APA does not enforce the guidelines except to the extent that they reiterate standards in the APA Ethics Code. Also, entities other than APA may attempt to use guidelines as if they were enforceable standards.

A Principle-Based Interpretation of the APA Ethics Code

As noted in Chapter 2, the prima facie moral obligations especially relevant to psychologists are beneficence, nonmaleficence, respect for patient autonomy, justice, fidelity, and general beneficence. These prima facie principles can be linked to standards in the APA Ethics Code. For example, psychologists demonstrate beneficence when they follow the standard of competence in terms of practicing within their areas of expertise (Standard 2.01a, Boundaries of Competence). They adhere to the principle of nonmaleficence when they refrain from entering into harmful multiple relationships with their patients (Standard 3.04, Avoiding Harm). Psychologists demonstrate respect for patient autonomy when they engage their patients in meaningful informed consent procedures (Standards 3.10a, Informed Consent; and 10.01, Informed Consent to Therapy). Psychologists fulfill their ethical ideals of justice when they avoid unfair discrimination against members of marginalized groups. Psychologists uphold the principle of fidelity when they protect patients' confidentiality (Standards 4.01, Maintaining Confidentiality; and 4.02, Discussing the Limits of Confidentiality). Psychologists act in accordance with the principle of general beneficence when they act to correct problematic ethical conduct by their peers (Standards 1.04, Informal Resolution of Ethical Violations; and 1.05, Reporting Ethical Violations). Of course these overarching ethical principles may overlap and some of the standards in the APA Ethics Code may reflect more than one moral principle.

We classify the standards of the APA Ethics Code into those that are key or foundational (i.e., closely reflect prima facie ethical principles); those that clarify, amplify, or apply the key standards; and those that create exceptions to the key standards. We can then link each of the standards in the Code to a prima facie ethical principle (Knapp & VandeCreek, 2004).

Key or Foundational Standards

Certain standards, such as 2.01a, Boundaries of Competence; 3.04, Avoiding Harm; 3.10a, Informed Consent; and 3.01, Unfair Discrimination, can be considered key or foundational. These standards closely reflect the application of prima facie ethical principles to the practice of psychology. For example, Standard 2.01, Boundaries of Competence, is a key or foundational standard that requires psychologists to uphold beneficence by ensuring that they are competent to practice.

Clarification, Amplification, or Application of Key Standards

Other standards clarify, amplify, or apply these key or foundational standards. For example, Standard 3.10a, Informed Consent, is a key or foundational standard that requires psychologists to respect patient decision-making by obtaining informed consent. However, this standard is amplified in other standards that deal with informed consent in forensic work (Standard 3.10c), with organizational clients (Standard 3.11, Psychological Services Delivered to or Through Organizations), in psychotherapy (Standard 10.01, Informed Consent to Therapy), with assessments (Standard 9.03, Informed Consent in Assessments), and in research (Standard 8.02, Informed Consent to Research). That is, all psychologists must meet the informed consent standard found in Standard 3.10a. However, Standard 3.10c expands on the informed consent obligations of psychologists when services are court ordered or otherwise mandated.

Some standards apply a key standard to specific types of professional activities. For example, Standard 2.01a, a subsection of Boundaries of Competence, is a key or foundational standard that requires all psychologists to be competent. Standard 2.01b applies that general standard of competence to working with diverse populations. Technically, Standard 2.01b should not be necessary because it could be inferred that the requirement to be competent includes the requirement to be competent when working with diverse populations. Nonetheless, the standard was added because it applies the standard in a situation in which historically there has been a potential for harm. To their credit, the framers of the APA Ethics Code properly determined that it should alert psychologists to an area in which the competence section might not be applied appropriately.

Exceptions to Key Standards

Finally, some standards make exceptions to the key or foundational standards. For example, Standard 8.02, Informed Consent to Research, requires researchers to obtain informed consent from prospective research participants. However, Standard 8.07, Deception in Research, allows for the dispensing of informed consent in certain types of research involving deception. Consistent with principle-based ethics, a principle can only be overridden if there is justification for doing so. As it applies to Standard 8.07, the assumption is that the promotion of public welfare through a deceptive research design can sometimes take

higher precedence than the ethical obligation to be fully honest and accurate in dealing with research participants. Chapter 16 discusses deception in research in more detail.

Also, consistent with principle-based ethics, an ethics code should narrowly draw any exceptions to a foundational or key standard. According to principle-based ethics, when one ethical principle is overridden, efforts should be made to minimize the harm to the offended ethical principle. When psychologists use deception, for example, they need to minimize the offense to the rule of honesty by debriefing the participants and allowing them to withhold their data from the research. Furthermore, psychologists may never deceive participants about research that is likely to cause them pain or serious emotional distress.

Similarly, as it applies to competence, Standard 2.01a, a subsection of Boundaries of Competence, is the foundational standard. Standard 2.01b, which applies competence to services to diverse populations, and Standards 2.03, Maintaining Competence, and 2.04, Bases for Scientific and Professional Judgments, either clarify, amplify, or apply the foundational standard. Finally, Standard 2.01d, which includes exceptions for underserved populations; Standard 2.02, Providing Services in Emergencies, which allows psychologists to practice outside of their competence during crises when other mental health services are unavailable; and 9.01b, a subsection of Bases for Assessment, which permits limited comments on persons not directly evaluated, are exceptions to the foundational standard. A similar analysis can be done with each of the key or foundational standards in the APA Ethics Code.

ETHICAL DECISION MAKING

Psychologists often have questions about how they should behave. These questions may arise because of psychologists' lack of familiarity with the APA Ethics Code (2017a), practice standards, or state and federal laws. However, at other times psychologists will encounter situations where the APA Ethics Code or laws do not explicitly direct psychologists how to act. In these situations, psychologists who have well-developed ethical decision-making skills have a greater likelihood of acting in ways that are consistent with the moral principles of the profession.

As discussed in Chapter 2, psychologists, like other moral agents, tend to "think fast" when they encounter an ethical dilemma. That is to say, the situation may elicit fast, automatic, and effortless System 1 thinking (Kahneman, 2011). Although System 1 thinking is adequate for most types of situations, psychologists who face ethical dilemmas can shift their thinking patterns to the slow, deliberate, and effortful System 2 thinking when making important ethical decisions.

In this chapter, we review the areas related to ethics in which psychologists need to apply their System 2 thinking skills to decision making. We then present a five-step ethical decision-making model (Bransford & Stein, 1993; C. Härtel & Härtel, 1997), which psychologists can use for most ethical dilemmas.

In later chapters, we demonstrate how to apply the five-step model to address specific ethical dilemmas.

AREAS TO APPLY ETHICAL DECISION-MAKING SKILLS

Psychologists need to use ethical decision-making skills when (a) an applicable ethical or legal standard requires them to use their professional judgment, (b) the APA Ethics Code or laws are silent, and/or (c) the APA Ethics Code conflicts with a law or an organizational policy. Each of these areas is discussed in more detail in the sections that follow.

Professional Judgment

Many standards of the APA Ethics Code require psychologists to use their judgment. This is particularly true when the Code uses modifiers such as *reasonably, appropriately,* or *potentially.* For example, Standard 10.01a, Informed Consent to Therapy, states that "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." Consequently, psychologists must determine when it is "feasible" to reach that agreement. Although the decision is routine in most situations, at times, such as when patients feel severe distress, psychologists may elect to delay the informed consent process.

When the APA Ethics Code or Legal Standards Are Silent

At times, neither the APA Ethics Code nor legal standards give direction on an issue. For example, the 2017 APA Ethics Code made no reference to the transmission of information through email or conducting health care services through electronic means. Although APA has since adopted guidelines on telepsychology (Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013), these guidelines still leave discretion to psychologists as to how to apply these standards in specific circumstances.

Conflicts With Laws or Organizational Standards

In some instances, a statute, regulation, or court order may differ from the APA Ethics Code. According to the APA Ethics Code, if its standards create obligations greater than those found in the law, then psychologists must follow the APA Ethics Code. However, if the APA Ethics Code conflicts with a particular law, then psychologists must "take reasonable steps to resolve the conflict" consistent with the Code (Standard 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority).

Likewise, if the APA Ethics Code conflicts with an organizational policy, then psychologists must take "reasonable steps to resolve the conflict" consistent with the Code (Standard 1.03, Conflicts Between Ethics and Organizational

Demands). The APA Ethics Code does not require a psychologist to follow the rules of an organization when those rules conflict with the Code. Alternatively, psychologists will not necessarily violate the APA Ethics Code when they comply with an organizational policy, if they make reasonable attempts to redress the incompatibility between the organizational policy and the Code. The notable exception to this standard was the result of amendments to the Code in 2017, which explicitly prohibited psychologists from violating basic human rights. What constitutes a reasonable action depends on the circumstances and options available. Some of the most difficult situations facing psychologists occur when institutional policies appear to conflict with professional ethics. Chapter 12 discusses organizational conflicts in more detail.

THE FIVE-STEP DECISION-MAKING MODEL

Virtually every ethics textbook presents some kind of decision-making model. Typically, these models contain sequential steps for the decision maker to follow, such as identifying the problem, defining the issues, consulting the laws and ethics code, seeking consultation, identifying legal and ethical obligations, generating alternatives, listing potential consequences including benefits and harms, acting, monitoring outcome, looking back, evaluating the impact, and so on (see M. K. Johnson et al., 2022, for a review of ethical-decision-making models). In this chapter, we present a five-step model that simplifies and improves on other stepwise decision-making models.

The five-step model increases the likelihood that psychologists will reach a good decision. Also, because it is easy to learn and overlearn, psychologists may use it effectively during periods of crisis. Furthermore, psychologists may incorporate other more specific decision-making models into the five-step model.

The five steps of this model are as follows: (a) identify or scrutinize the problem, (b) develop alternatives or hypotheses, (c) evaluate or analyze options, (d) act or perform the best option, and (e) look back or evaluate the results. These five steps have been borrowed from the IDEAL system (identify, develop, explore, act, and look back; Bransford & Stein, 1993) and the SHAPE system (scrutinize, hypothesize, analyze proposed solution, perform, and evaluate; Härtel & Härtel, 1997). These IDEAL and SHAPE decision-making models were not designed specifically for ethics but appear applicable to ethical issues. Indeed, variants of the five-step model seem quite pervasive (e.g., problem-solving therapy; Heppner & Lee, 2002).

The Five-Step Model and Principle-Based Ethics

The five-step model can be used to implement ethical decision making using different philosophical models. We describe it from the standpoint of principle-based ethics. As noted in Chapter 2, principle-based ethics allows the decision maker to have one moral principle override another if they have a good reason to do so. However, the decision maker should attempt to minimize harm to the offended moral principle.

EXHIBIT 4.1. Incorporating Principle-Based Ethics into the Five-Step Model

1. **Identify or scrutinize the problem.** Activities that violate or threaten to violate one of the moral principles are identified as moral concerns.
2. **Develop alternatives or hypotheses.** The alternatives should be based on or at least be consistent with general moral principles.
3. **Evaluate or analyze options.** The option chosen depends on which one strikes the optimal balance or ranking of moral principles.
4. **Act or perform the best option.** Although one moral principle may be violated, efforts are taken to minimize the harm to the offended principle.
5. **Look back or evaluate the results.** The activities are evaluated according to the extent to which they fulfill, balance, or minimize harm to offended moral principles.

The goal in a principle-based model is to reach a "good decision" that has the following features: (a) It is consistent with the values or moral principles of the psychologist in that there is sufficient justification for acting on behalf of one moral principle or norm rather than another; (b) the action has a good chance of success; (c) no morally preferable alternative is available; (d) the infringement of the offended norm is the least possible, consistent with the primary aims; (e) the psychologist seeks to minimize any negative effects of infringing on the offended moral principle; and (f) the decision must be made impartially (Beauchamp & Childress, 2019). Exhibit 4.1 summarizes the relationships between the five-step and principle-based models.

Principle-based decision making has been applied when ethical principles or standards conflict with the law or organizational policies (Knapp et al., 2007), the overarching values of different cultures appear to conflict (Knapp et al., 2015; Knapp & VandeCreek, 2007b), religious beliefs appear to harm the well-being of patients (Knapp et al., 2010), and the principle of respecting patient autonomy appears to conflict with public welfare (Knapp & VandeCreek, 2007a; Mbroh et al., 2020.

CASE EXAMPLE OF AN ETHICAL DILEMMA: A PROBLEMATIC COMMENT

To illustrate how the five-step decision-making model can be applied, we will be following an example ethical dilemma in which a White, female psychologist was conducting a routine session with a White, female patient who suddenly used the "n-word" in psychotherapy, laughed, and said, "You know what I mean." The racial identity of the person described did not have any apparent relationship to the patient's treatment goals.

This dilemma is a fictionalized version of a similar incident that happened to the me (Samuel J. Knapp) 40 years ago. I was unprepared for the comment, and the patient could see my stunned reaction. I simply said, "Don't talk that way; you sound prejudiced," and the patient said, "Okay," and we went on. We never processed or discussed the event again.

When I described this situation to my graduate students years later, some of them stated that I had acted unethically because I had interrupted psychotherapy with a comment unrelated to the patient's reason for psychotherapy, thus violating the ethical principle of beneficence. Others stated that I acted unethically because I had an opportunity to talk to my patient about racial prejudice and I failed to do so, thus violating the ethical principle of general beneficence. How then should we respond to situations like this that could occur in psychotherapy?

Our social world is filled with persons of diverse nationalities, languages, ethnic backgrounds, sexual orientations, and other differences. These differences can enrich our lives, but they can also be a source of conflicts. Therefore, it can be helpful to consider overarching ethical principles for guidance. In the example dilemma concerning the problematic comment, psychologists can use the five-step method to formulate a response.

Step 1: Identify or Scrutinize the Problem

In Step 1, psychologists identify the ethical dilemma or conflict. At first glance, this step seems like the easiest of the five. However, in practice, psychologists are sometimes unaware that they are facing an ethical issue that requires decision making. This may be particularly true when psychologists are practicing in a new setting or with a unique client presentation. It is therefore important for psychologists to familiarize themselves with the APA Ethics Code so that they know when they need to use their ethical-decision-making skills. Regular supervision/consultation with colleagues can also help psychologists to identify their ethical "blind spots."

Identification of ethical issues can occur on either a cognitive or emotional level. However, for many psychologists the first indication of a problem comes from their own gut reactions to their patient. Emotional reactions do not always disrupt ethical thinking. Sometimes psychologists first become aware of an ethical problem when they experience emotional uneasiness, which can prompt them to analyze their feelings and locate the source of their concern (Korkut & Sinclair, 2020).

Step 1 for the psychologist in the example dilemma is to identify or scrutinize the problem, which, according to the principle-based process, means identifying the relevant ethical principles. Although one could link every overarching ethical principle to this vignette in some way, the most salient moral obligations for the psychologist are to

1. protect the welfare of the patient from harm (nonmaleficence),
2. promote the well-being of the patient (beneficence),
3. protect the general welfare of society by addressing hate speech, which contributes to the oppression of others and creates disharmony in society (justice, general beneficence).

Step 2: Develop Alternatives or Hypotheses

Step 2 involves the generation of alternative solutions. In this step, the psychologist in the example dilemma may feel tempted to dichotomize her decision

options (i.e., confront the patient immediately or do nothing). To a large extent, her ability to reach the best decision requires considering possible options. Psychologists can improve the quality of their options if they consider contextual factors, the role of nonrational factors such as emotional reactions or cognitive biases and seek consultation.

Contextual factors. One of the contextual factors to consider is the emotional state of the patient. If the patient is highly fragile and suicidal, for example, the consequences of confronting the patient and causing a break in the treatment relationship could be severe. Such a patient condition would tilt the psychologist toward ignoring the comment or at least delaying a response until the patient were more stable. On the other hand, if the patient's problems are not life-threatening and the patient and the psychotherapist have a good relationship, then a confrontation may help the patient gain useful insight on how she comes across to others (Mbroh, 2020).

If the patient had made the comment in the context of their presenting problem, say, for example, a conflict with a Black person, then the psychologist could address the comment clinically as one that reflects anger at a specific person, although expressed inappropriately. The psychologist could respond within the context of the goals of the psychotherapy. If a child made such a comment, then it would be appropriate for the psychologist to take an educational approach and explain why such statements were harmful.

If the patient had made such a comment in a group psychotherapy session, then the psychologist would almost always need to address the comment immediately to protect other group psychotherapy members. In that situation, the obligation of nonmaleficence toward the other group members (protecting them from harm) would override beneficence toward one patient.

Nonrational factors that influence solution-generating abilities. Psychologists improve the quality of their ethical decision making when they consider the emotional aspects of human behavior. Although feelings motivate people to solve problems, the quality of problem solving tends to decline when individuals are in crisis or in emotional turmoil. Intense negative emotions may interfere with the cognitive processes necessary to generate or evaluate solutions.

The psychologist felt a range of intense emotions during the session after the patient's racist comment. She felt anger that her patient would make such an offensive, gratuitous comment, and she knew that she would likely feel angry or disappointed in herself if she allowed the comment to go unchallenged. The addition of "you know what I mean" added to her anger in that she did not want to be associated with anyone who would condone such comments. On the other hand, the psychologist felt conflicted because she did not want to derail the treatment relationship by confronting her patient too abruptly.

Factors in the personal life of the psychologist may also influence her emotions. Ideally, as a psychologist, we would hope that she felt a personal commitment to be antiracist. Also, she might be married to a Black person, or

have Black people in her family or in her close circle of friends. She or her loved ones may have recently been the target of racial slurs herself, so that the comment of her patient may have hit a raw nerve. Although this vignette deals with a racial slur, we have known psychologists who have invisible identities (i.e., identities that cannot be easily determined through visual cues) who have experienced derogatory comments directed toward their group and have had to decide how to respond. Often patients make these comments without knowing the identity of their psychologists. However, it seems that any deliberate comment directed at the psychologist needs to be dealt with immediately.

Psychologists should not expect themselves to be aloof from all emotions. Although psychologists strive toward unconditional positive regard toward their patients, it is only human to feel offended when one or one's circle of loved ones is a target of such attacks. Often psychologists can respond with detached equanimity to such comments, but not always. Psychologists are not disembodied vessels of unlimited virtue, and their emotional response will depend on the patient's intent, the present state and personal background of the psychologist, and the context. Most of the time, psychologists are able to step back, focus on their goals, and respond in a professional and helpful manner. Nonetheless, we are aware of rare situations where the high intensity or persistence of a patient's remarks combined with their lack of reception to feedback was such that the psychologists decided that they could no longer work with the patient and initiated a transfer.

High anxiety may cause a psychologist to select the first or one of the first solutions that comes to mind only because having a solution temporarily reduces anxiety. However, the first halfway reasonable (*just-good-enough*) solution to come to mind may not be the optimal one. It may be prudent to consider the Aristotelian golden mean when it comes to emotions and decision making. Too little as well as too much emotion can undermine the quality of the decision-making process.

Cognitive biases. Other nonrational factors could influence psychologists' ability to make good decisions, such as confirmation bias or premature closure (Kahneman & Klein, 2009; Rogerson et al., 2011). Psychologists may be vulnerable to confirmation bias, a tendency to focus on one conclusion and interpret all subsequent data in light of that conclusion versus considering alternative hypotheses. Sanders (2009) found that confirmation bias was one of the major causes for treatment failures in an urban hospital.

One could easily imagine a situation where confirmation bias could occur. A psychologist might feel stressed or pressured to develop a quick solution to an ethical dilemma. For example, when dealing with a patient with thoughts of suicide, a psychologist may focus too much on the patient's initial statements of a wish to die. As a result, they may interpret later information selectively to justify their initial impression that their patient presents an imminent risk of suicide and that intrusive interventions, such as a hospitalization are needed. However, it would be more desirable for psychologists to take the time to thoroughly explore the patient's life circumstances, social history, emotions,

and thinking patterns to ensure that their conclusions were justified. In reality, patients with suicidal thoughts often benefit greatly when their psychotherapists show interest in them and let them tell their story without judgment or interruptions (Knapp, 2020). Other cognitive errors could similarly lead to poor decisions.

In the vignette of the patient's racist comment, the psychologist may have immediately concluded that the patient has deeply held and pervasive bigoted beliefs and then went on to interpret other comments of the patient in that light. However, it may be premature to jump to that conclusion without talking with the patient in more detail. Ideas on race may be more nuanced than what first appears, and the patient might hold some foundational principles of fairness that the psychologist could mobilize so that the patient could come to censure her own statement.

Benefits of consultation. In this situation, the psychologist felt urgency in responding immediately to the patient's racist comment, although nothing required her to respond immediately. Many ethical dilemmas allow time for reflection. Consulting with others often improves the quality of decisions. Consultants can help psychologists address both the cognitive and emotional aspects of decision making. From a cognitive perspective, consultants may be able to identify sources of knowledge, types of interventions, or resources that could be useful to the psychologist. From an emotional perspective, consultants may help psychologists to reduce strong emotional affect and allow them to process information more clearly. Finally, the very process of describing the dilemma may help psychologists to clarify and think through the dilemma themselves. Perhaps the most effective consultants challenge psychologists to explore their perceptions, intuitions, assumptions, and logic. Everyone has blind spots, and the effective consultant may be able to help the psychologist to identify feelings and balance options. Ideally, the consultant will help the psychologists slow down their thinking and consider the consequences of their proposed solutions (Gottlieb et al., 2013). Chapter 9 describes the use of consultation as a quality enhancement strategy and provides examples of using it when treating life-endangering patients.

The goal of soliciting the involvement of impacted parties demonstrates that principle-based ethics is not necessarily conducted entirely in the head of the decision maker. Instead, effective decision making using principle-based ethics can be a social process that incorporates the perspectives of others, especially the persons affected by the decision, and is done with an eye to preserving or enhancing relationships. Decisions on how to minimize the infringement on other moral principles or reduce the negative impact of decisions are often best made with input from the affected parties.

The psychologist in the vignette had thought through such dilemmas before and knew of several options, including ignoring the problem, criticizing the patient for her racist comments, getting more information from the patient as to why she made that comment, or asking the patient to consider the impact of the statement on her (the psychologist) and possibly others.

Step 3: Evaluate or Analyze Options

Part of generating the optimal solution is to identify the advantages and disadvantages of each potential solution. A general strategy may be to select a solution that combines the best elements of the different solutions proposed through a process akin to "theory knitting." In experimental psychology, "theory development progresses through the integration of the strongest features of the alternative theories with one's own ideas about the phenomenon under investigation" (Sternberg et al., 2001, p. 107). Similarly, psychologists can "knit together" solutions by integrating the best aspects of possible alternatives. Psychologists can compare the conflicting properties of the alternatives evaluated. Ideally, the psychologist will have considered the likely consequences of each of the alternatives considered in Step 2 and knitted together or integrated an intervention that maximizes the benefits and minimizes the liabilities of those alternatives.

In the vignette of the patient's racist comment, the possible alternatives (criticizing the patient, ignoring the problem, or gathering more information from the patient) have advantages and disadvantages. Ignoring the problem would relieve the psychologist of the risk of a confrontation and a disruption in the treatment relationship but would not give the patient a chance to reflect on her comment and its underlying assumptions. Criticizing the patient would get the issue out in the open and let the patient know that such comments were unwelcome but might harm the treatment relationship. Getting more information might clarify the decision and, if done tactfully, need not alienate the patient.

The psychologist knew that statements that demeaned her patient would not change her opinions and may even activate resistance. It would help more to get her patient to reflect on her statement and its implications. People are complex and often hold contradictory beliefs. We do not know, for example, if this patient holds some racist beliefs or if she has some foundational beliefs in fairness that could be mobilized. Ideally, the goal would be for the patient to see how her comment violated her own internal fairness standard and for her to commit herself to living more closely to her deeply held beliefs in fairness.

Step 4: Act or Perform the Best Option

It should not be assumed that psychologists who reach a solution will necessarily act on that solution. As noted in Chapter 2, Bernard and Jara (1986) found that many psychology graduate students who reached the "right" solution to an ethical dilemma did not actually intend to act on that solution. The reasons for this finding are not clear. It could perhaps indicate a lack of moral courage on the part of the psychologist. On the other hand, it could be that the solution they reached intellectually did not sit well with them emotionally. That is, their response reflected what they thought the APA Ethics Code, law, or risk management guidelines required of them but did not reflect what they truly believed was the most ethical response.

In addition, the manner in which a decision is implemented can be as important as the decision itself. People can act badly while trying to do good. The ideal solution to an ethical dilemma requires that the actor try to minimize harm to the offended moral principle. This may require tact, sensitivity, and social skills. The emotions and motivations of the psychologist become important. A psychologist who is motivated by a beneficent attitude toward patients will be more likely to show kindness and courtesy in implementing that decision. In contrast, another psychologist could reach the same conclusion as to the optimal intervention but deliver it in a less sensitive manner by choosing less sensitive words, minimizing eye contact, or giving the patient less opportunity to respond. Thus, two different psychologists could implement the "same" intervention but with a considerably different impact.

The psychologist believed that her relationship with her patient was good enough that she could talk to her about this issue in a curious and non-judgmental manner. In other words, she believed that talking about it with her patient had a reasonable likelihood of being successful in getting her patient to rethink her language. "That is so unlike you to use such unpleasant language," she said to her patient. She also said that the comment seemed out of character for someone who is generally courteous, respectful, and well-liked by most people.

The psychologist balanced sensitivity to the feelings of her patient with a commitment to public welfare. This solution knitted together the advantages of the previous alternatives. It included general beneficence in that it mobilized the patient to see how her comments could harm others, and it did not violate the principle of beneficence in that the psychotherapist did not derail the psychotherapy process by her comments.

Step 5: Look Back or Evaluate the Results

Step 5 is to look back and evaluate the problem-solving intervention according to the standards of a good decision listed above (has a realistic chance of success, there is no plausible alternative, etc.). In addressing her patient's racist comment, the short and long-term goals of the psychologist were to help her patient to re-evaluate her attitudes toward Black people, or at least how she referred to them. The intervention was consistent with the values of the psychologist. She valued general beneficence (promotion of public welfare) highly but was also concerned about beneficence or the welfare of her patient.

Although looking back (or evaluating) is Step 5 in the five-step model, it may or may not be the final step in the process. In many cases, the five-step process will result in a solution that essentially ends the ethical dilemma. In other cases, it will be appropriate to look back, evaluate the effectiveness of the intervention, and determine if another intervention is warranted. In this vignette, the patient understood and appreciated the concerns of the psychologist and how her comments were hurtful. This insight could occur because the psychologist treated her patient with respect and concern throughout their discussions.

The five-step model is not necessarily linear. Psychologists can view the five steps as dynamic and not fixed. For example, the resolution of one dilemma may give rise to subsequent dilemmas, or the resolution of one step in the model may provide more information that causes psychologists to alter their previous interpretation of the problem and return to previous steps of the five-step model. For example, work on Steps 2 and 3 (develop and analyze options) may lead a psychologist to go back to Step 1 (identify or scrutinize the original problem). Also, sometimes it is not until Step 4 or 5 (act or perform and look back or evaluate) that the psychologist becomes aware of contextual factors that would have modified the options generated in Steps 1 and 2.

EMERGENCY OR CRISIS DECISION MAKING

At times, psychologists will have time to go through the five-step model carefully using their System 2 skills. They will have time to identify the problem, develop alternatives, consult with others, or do some detailed reading in the problem area. At other times, psychologists may need to act immediately. For example, if a patient unexpectedly expressed a serious homicidal threat during psychotherapy, psychologists need to act without the option of careful deliberation. These kinds of situations often evoke high emotional arousal, and psychologists may feel a need to resolve the situation quickly to reduce their emotional discomfort. Nonetheless, psychologists can increase the likelihood of making reasonable decisions in emergencies or crises if they know the APA Ethics Code and other disciplinary codes. Knowing these materials well should help alert psychologists to when an ethical dilemma has arisen. Also, psychologists who are aware of their own emotional states should be better able to detect their nagging doubts and begin their ethical-decision-making response.

Furthermore, psychologists can anticipate problems that could occur in their type of practice. For example, psychologists who work with families can anticipate problems when dealing with confidentiality with adolescents, keeping family secrets, or with potential conflicts of interests. For example, family therapists should be prepared to respond when their patients offer "secret" information about another family member. Ideally, psychologists will have thought out, consulted on, and formulated possible responses.

Finally, psychologists can overlearn the five-step model and use it even during periods of stress. That is, psychologists should be immediately able to outline the steps of the decision-making process. While other decision-making models may be thorough and have numerous sub steps, the five-step model is simple enough for psychologists to rely on during crises.

5

Competence

The overarching ethical principles of beneficence and nonmaleficence form the primary basis for competence. Psychologists should work to benefit and to avoid harming those with whom they work. Psychologists also need to adhere to the other overarching ethical principles (e.g., respect for patient autonomy, justice, integrity) to deliver their best services.

Many definitions of competence refer to the integration of knowledge, attitudes, and skills (e.g., W. B. Johnson et al., 2012). However, a more detailed definition from Epstein and Hundert (2002) considers *competence* as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (p. 226). We would add cultural competence to this otherwise comprehensive definition. This useful definition considers competence to include both everyday habits as well as judgment in applying specific skills.

The lack of competence could result in a disciplinary action from a malpractice court, the Ethics Committee of the American Psychological Association (APA), a state ethics committee, or a state licensing board, many of whom adopt the *Ethical Principles of Psychologists and Code of Conduct* (APA Ethics Code; APA, 2017a) or a variation of it. From a practical perspective, allegations of incompetence are more frequent during the delivery of forensic services because the services of the psychologist are under greater scrutiny and because disgruntled clients are more willing to file complaints if they believe they were

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harmed. However, the best way to avoid being disciplined for lack of competence is to aim for the ceiling by upgrading one's knowledge, practicing and honing skills, and approaching one's work with an attitude of humility.

In this chapter, we review essential information about competence, including strategies for maintaining competence, competence in supervision and consultation, competence in telehealth, and the necessity of cultural competency. We also discuss considerations when moving into new areas of practice, exceptions to the general rules of competence (which include emergencies or providing services in underserved areas), and emotional competence.

PRACTICING WITH COMPETENCE

The APA Ethics Code Standard 2.01a, Boundaries of Competence, states, "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." A subsequent standard expands on Standard 2.01a and requires psychologists to base their work on the knowledge foundation of the discipline or profession of psychology (Standard 2.04, Bases for Scientific and Professional Judgments). Finally, Standard 3.04, Avoiding Harm, states that "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."

Determining Competence

Professional psychologists become proficient in an area of service after they have submitted their work for external feedback. The most obvious example of external feedback occurs when students attend training programs in psychology, and faculty and supervisors evaluate their performance. External feedback also occurs when experienced psychologists supplement their individualized or group study by having colleagues evaluate their work to determine whether they have reached or are maintaining acceptable standards of proficiency. The external feedback will be most helpful when psychologists have cultivated a habit of healthy self-doubt. As stated by Nissen-Lie et al. (2017), psychotherapists should learn to "love yourself as a person, doubt yourself as a therapist" (p. 48). Although psychologists are responsible for determining their own competence, the problem is that psychologists, like others, need this healthy self-doubt and external feedback because they may have blind spots and may overestimate their abilities.

External feedback protects against cognitive biases such as confirmation bias (discussed in Chapter 4), the fundamental attribution error, illusory optimism (W. B. Johnson et al., 2012), or the Dunning-Kruger effect wherein people overestimate their positive qualities or abilities. For example, Epley and Dunning

(2006) found that people often overestimated how much they gave to charity or how frequently they completed tasks on time.

Similarly, health care professionals may overestimate their abilities. For example, Walfish et al. (2012) found evidence of the Dunning-Kruger effect among mental health professionals. In a sample of 129 mental health professionals, 25% placed themselves in the top 10% of competence and none placed themselves in the bottom 50% of competence. The mean ranking was 80th percentile and the modal ranking was 75th percentile. On average, mental health professionals believed that only 3.6% of their patients deteriorated during treatment, a rate that is below the 5% to 10% deterioration rate reported by Castonguay et al. (2010).

Teaching psychologists have presumably developed competency through the courses they have taken, the supervised experiences they have had, and through the external feedback they have received in their doctoral programs. Nonetheless, because of sudden vacancies in the department or other unusual events, faculty members may sometimes teach courses for which they have not had the optimal academic preparation. In these instances, they should strive to master the subject matter, perhaps through consultation with other faculty.

Competent teachers also need good pedagogical skills. However, many conscientious teachers have had to learn how to teach on their own because their departments failed to educate or mentor teaching assistants or provide resources and feedback on teaching skills for its faculty (Komarraju & Handelsman, 2012). Nonetheless, those psychologists should be able to fulfill their competence obligations under the APA Ethics Code if they undertake appropriate study or consultation.

Research psychologists similarly obtained their proficiency through external feedback in their doctoral programs through course grades and oversight of their research. Following graduation, however, most of the responsibility for the quality of research rests with each individual, institutional review boards, funding agencies if applicable, and feedback from fellow researchers and peer reviewers.

Ensuring Continued Competence

Psychologists need to stay current and competent in their professional skills because the knowledge base for psychology continues to change. It is not enough for psychologists to maintain their skill sets, they need to evolve their skills to meet the changing demands of the field (Washburn et al., 2022). The half-life (i.e., the amount of time it takes for half of the knowledge base to become outdated or inadequate) for accumulated psychology knowledge is becoming shorter. Neimeyer et al. (2014) estimated that the half-life for psychology at the time of their paper was 9 years, but in the future, it would be 7 years.

Past training, in the absence of ongoing readings, study, experience, or workshops, is not sufficient to maintain competence if the standard of practice in

an area has shifted. Although all state boards of psychology now require continuing education (CE) as a condition of licensure renewal, these requirements only represent the minimum amount of professional education that psychologists should receive. Most psychologists report that CE helps them to improve their competence (Neimeyer et al., 2010). Psychologists who attended longer programs that involved different methods of instruction learned the most from their CE programs (Buttars et al., 2021). Furthermore, Wenghofer et al. (2015) found that physicians who had the most group CE had the fewest patient complaints.

In the meantime, a movement within medicine is promoting the concept of maintenance of certification (MOC) whereby medical specialty boards will give board certification for a limited time, but then require the board-certified physicians to undergo some form of reevaluation to retain their certification. This movement is not without its problems, in that some physicians have such highly specialized practices that no examination process currently exists to measure their competence (Irons & Nora, 2015). Nonetheless, preliminary data suggest that it can improve the quality of medical practice (Price et al., 2018).

The American Board of Professional Psychology, which is a voluntary association without legal authority, has instituted a similar process for psychologists who were board certified after January 1, 2015. The Association of State and Provincial Psychology Boards (ASPPB; 2021)[1] has also explored this issue, although any change is likely to be many years away.

W. B. Johnson et al. (2012) stated that one of the best ways to ensure continued competence is to embed oneself in a *competence constellation*, or a "network or consortium of individual colleagues, consultation groups, supervisors, and professional association involvements that is deliberately constructed to ensure ongoing multisource enhancement and assessment of competence" (p. 566). For example, participation in a consultation group may be one element of that competence constellation. No psychologist has proficiency in all areas of practice, and all psychologists may benefit from discussions with others from time to time. Some consultations are done on an as-needed basis. Other consultations occur through ongoing peer consultation or mutual consultation groups in which participants share information about treatment plans and techniques. Supervision and mentorship (W. B. Johnson, 2007; W. B. Johnson et al., 2013) can help socialize psychology students into the benefits of creating a competence community.

[1]ASPPB is the association of licensing boards from Canadian provinces and territories and American states, territories, and the District of Columbia and Puerto Rico. Among other activities, ASPPB develops the Examination for the Professional Practice of Psychology (EPPP) and provides background information and resources for psychology licensing boards. The recommendations of ASPPB are not binding on any state, province, or territory. Nonetheless, they do reflect the current thinking of some leaders in the regulation of professional psychology.

CASE EXAMPLE: A GROUP OF THOUGHTFUL PSYCHOLOGISTS

Five psychologists in solo practice belonged to a "journal club," which met once a month for many years. Each participant brought an article to discuss at each meeting. However, the group involved more than just discussions of the articles and provided an opportunity for these psychologists to share perspectives on difficult cases and reflect on their day-to-day practices.

These psychologists knew that they performed at their best when they shared ideas and regularly sought consultation. One group member said, "My colleagues saved me from a clinical mistake that could have had tragic consequences." Consultation groups, however, do more than just keep their participants from making big errors; they also allow participants to share their positive experiences with others, which leads to greater closeness, group cohesion, and a willingness to share. Perhaps the key quality of these interactions is that they help psychologists self-reflect on their opinions, intentions, and skill level.

Of course, most psychologists want to excel in their work; they do not feel satisfied with only being minimally competent. Although the data on what constitutes a highly effective psychotherapist is evolving, evidence suggests that highly competent psychotherapists have strong interpersonal skills, know how to form productive alliances with their patients, engage in deliberate practice (i.e., conscious activities designed to improve their current level of competence), and show healthy self-doubt, which allows them to solicit feedback on their performance (Wampold et al., 2017). Sources of feedback could come from discussions with peers, case presentations, feedback from patients through standardized interviews or from routine outpatient monitoring, or other sources.

SUPERVISION AND CONSULTATION

Standard 2.05, Delegation of Work to Others, of the APA Ethics Code requires psychologists to ensure that their supervisees or assistants have the abilities to perform the duties assigned to them and to ensure that they perform the work competently. The supervisory relationship is a hierarchical one. Supervisees have no independent authority to make decisions regarding patient care or any other professional responsibility. Psychologists commonly supervise unlicensed employees and unlicensed psychology trainees who are obtaining the experience required to qualify to take the licensing examination. The same obligations to ensure quality apply to all employees, even those who are not undergoing the supervision required for licensure (e.g., administrative support staff, interpreters). Some state licensing boards even require courses in supervision before a psychologist can supervise psychology trainees.

CASE EXAMPLE: CLEARING UP A MISUNDERSTANDING

A psychologist was contacted by a young social worker who wanted supervision. Upon further discussion, it was clear that the social worker wanted to retain his independent practice but only have the psychologist sign insurance forms for some patients.

The social worker did not understand the meaning of the word "supervision." He could not have an independent practice and be supervised at the same time. Furthermore, it was not entirely clear if insurance companies would have reimbursed for services provided with this level of supervision. Supervision differs from consultation. In consultation, the consultee retains responsibility over the final work product. In supervision, the supervisor retains all responsibility for the work product. Chapter 15 presents more information on supervision and consultation.

TELEHEALTH

Telepsychology, which is a form of telehealth, refers to "the provision of psychological services using telecommunication technologies" (Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013, p. 792). This could include texting, telephones, or emails, although psychologists use Zoom or other forms of video conferencing the most. Psychologists used telehealth infrequently before the COVID-19 pandemic, but now they use it commonly for psychotherapy or even for psychological assessments. A meta-analysis found that video conferenced psychotherapy achieved roughly equivalent outcomes as face-to-face psychotherapy (Batastini et al., 2021).

Telehealth opens opportunities to deliver services to persons who otherwise would have difficulty getting them. Patients who have mobility problems or who live in remote areas might now receive services that were previously unavailable. Also, telehealth may allow psychologists to continue to provide services to patients who have moved or who are on extended vacations or work assignments. In addition, patients with highly specialized needs can get services from psychologists who live at a distance from them.

All of the ethical obligations for psychotherapists including requirements to be competent, to maintain boundaries, and to have an acceptable informed consent process apply to telehealth services as much as they do to face-to-face services. In addition, the use of telehealth requires specific competencies, which are outlined in APA's *Guidelines for the Practice of Telepsychology* (Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013). Among other things, psychologists need to ensure that they have the technological skill and equipment to perform telehealth services appropriately. They should be mindful of the security of the telecommunication platforms that they use and ensure that they comply with the Health Insurance Portability and

Accountability Act of 1996 (HIPAA) and other federal or state laws. Psychologists should also ensure that their patients can use the technology appropriately and have a private location from which to receive services. Psychologists should inform patients of the limitations of telehealth, including the risk of a confidentiality breach, even if unlikely, and any unusual billing issues. They should have a back-up way to communicate with patients if the teleconnection is lost.

Also, psychologists should know the relevant interjurisdictional issues. It is commonly assumed that health care occurs where the patient is physically located. Consequently, psychologists should be licensed or otherwise permitted to practice in the state where their patients are located. Many, but not all states have provisions that allow psychologists licensed in other states to practice temporarily in a state where they are not licensed. In addition, 34 states (at the time of this writing) participate in the Psychology Interjurisdictional Compact (PSYPACT; https://psypact.org/), which is an interstate agreement that allows psychologists with special certificates to practice telehealth or temporary face-to-face psychotherapy in participating states. Despite some efforts to permit reciprocity across states, there is still a patchwork of laws and requirements among states, provinces, and territories, so that many psychologists will have some disruption in their services across jurisdictional lines (Younggren et al., 2022).

Of course, when patients live in another state, their treating psychologists need to understand and follow that state's laws, rules, and regulations governing the practice of psychology including child abuse reporting and any duty to warn or protect (Younggren et al., 2022). In addition, some states have specific rules for telehealth services that out-of-state psychologists must follow.

Being legally allowed to provide a service does not necessarily mean that it is ethically or clinically indicated to do so. Assuming that psychologists are legally authorized to practice in the state where the patient is located, we present three scenarios in which telehealth could occur: regularly scheduled patients who need additional services between face-to-face sessions, ongoing patients who have moved out of the area, and new patients whom the psychologists have never seen before.

The first scenario (regular patients who need services between sessions) presents the lowest risk because the parties already have an established therapeutic relationship. However, if the patient has not used telehealth before, the psychologist needs to ensure that their patients are comfortable with the technology and that they have explained the unique aspects of telehealth to their patients.

In the second scenario (ongoing patients moving to a new location), psychologists may continue to treat a patient if they know the patient well enough to determine whether distant treatment is clinically indicated. However, some patients, especially those who have complex needs (such as those who are at suicidal or homicidal risk), may benefit more from working with a local mental health professional who can better access local resources if needed. In these

instances, the psychologist might limit subsequent contacts to only a few sessions to facilitate the transition to a new mental health provider.

In the third scenario (taking new patients through telehealth), psychologists assume more legal risk. Psychologists may encounter patients who turn out to have more serious problems than they originally believed and may need additional services such as emergency crisis services, a psychiatric referral, a day treatment program, or a psychiatric hospitalization. Some patients may seem relatively well adjusted in the first session, but then reveal more significant and pervasive problems in future sessions. Treating psychologists who do not know local resources may experience significant delays in identifying the services needed by such patients or facilitating a referral.

In some situations, psychologists can take steps to ensure that they can safely accept new patients remotely. For example, the psychologist may review previous psychotherapy records to better understand the needs of these patients and then identify a local agency or physician who can act as a back-up in case of emergencies or help the psychologists to identify additional resources if needed. However, psychologists need to think through such precautions carefully. If there was an allegation of substandard treatment, then the psychologist would have the burden to show that they took reasonable measures to foresee, prevent, or minimize problems.

Psychologists can also communicate with patients through emails or texts in a manner that conforms with state and federal laws (Chapter 8 discusses confidentiality issues dealing with emails and texts). Psychologists who communicate with patients through email or texts should discuss with their patients their policies concerning electronic communications, such as when they believe those communications are appropriate and how long they generally take to respond. For example, many psychologists establish a policy that they will not be available to respond immediately to emergency texts or emails and may limit emails or texts to routine scheduling for patients or to check in periodically on clinically relevant issues. Psychologists should document clinically meaningful electronic contacts either through notes or by storing a copy of those emails and texts in the patient's chart.

COMPETENCE WITH DIVERSE PATIENTS

Effective psychologists consider the unique needs of each patient. Ideally, psychologists will have the specialized knowledge and skills to deal with all of the patients they treat. The APA Ethics Code requires psychologists to be competent, refer, or obtain supervision when special knowledge "is essential for effective implementation of . . . services or research." This includes knowledge of such factors as "age, gender, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status" (Standard 2.01b, Boundaries of Competence). In addition, Hays (2009) developed the

ADDRESSING acronym to help psychologists remember cultural and diversity factors: age/generational, developmental disabilities, disabilities acquired later in life, religion and spiritual orientation, ethnic and racial identity, socioeconomic status (SES), sexual orientation, Indigenous heritage, national origin, and gender. To this list one could also add citizenship or immigration status. Psychologists who lack proficiency should "obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services or make appropriate referrals" (APA Ethics Code Standard 2.01b, Boundaries of Competence). Exceptions are permitted for emergencies (Standard 2.02, Providing Services in Emergencies) or when services are not otherwise available (see Standard 2.01d).

Several overarching principles form the basis for viewing issues through a multicultural or diversity lens, such as beneficence and nonmaleficence (which require psychologists to be competent when they provide services), and justice, including procedural justice (which requires psychologists to treat all persons fairly). Finally, one of the major reasons for disparities in health care is that marginalized individuals underutilize health care services. Consequently, from the standpoint of distributive justice (which requires equal access to quality psychological services for all individuals), psychologists should take steps to ensure positive and welcoming treatment experiences for persons with all identities.

Although the APA Ethics Code established the minimum standards for the profession, we encourage psychologists to go beyond the minimum and follow the recommendations found in APA's (2017b) *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality*, *Guidelines on Race and Ethnicity in Psychology* (APA Task Force on Race and Ethnicity Guidelines in Psychology, 2019), *Guidelines for Psychological Practices With Sexual Minority Persons* (APA Task Force on Psychological Processes With Sexual Minority Persons 2021), *Guidelines for Psychological Practice With Transgender and Gender Nonconforming People* (APA, 2015b), and other APA guidelines. The goal is not just to avoid being disciplined but to ensure that patients from diverse backgrounds benefit from the services they receive. Although few psychologists consciously hold bigoted beliefs, all psychologists may have implicit prejudices that inadvertently distance them from certain patients on the basis of the patient's identity. It is a rare person who can live in society and be immune from prejudices or preferences, which are subtly or not-so-subtly promoted in the media or by others around us. Even well-intentioned White psychologists may not realize how their own socialization process may have influenced their assumptions about their patients. For example, a dedicated and caring pediatric psychologist pleaded with a mother to be more conscientious about the medical care for her daughter's diabetes. She implored the mother, "Don't you want to see your child grow up and to be there for her wedding?" And then she immediately realized that marriages were not common in this family and that she had imposed her own cultural expectations on her patient.

Competence With Racial, Cultural, or Ethnic Groups

Cultural competence involves an attitude of cultural humility, "the life-long commitment to learning and refining the skills of responsiveness, engaging in self-reflection, and challenging one's own assumptions about other races and ethnicities" (APA Task Force on Race and Ethnicity Guidelines in Psychology, 2019, p. 17). This includes curiosity or a sincere interest in learning more about the client's life, culture, and worldview. It also includes a willingness to look at one's own implicit biases.

Some European Americans may feel discomfort at multicultural or diversity approaches that involve discussions of implicit prejudices or *White privilege* (i.e., unearned advantages of being European American). Perhaps they grew up in a family or social system that promoted *racial ignorance* ("a general lack of knowledge about how race shapes the experiences of people in society"; Dupree & Kraus, 2022, pp. 270–271) or which saw *color blindness* as a virtue. Perhaps they assumed that acknowledging implicit prejudices or unearned advantages stigmatizes them or diminishes their worth as a person.

Finally, they may feel discomfort with multicultural or diversity approaches because they have adopted a *zero-sum approach* (Wright, 2000). In a zero-sum game, such as chess, one person wins and another loses. Applying a zero-sum approach to culture, some White Americans believe that any advancement in the status, income, or well-being of a marginalized population necessarily means that their own status, income, or well-being will suffer proportionately (Rasmussen et al., 2022).

According to a nonzero-sum approach, the interests of parties overlap Thus, White Americans, we believe, will benefit from an approach that values diversity. On a societal level, everyone benefits when the most qualified persons enter professions or occupations that deliver services, start businesses, or copyright patents. Consider gender, for example: Fifty years ago women physicians ("lady doctors") were rare. But consider how diminished our health care system would be if barriers to medical education for women still existed both in terms of the workforce needs and research contributions.

Second, a multicultural or diversity perspective can uplift individual European American psychologists if they see it as something that helps them become closer to their patients and colleagues, helps them to become more competent in dealing with their patients, and gives them useful skills to rely upon as they face life challenges. If psychologists approach multiculturalism this way, then it meshes with the intrinsic goals of relatedness, competence, and autonomy (Ryan & Deci, 2008).

In addition to the factors identified in Standard 2.01b, Boundaries of Competence, of the APA Ethics Code, psychologists should also consider intersectionality, or the "multiple dimensions of identity and social systems as they interact with each other" (APA, 2017a, p. 166). For example, differences in age, gender, sexual orientation, and SES could lead to much different life experiences for two persons who identify as the same race. Intersectionality may also lead to complex interactions. A wealthy gay White man may, for example,

be advantaged because of gender, race, and income, yet disadvantaged and stigmatized because of his sexual orientation.

Also, psychologists should look for diversity within marginalized groups (Nezu, 2010). The assumption that all persons from the same ethnic group are largely similar is called *ethnic gloss*. For example, a high-income American of Hispanic background from one of the landed Spanish families that predated the American Revolution may have little in common with recent immigrants from Mexico or Central America, who might not even have Spanish as their primary language.

Moving Toward Cultural Competence

A doctoral intern at a counseling center was from a Chinese American background, but her family had lived in the United States since the 1850s. Because of her appearance and Chinese name, the supervisor assumed that she was especially competent to work with the Asian students who came to the counseling center. Although she was willing to undertake the study necessary to ensure cultural competence, the assumption that she was culturally competent with students from China was not necessarily warranted, as she had little in common with students from China at the university.

Many people have bicultural identities. For example, a young adult from India may fit in very well socially within his company that is dominated by European Americans, but still expect his parents to arrange his marriage (Arnett, 2002).

Ascribed identity (how others classify a person) is not always the same as self-identity (how persons identify themselves). Years ago, I (Samuel J. Knapp) met a hereditary princess of the Delaware Nation (a Native American tribe) who had blonde hair and blue eyes. Although others may ascribe a European American identity to her, she ascribed a Native American identity to herself.

Finally, psychologists should welcome the opportunity to define culture broadly. Culture refers to the "belief systems and value orientations that influence customs, norms, practices and social institutions, including psychological processes" (APA, 2017b, p. 165). Consequently, the term *culture* could refer to certain subgroups within the United States who have their own unique assumptions and values, so that one may speak of cultural competence when working with members of the American military or among persons who hold deeply held beliefs about firearm ownership.

Psychologists should consider the level of education, awareness, and skills needed to treat an individual from a nondominant cultural or linguistic group. Certainly, psychologists need basic therapeutic skills, such as the ability to form relationships, and diagnose patients appropriately. But competence means more than memorizing a list of facts about cultures; it means being able to think in cultural terms and to focus on process as well as content.

Psychologists who work effectively with patients who are culturally different from themselves recognize the impact of their own cultural heritage on their

values and assumptions and appreciate the generational and life histories of their patients. The patient's family structure, worldviews, and values may influence the treatment relationship and process. Culturally adapted interventions may make treatments compatible with their patients' cultural patterns and values (La Roche, 2021). For example, compared with many other cultures, American culture emphasizes individual growth and autonomy while other cultures emphasize group and family needs (Stevenson & Haberman, 1998). This could have implications for some basic psychotherapeutic techniques. For example, instead of introducing relaxation techniques as an intervention to help patients feel better, psychologists may introduce relaxation techniques as an intervention to help patients become calmer and more effective when dealing with family members.

Also, the European American culture views people as basically good and values self-esteem. However, other cultures may view people as potentially evil and attend carefully to individual flaws and tendencies to violate moral principles (Stevenson & Haberman, 1998). So, for example, statements designed to promote a patient's self-esteem may not necessarily be congruent with their worldview. Other patients may come from a "face saving culture" (e.g., Korea) that discourages public displays of one's shortcomings. Consequently, they may benefit from a problem-solving model that focuses less on patients' awareness of their internal experiences (Hall et al., 2021).

Psychologists can deliver services more effectively when they understand cultural factors that influence the attitudes of patients toward mental health care. These include normative health-seeking behaviors and attitudes toward health professionals. Such cultural factors may affect patients' willingness to seek help, continue in treatment, or how they relate to the psychologist. For example, they may view the psychologist as a wise counselor whose role it is to give specific advice on life issues, not to help in self-exploration.

European American psychologists, if properly trained, can have effective outcomes when working with marginalized patients. Nonetheless, if possible, psychologists should honor patient requests or preferences for a patient-therapist match. Patients achieve better outcomes when psychotherapists honor their requests for matching psychotherapist identities (McAleavey et al., 2019).

Second, psychologists from the dominant culture are likely to be more effective in their work with persons from historically marginalized groups when they appreciate the psychological sequelae produced by their history of trauma, oppression, prejudice, discrimination, and minority stress. This knowledge may also help European American psychologists to understand the wariness with which some individuals from marginalized groups approach them.

Lack of cultural awareness may increase the likelihood that a psychologist may engage in a *microaggression*, which is a brief statement or behavior that—even if unintentional—conveys something negative about the target person or group. In the 1960s, I (Samuel J. Knapp) was attending a conservative Christian college and the president, an older Southern gentleman, was publicly beaming with pride over the accomplishments of one of the school's top

athletes. He claimed that the student "was a credit to his race," and that he "did not even think of him as a Black man." This is an example of a microaggression because, although the speaker was intending to be complimentary, he was implying that there was something wrong with being Black.

Even subtle cues can convey the cultural attitudes of the psychologist. For example, having readings that are of special interest to members of specific ethnic groups, having artwork from many cultures in the waiting room, and having a culturally diverse staff can create an environment that communicates openness and safety to marginalized individuals.

A lack of cultural awareness increases the risk of an inaccurate diagnosis (Schouler-Ocak et al., 2015). The evaluation process often requires psychologists to know the cultural background of their patients including culture-bound syndromes. Some of these could include *amok* (a culture-bound psychiatric syndrome in Southeastern Asia), religion-induced trances (states of mind common among Latinx spiritualists), *Shin-byung* (Korean beliefs about spirit possession), *hikikomori* (extreme self-isolation first identified in Japan), or *coraje* (psychosomatic manifestations of emotional upset among native Mexican tribes). In addition, a lack of cultural knowledge may lead some psychologists to misinterpret culturally normative behavior, such as viewing the avoidance of eye contact as a sign of pathology. Although no psychologist could be expected to be knowledgeable of all cultures, they can, nonetheless, prioritize self-reflection, a commitment to redress imbalances of power, and curiosity about others and a recognition that their patients are the experts on their own ethnocultural and racial experiences (APA Task Force on Racial and Ethnic Guidelines in Psychology, 2019).

The failure to use culturally appropriate assessment instruments or to adapt traditional instruments may also increase the risk of an inaccurate diagnosis. A literal translation of the words on a psychological test may not result in testing the equivalent domain. For example, the proverb "shallow brooks are noisy" is a metaphor for the concept that sometimes people who talk a lot have little to say. However, its literal translation into Spanish does not have the same meaning. If the goal is to assess the individual's ability to evaluate idiomatic expressions, then psychologists can use Spanish phrases such as *Tirar la casa por ventana* ("Throw the house out the window"), which is an idiom that means wasting money (Vallecillos, 2008). Chapter 10 also discusses diversity issues in assessments.

Ideally, psychologists will deliver services in their patients' preferred language, but this is often not possible. Almost one fifth of Americans regularly use a language other than English in their homes, including 37 million who speak Spanish; 3 million who speak a Chinese language (either Cantonese and Mandarin); more than 1 million who speak either Vietnamese, Tagalog, or Korean; and 2.6 million who speak a Native American language. Of those, about 25 million Americans reported that they spoke English "less than well" (United States Census Bureau, 2021). Nonetheless, few American psychologists are fluent in languages other than English. Consequently, they may need to find a language-proficient psychotherapist or an interpreter.

Professional interpreters understand the basic rules and technical issues of interpretation, which untrained individuals would not necessarily know. Urban areas have commercial interpreter services, although rural areas seldom do. Psychologists in rural areas may need to use another fluent person such as an instructor of the foreign language. Because of the risk of conflicts of interest and their potential to contaminate information, friends or relatives of family members should only be used as interpreters as a last resort or in emergencies. Sometimes psychologists need to explain the psychotherapeutic process to interpreters and especially cover issues involving confidentiality and boundaries. For example, it could be explained that "the patient is the expert on their experience, the interpreter is the expert on interpreting, and the psychologist is the expert on providing psychological treatment" (Martin et al., 2020, p. 625). Debriefing with interpreters after sessions may sometimes head off or minimize future problems.

Psychologists should not assume that bilingual patients use languages interchangeably. For example, patients may switch to their language of origin when discussing emotional events that occurred during childhood (Altarriba, 2005). Patients who want to experience the depth of their emotions may prefer to use the language that was dominant when the event occurred. Those who want to distance themselves from their emotions may prefer to use a language that they acquired later in their lives.

Competence With LGBTQ+ Persons

Lesbian, gay, bisexual, transgender, questioning or queer (LGBTQ+) are among the marginalized populations a psychologist will encounter. Variations in sexual orientation and gender identity are normal representations of the human experience (APA Task Force on Psychological Processes with Sexual Minority Persons, 2021). Although LGBTQ+ and gender nonconforming patients may struggle with many of the same issues as heterosexual and gender conforming patients, they also have unique problems, and minority stress may exacerbate their normal developmental issues (Pachankis, 2014). Throughout their lives, many LGBTQ+ persons have been physically or sexually assaulted or have been alienated from their families. Years of legal and social stigmatization have left many with an emotional legacy of distrust and fear. They have a higher risk than heterosexual individuals of developing depression, personality disorders, or other mental illnesses. Suicidal risk is especially high among LGBTQ+ adolescents (e.g., Wyman-Battalen et al., 2021), although suicide risks are reduced for those who have family and social support (Standley & Foster-Fishman, 2021).

Of course, psychologists should avoid showing prejudice and discrimination against persons whose sexual orientations or gender identity differs from their own (APA, 2015b; APA Task Force on Psychological Processes with Sexual Minority Persons, 2021). However, being effective with LGBTQ+ patients involves more than just refraining from overtly harmful acts. Straight psychologists can

work better with LGBTQ+ patients if they are attuned to their own attitudes about sexuality. Even psychologists who do not believe that homosexuality is a form of pathology and would strongly defend the rights of LGBTQ+ individuals may hold implicit negative attitudes or inadvertently engage in microaggressions.

In contrast, gay-affirmative psychologists know the issues and stressors facing their patients, understand their emotional reactions to LGBTQ+ patients, and feel comfortable dealing with explicit sexual issues. They understand the importance of LGBTQ+ relationships and how *family* is defined. Refer to the *Guidelines for Psychological Practice With Sexual Minority Persons* (APA Task Force on Psychological Processes With Sexual Minority Persons, 2021) and *Guidelines for Psychological Practice With Transgender and Gender Nonconforming People* (APA, 2015b) for more details on these general principles.

CASE EXAMPLE: WHAT IS THE TREATMENT GOAL?

A patient entered psychotherapy following a grief reaction precipitated by the death of his mother. The therapist interrupted his comments several times to explore how his mother felt about his sexual orientation. The patient, however, believed that such questions distracted him away from his real presenting problem, which was his grief.

Here, and in other cases, it would not be appropriate for psychologists to assume that sexual orientation itself is the presenting problem for any LGBTQ+ patient. However, at times confusion about sexual orientation is the presenting issue. In those situations, psychologists should have enough information so that they can correct misconceptions on the part of the patients. Patients may have internalized homophobia and believe, for example, that same sex attraction is a sign of mental illness, moral weakness, or simply a phase that they will grow out of.

Some counselors have promoted *reparative therapy* or *reorientation therapy* (i.e., therapy focused on changing the sexual orientation of the patient). Proponents may claim that some highly motivated individuals have changed their sexual orientation. Furthermore, they could argue that competent individuals have the right to make an informed decision to reorient their sexual orientation to make it consistent with their religious beliefs.

The informed consent process in many of these reparative or reorientation programs is misleading in that they exaggerate their "successes" and minimize the harms that they create. No controlled studies attest to the effectiveness of reorientation therapy, and many people have suffered severe harm because of their participation in these groups (Haldeman, 2022). These programs may reinforce ego-dystonic beliefs about their sexual orientation (*internalized homophobia*) and misrepresent variations in the expression of sexuality as a form of pathology (APA Task Force on Psychological Processes With Sexual Minority

Persons, 2021). Although the problems associated with reorientation therapies have long been known (e.g., American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009), some counselors continue to offer sexual reorientation programs (Haldeman, 2022). Psychologists should neither participate in nor promote sexual reorientation therapies.

Competence With Diverse Religious Beliefs

Religious beliefs sometimes profoundly influence the thoughts, feelings, and behaviors of believers. A large percentage of Americans believe in God and attend religious services regularly. Psychologists, on the other hand, tend to participate less in organized religion, although many consider themselves "spiritual" as opposed to religious (Shafranske & Cummings, 2013).

Psychologists can improve their interventions if they appreciate the role that religion may play in the lives of their patients and are open to incorporating the religious and spiritual beliefs and practices of their patients into psychotherapy. Specific competencies are needed when treating religiously committed patients from unique backgrounds. For example, Amish and Old Order Mennonites withdraw from "English" society, highly regulate their use of technology, and have strict codes of conduct.

CASE EXAMPLE: A RESPECTED PSYCHOLOGIST

The local bishop of the Amish community sometimes referred parishioners for counseling to a local Mennonite psychologist. Mennonites have theological and historical links with the Amish but are more "worldly" (e.g., most own cars and other modern appliances, permit higher education, and some even vote). The Mennonite psychologist understood the Amish worldview and thus, she was able to help most of her Amish patients.

Amish people live according to the *Ordnung* (a set of rules of living) that includes community obligations, harmony within the community, deference to the authority of the local bishop, and skepticism of any technology that interferes with their traditional way of life (Cates, 2005). The Mennonite psychologist knew that understanding and respecting the Ordnung was essential for effective psychotherapy.

Sometimes liberal psychologists may feel a clash of values with religiously conservative patients. For example, religiously conservative patients may prefer hierarchical rather than egalitarian marriages and may raise their children with a greater emphasis of corporal punishment as opposed to positive reinforcement and modeling. Usually, psychologists can gently guide patients to consider alternative ways to consider their problems. One experienced child psychologist

encountered highly resistant parents who said that they only came for one appointment of psychotherapy to "get the Children and Youth agency" off their back and had no interest in coming back. They cited religious doctrines to support their child-rearing practices. Instead of arguing with the parents about their child-rearing practices or trying to shame them, the psychologist listened carefully to their concerns and ensured that they felt heard. At the end of the session, the couple agreed to come back to see the psychologist. The treatment goal of "getting Children and Youth off our backs" was the same, but there was an added understanding that achieving this goal may involve revisiting some of their parenting practices.

Some religiously conservative patients look askance on psychologists. Even when they do participate in psychotherapy, they may take longer to trust their psychotherapists. Patients want psychologists who are willing to listen to them carefully and sensitively. For example, one psychologist, who is not a Christian, often receives inquiries from prospective patients who ask her if she is a Christian. She tells the prospective patients that she respects their religious values and tries to work within their own value system to help them find good solutions to their problems. The prospective patients almost always find her response reassuring and enter psychotherapy with her.

Conversely, Knapp et al. (2015) cautioned that problems can also occur if psychologists and patients share the same religion, and the psychologists assume that they know what their patients believe or how they feel. Just because a psychologist and patient are both devout Roman Catholics, for example, does not mean that they necessarily share the same worldview on many important issues.

Effective psychotherapy often requires psychologists to inquire about their patients' deeply held centers of meaning (Silberman, 2005) or religion (Knapp et al., 2010). As B. Greene (2009) concluded, "religious and spiritual perspectives and their use are no more entitled to be free of scrutiny in therapies . . . than other beliefs, particularly if there is reason to believe that their implementation will harm someone" (p. 705). It seems like it would be harder to get meaningful change in psychotherapy if the patients are withholding discussions of their deeply held beliefs and worldviews. Of course, psychologists must be respectful and sensitive when exploring religious or spiritual issues. Some psychologists will include a brief question on their intake form as to whether patients wish to integrate a religious or spiritual perspective into their treatment. An affirmative answer opens the door for psychologists to raise these issues and conveys to patients that they should feel free to raise these issues as well.

If psychologists wish to integrate religious rituals or use a shared religious perspective in psychotherapy, then they should consider several factors, including whether they have examined the potential for their own biases or blind spots (Plante, 2014) and if they have the necessary attitudes and knowledge to integrate religion and psychotherapy effectively (Vieten & Lukoff, 2022). For example, psychologists should show empathy for clients from diverse religious

backgrounds, know how religion can facilitate or harm mental health, and have skills to help patients to explore the mental health implications of their religious beliefs (Vieten & Lukoff, 2022). Unfortunately, many clinicians have little or no training in some of the areas of required competency (Vieten et al., 2016). Psychologists should not use a religious-based intervention to prioritize a specific religious worldview at the expense of the patient's treatment goals or the treatment relationship. Nor should they confuse the role of a psychologist with that of a religious counselor. That is, the goal of the psychologist is to treat mental distress or relationship problems; it is not to strengthen faith, improve adherence to religious practices, or clarify religious questions.

Psychologists should only integrate religion or spirituality into psychotherapy with the clear understanding and consent of their patients. Part of the skill set for religiously oriented psychologists is to determine when or how to integrate religion into psychotherapy, and when not to do so. Some of the ways that religion can be integrated into psychotherapy include using prayer and meditation, teaching spiritual concepts, and using a religious community for support (Pargament, 2007).

The integration of religion or spirituality into psychotherapy requires knowing psychopathology as well as religion. Consider the following example.

CASE EXAMPLE: A PSYCHOLOGIST-PRIEST

A Roman Catholic priest who was also a licensed psychologist accepted a patient who presented his concerns in highly religious language. The patient reported substantial marital discord prompted largely by his almost continual praying. Further inquiry suggested that this behavior was a manifestation of obsessive-compulsive disorder. The psychologist-priest knew that "overscrupulousness" has been recognized by Roman Catholic authorities for centuries and that it must be distinguished from piety. The psychologist-priest treated the patient using evidence-supported treatments for obsessive-compulsive disorders.

Similar scrupulosity-related problems have also been found among persons of many different religious backgrounds (Siev & Huppert, 2016).

Competence With Low-Income Patients

As discussed in Chapter 3, low income is associated with poor health. Poverty results in many preventable illnesses and premature deaths. Poverty increases the risk of chronic stressors because people who are living below the federal poverty threshold must struggle just to acquire food, shelter, and the other necessities of life. Many people with low-paying jobs often live from one paycheck to another, and one life event away from a catastrophe. A car repair or an illness in the family, which may be an inconvenience for a middle-class

family, could result in a cascading series of losses, such as the loss of one's job or home. The childhood adversity associated with poverty increases the risk of asthma, cognitive delays, infections, and a weakened immune system (Oh et al., 2018). Not only does poverty challenge one's ability to obtain the necessities of life, those living in poverty may live in substandard housing where they are exposed to lead paint, asbestos, and other toxins and live in neighborhoods without easy access to parks, grocery stores, or other amenities. Poverty is often associated with a set of attitudes involving alienation, pessimism, and reduced self-esteem. If they enter treatment at all, people who are economically disadvantaged may do so with a heightened fear of disapproval or disdain from others.

Psychologists may need to consider any implicit biases they might have toward patients of lower SES (Juntunen et al., 2022), and should pause a moment before being too critical of them. For example, when noticing unhealthy lifestyle habits, such as smoking cigarettes or buying too much non-nutritious foods ("junk foods"), psychologists may wish to adopt a more understanding attitude. What may appear to be maladaptive to outsiders may be adaptive to some extent if one considers the totality of patients' lives (Kim & Cardemil, 2012). Instead of condemning patients as having personal weaknesses, psychologists might consider that they acquired the addiction to cigarettes because it was one of the few options that they had to reduce their stress or that they learned to make junk food a staple in their diet because it was the only filling food that they could afford or to which they had access. Because some persons living in low SES neighborhoods have limited access to fresh foods and easy access to low-quality, processed food, they may also feel more familiar with those "junk" foods even in cases where fresher foods have become available.

Poverty increases the likelihood that a patient has had adverse childhood events and high levels of stress (Thompson et al., 2019). Psychologists should appreciate the roles that stress and trauma have played in the lives of their low-SES patients, including victimization by crime (Woods-Jaeger et al., 2019). Chronic unemployment or underemployment can result in demoralization, pessimism, or shame.

Nonetheless, when given the opportunity, low-SES patients can develop good relationships with their psychotherapists and respond well to treatment. I (Samuel J. Knapp) spent most of my psychotherapist life working with low-SES patients in rural Pennsylvania, and I found the same emotional rewards and sense of personal accomplishment as my colleagues working with more middle-class or affluent patients.

Working with low-SES patients may require forbearance or patience on the part of the psychotherapist. While psychotherapists would ordinarily adopt a clear no-show policy with their patients, they should show far greater flexibility with low-SES patients. Low-SES patients may have transportation problems which keep them from making appointments as much as they would like. They are less likely to have the option of taking off work to attend psychotherapy appointments.

Psychologists may enhance the well-being of their patients by *social prescribing* (Roland et al., 2020), which means referring patients to community agencies that could help them with housing, food, or other safety net resources. Patients who are hungry might not be able to focus well in psychotherapy. It is often wise to combine case management services with psychotherapy (Kim & Cardemil, 2012).

In addition to delivering direct services to low-SES patients, psychologists can advocate for social policies to mitigate poverty. Even modest improvements in access to food stamps or increases in the minimum wage noticeably improve the lives of low-SES people. Chapter 3 discussed advocacy in more detail.

Culture Wars

We live in a nation whose citizens have widely differing views of moral or normative behavior. Often, people feel contempt for those who think or act differently from themselves. As members of the public health workforce, psychologists offer services to all persons regardless of their religious or political beliefs. They listen carefully to their patients, respect their autonomy to make decisions about their lives, avoid harming their patients, and otherwise uphold the same professional standards for all patients, even those with whom they might disagree. Psychologists can better implement these values if they monitor their feelings, discuss problematic emotional reactions with concerned colleagues, and keep their overarching ethical goals in mind.

Usually, the political or religious beliefs of patients do not influence the course of psychotherapy, but sometimes they do. For example, the presence of loaded and unlocked firearms in the house increases the risk that suicidal persons will fatally shoot themselves. Temporarily creating a barrier between the firearms and the patients will greatly reduce the risk of a suicide. While firearm safety is important in all households, it becomes especially important when someone in the family has suicidal thoughts (Miller et al., 2022). However, some patients who own firearms may resist recommendations to create barriers between themselves and their firearms because they suspect that health care professionals are using the risk of suicide as a subterfuge for their real goal of removing firearms from the public. Fortunately, skillful psychologists who understand firearm culture and who treat firearm owners respectfully can often overcome these obstacles and motivate patients to take steps to protect their lives. For example, Hoyt et al. (2021) effectively used motivational interviewing to encourage patients to store their firearms safely.

MOVING INTO NEW AREAS OF COMPETENCE

Competent psychologists may want to develop proficiency in areas of practice in which they did not receive formal academic training. According to the APA Ethics Code, "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" (Standard 2.01c, Boundaries of Competence). In some domains of practice, it is possible for psychologists to ensure their competence by working for a proficiency credential, such as a diplomate in forensic psychology or a proficiency certificate in the treatment of persons addicted to alcohol or other drugs.

Prescriptive Authority

In recent years, Idaho, Illinois, Iowa, Louisiana, and New Mexico have amended their psychology laws to permit certain psychologists with advanced training in psychopharmacology to prescribe medications from a formulary limited to psychotropic medications. These psychologists need to have an advanced degree in psychopharmacology from an approved program and supervised experience in prescribing, and to pass a proficiency examination in psychopharmacology, among other requirements. In addition to attending to the scientific and professional aspects of prescribing, these psychologists also need to ensure that they are aware of the unique ethical issues that could occur when prescribing medications. Preliminary data suggest that these prescribing psychologists are respected by their colleagues and are fulfilling their goal of providing needed services to underserved populations (Peck et al., 2021).

Practice Expansion When No Standards Exist

In other domains of practice, no specialty credentials exist. Moreover, experts may not agree on a uniform sequence of experiences, study (set of readings, workshops, or classes), or examinations to ensure proficiency. Furthermore, there is no guarantee that psychologists have acquired the knowledge and skills found in the books or workshops. Competent performance in a new domain may require actual skills as opposed to just factual knowledge. For example, psychologists who work with children need to have a personal style appropriate for children. It may require nuances of body language, tone of voice, and choice of vocabulary that psychologists can best acquire through direct contact with children as opposed to just reading about them.

Although learning the standards in a new area of practice is essential, psychologists should not consider themselves competent in a new domain until another professional with proficiency in the field has monitored or supervised them. Working in a new setting requires that psychologists understand the treatment milieu, including the informal traditions and expectations of that new work environment. Psychologists should ask themselves if their knowledge is current with the scientific literature in the relevant domain, and if they have mastered the needed clinical skills and appreciate any ethical or legal issues involved in practicing within the domain (Belar et al., 2001). Fortunately, APA has published guidelines specific to many areas of practice, such as working with older adults (APA, 2014) and with girls and women (APA, 2018a), which can help guide their study.

Because of the movement toward integrated care, many psychologists now work in primary care or other medical settings either as part of an integrated team or simply colocated (meaning that they deliver their services in the same physical location as physical health services). Working effectively in an integrated care setting requires, among other things, familiarity with the roles of different health care professions and medical terminology, and an appreciation of the different confidentiality and informed consent rules in a medical practice (Chenneville & Gabbidon, 2020). Finally, competent integrated health care psychologists know how to deliver the services expected in a health care setting, which are often brief and targeted screenings or interventions.

CASE EXAMPLE: A STEEP LEARNING CURVE

During her first week working in a primary care setting, a young psychologist included detailed notes of every encounter with a patient, no matter how brief. A friendly physician took her aside and politely told her to "keep it brief; just give us the essential facts. We don't have time to read through a lengthy report."

The psychologist appreciated the comments, recognizing that the value of the notes in a primary care setting depended, to a large extent, on their usefulness to other members of the treatment team.

EMERGING OR EXPERIMENTAL TREATMENTS

According to APA Ethics Code Standard 2.01e, Boundaries of Competence:

> 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.

Before using an experimental technique, psychologists need to ask themselves several questions. Does evidence support the use of the technique for this person? If so, under what conditions could it be of benefit? Do other treatments have a greater likelihood of success? Could the treatment harm patients? Has the psychologist consulted with peers about when or how to apply this technique? Are patients informed about its innovative nature? Will the psychologist monitor the progress and welfare of patients throughout the course of treatment? Does the psychologist have enough training in the technique? Will patients feel discouraged from trying more conventional approaches if the experimental treatment fails? Ineffective treatments are not morally neutral if they discourage patients from taking advantage of more effective ones.

Psychologists should use similar caution when referring patients to new or experimental treatments. For example, although psychologists are not licensed to administer psychedelics, their patients may request a referral for

psychedelic-enhanced psychotherapy. Some promising evidence has emerged concerning the effectiveness of psychedelic-assisted psychotherapy, although there are still questions concerning its long-term effectiveness, such as its effectiveness compared to other treatments, what conditions it can be effective with, and what kinds of psychotherapy are best employed in conjunction with the psychedelics (Wheeler & Dyer, 2020).

Complementary or Alternative Medicine

C*omplementary* treatments are not taught regularly in professional programs and are used in conjunction with traditional treatments. *Alternative* treatments are not taught regularly in professional programs and are used in place of traditional treatments. The definition of a complementary or alternative treatment (CAM) may vary according to the disorder being treated. Relaxation exercises might be a traditional treatment for an anxiety disorder, but a CAM for a personality disorder. Also, the definition of a CAM may vary according to the patient's culture. Many CAMs are well accepted within some cultures. For example, Mexican Americans may be more likely to seek treatment from a *curandera*, a traditional native healer, whereas non-Hispanic White Americans may be more likely to seek services from a massage therapist. Common CAMs include herbal teas, vitamins, nutritional supplements, massage therapy, special diets, tai chi, yoga, meditation, or Ayurvedic medicine. The CAM may represent the patient's differing worldview of the origin of their illnesses, which is something that psychologists should explore and understand. For example, some patients may believe that their psychological pain arises from their poor behavior in a past life or from the presence of demons or negative spirits. Consultation or coinvolvement of Indigenous healers who may employ CAMs may help some of these patients (APA Task Force on Race and Ethnicity Guidelines in Psychology, 2019).

Patients with psychological problems may use CAMs either before or while they are receiving psychological treatment. For example, many patients with depression use omega-3 fatty acids, St. Johns' wort, or ginkgo biloba for depression (Asher et al., 2017). About 80% of persons with attention-deficit/hyperactivity disorder (DeFilippis, 2018), and more than 70% of parents of children with Tourette's disorder reported using CAMs (Patel et al., 2020).

Marijuana or marijuana-based derivatives including tetrahydrocannabinol (THC) may either be a traditional treatment or a CAM, depending on the patient's problem area. The Food and Drug Administration has approved THC-based medications to control some forms of epilepsy, to treat patients with nausea secondary to chemotherapy for cancer, and to stimulate the appetites of patients who are experiencing wasting syndrome secondary to AIDS. However, other uses of marijuana-based products for mental health conditions such as anxiety disorders, PTSD, autism, Tourette's syndrome, chronic pain, or other disorders has shown promising results, but not sufficient enough to make them front-line interventions for these disorders, although research is ongoing. Furthermore,

marijuana use can have severe secondary effects for children, and pediatricians warn against its use except in highly unusual circumstances (Ammerman et al., 2015).

Psychologists should use caution when recommending marijuana for their patients. They need to balance the potential benefits to their patients with the costs in terms of money, time, and any possible iatrogenic effects. The benefits of medical marijuana have been promoted extensively, and the claims of its effectiveness are often overstated. For example, Boatwright and Sperry (2020) found that only 10% of websites contained accurate information on the medical benefits of marijuana. The use of marijuana is complicated by the fact that some patients use it legally with a prescription while other patients use illegally obtained marijuana for both medical and recreational purposes. When patients self-medicate with marijuana, it is unknown what the impact of the euphoric effects of marijuana will have on the treatment process (Feingold, 2020). Nonetheless, anecdotal evidence suggests that it can help some patients and could be a treatment option when more traditional treatments have failed (e.g., Skelley et al., 2020, for a review of marijuana and anxiety disorders).

Ideally, psychologists will talk to their patients about any risks and benefits of CAMs they might be using or considering. Psychologists risk alienating their patients if they criticize their use of CAMs too directly. Compromise may be clinically indicated in some situations. Nonetheless, psychologists should not blindly acquiesce to the treatment theories of their patients, especially when they involve herbal or dietary supplements that lack proven efficacy. Patients may not know that some "natural" remedies have toxic effects or may interact with some prescription medications. Furthermore, the lack of standardization in herbal content across product brands may make it hard to determine their efficacy. Before commenting on nonprescription medications or herbal remedies, psychologists can always consult with the patient's physician.

Electronic Supplements to Traditional Psychotherapy

Many psychologists have found it helpful to use medical devices or applications on mobile devices to supplement telehealth or traditional face-to-face psychotherapy (sometimes referred to as e-Health or mHealth apps). Given the great shortage of mental health professionals, these applications have received renewed attention. The Food and Drug Administration approves medical devices although they exempt devices that pose minimal risk to the public (Kinney, 2018). Many of the apps used by mental health professionals fall within this exception. Other digital or electronic interventions show promise as well. For example, psychologists may recommend the use of wearable devices such as wristbands or watches to gather real-time physiological data on patients, which can be used for treatment purposes, or as standalone interventions (Hunkin et al., 2020). Virtual reality devices have been used to facilitate the treatment of posttraumatic stress disorder (e.g., Vermetten et al., 2020). Unfortunately, many of these interventions are proprietary, and the manufacturers have not always made the outcome data public.

Similarly, many apps help patients by tracking their symptoms or sending them self-help reminders. The decision to use smartphone apps depends on patients' concerns about privacy, their comfort with mobile technology, access to Wi-Fi, financial resources, and other factors. Psychologists who recommend apps should explain the procedures, benefits, and uses of the apps to their patients and educate them about how to safeguard their data (Edwards-Stewart et al., 2019).

Many patients use smartphone apps comfortably and effectively (Melvin et al., 2019). The number of apps for mental health services is large and growing. Martinengo et al.'s (2019) survey reported 69 apps for depression and suicide. Unfortunately, these apps varied considerably in quality. Some of the apps had the wrong phone number for suicide crisis centers, and others failed to include many of the prevention steps commonly recommended for suicidal patients. Psychologists need to ensure that the apps meet their therapeutic goals.

EXCEPTIONS TO COMPETENCE

Standard 2.01d, Boundaries of Competence, of the APA Ethics Code makes an exception to the general requirements of competence when services are not otherwise available (e.g., in rural or other underserved areas) or in an emergency. Some psychologists work in geographical areas where mental health services are not readily available. For nonemergency services in underserved geographical areas, psychologists can make an exception and deliver services if they are competent in closely related areas and make reasonable efforts to obtain the necessary competence. The expansion of telehealth services has greatly increased treatment options for patients and reduced the likelihood that rural psychologists will be the only ones available who can treat a disorder and will be asked to treat patients outside of their areas of competence.

It is difficult to determine fixed rules for how much psychologists can stretch their competence in providing services outside of their areas of expertise. It may be necessary to do a utilitarian calculus and determine whether patients are better off with the not-yet-competent psychologist or waiting until they can identify a more qualified professional.

Of course, psychologists may provide services to anyone in an emergency. It is assumed that any competent psychologist will have basic relationship-enhancing and diagnostic skills to help a person in crisis. However, after the emergency is over, they should refer the patient elsewhere if necessary to ensure an adequate level of ongoing care.

EMOTIONAL COMPETENCE

Most psychologists like their jobs, feel satisfied with their careers, and feel optimistic about the future of psychology (Leitzel & Knapp, 2021). They like their interactions with other people, feel intellectually stimulated, and often

feel a sense of accomplishment in helping other people. However, professional psychologists may also experience many work-related stressors. Psychologists can best manage these stressors if they can anticipate them and incorporate self-care into their plans for maintaining competence.

Practicing Self-Care

Standard 2.06, Personal Problems and Conflicts, of the APA Ethics Code requires psychologists to "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." In addition, it requires psychologists to "take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties" when they become aware that personal problems might limit their professional effectiveness.

The same moral principles of beneficence and nonmaleficence that require psychologists to promote the welfare of their patients also require psychologists to promote their own welfare. In addition, from a practical perspective, psychologists with impaired health risk delivering less than adequate services. General Principle A of the aspirational section of the APA Ethics Code acknowledges this relationship when it states, "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."

Maintaining competence means more than just keeping up to date with the changing knowledge base and standards of care. Maintaining competence requires self-care ("engagement in behaviors that maintain and promote physical and emotional well-being"; Myers et al., 2012, p. 56). Although some people enter the field of psychology with pre-existing emotional problems or vulnerabilities, other psychologists experience *burnout*, or a psychological state characterized by emotional exhaustion, depersonalization of patients, and the lack of a sense of personal accomplishment (Maslach & Jackson, 1981). Zaki (2020) looked at burnout as the repetitive strain injuries of health care professionals.

To help others, psychologists need to function well. Psychologists with good emotional health can best display the interpersonal and facilitative skills that lead to good patient outcomes, while psychologists who are experiencing burnout may lack the ability to show empathy or identify their patients' emotions (Simionato et al., 2019). Psychotherapists reporting higher levels of burnout also reported that they delivered a lower quality of care (Salyers et al., 2015). Those with a low sense of personal accomplishment reported decreased productivity and more absenteeism (Hammond et al., 2018). Delgadillo et al. (2018) found that patients had poorer outcomes if their psychologists scored higher on burnout scales. In contrast, resilience and confidence among psychotherapists predicted significant patient improvement (Green et al., 2014), and

mindfulness and resilience among psychotherapists predicted reductions in patient depression scores (Pereira et al., 2017).

Data on the emotional health of psychologists are mixed. Surveys indicate that many psychologists reported feeling burned out, while psychology students reported high levels of emotional distress (Hobaica et al., 2021; Myers et al., 2012), and many psychology students come from dysfunctional families (e.g., Brems et al., 1995). Nonetheless, the prevalence of psychological distress among psychotherapists may be no greater than that found for lay persons (Norcross et al., 1986). On the Neuroticism scale of the Big Five, the scores of psychologists did not differ significantly from the scores of nonclinical samples (psychologists 5.1, compared with 4.8; Blume-Marcovici et al., 2013). Perhaps all of these are true: Most psychologists are emotionally healthy, some psychologists are experiencing burnout or distress, and many psychology students experience high levels of distress.

The very process of being a psychologist means facing chronic hassles such as having too much paperwork, having inadequate time to fulfill obligations, and dealing with restrictions imposed by managed care companies. These all occur against the backdrop of the continual stress of dealing with the emotional pain of others and sometimes responding to difficult and demanding patients (Rupert et al., 2015).

Psychologists need to be especially aware of *compassion fatigue*, or the inability to feel empathy for patients caused by overwork. They may feel responsibility to take on more patients or to take on patients with special needs that tax their resources, such as treating many trauma survivors. Zaki (2020) referred to this as the caregiver's dilemma in that showing empathy facilitates patient care, but it can also contribute to burnout if not managed properly. Psychologists who have a personal history of trauma, who deal with many trauma patients, or who have not established clear boundaries with patients have a higher risk for burnout (Mailloux, 2014). Psychologists need to ensure that their exposure to exhausting or draining patients does not prevent them from meeting their primary obligations to friends, family, or other patients.

According to the professional acculturation model presented in Chapter 2, those psychologists who use separation strategies (i.e., those with strong personal ethics but weak professional ethics) may have greater vulnerability to compassion fatigue than those who use integration strategies that are aligned with one's personal values and professional obligations. Although they have strong feelings of compassion based on a personal code of morality, psychologists using assimilation strategies may not have internalized the therapeutic detachment needed for effectiveness as a psychotherapist.

Burnout is linked to whether psychologists work in independent practices or agencies, their age, whether they have social support, and certain personal characteristics. Psychologists who work in agencies report more burnout (Yang & Hayes, 2020). Perhaps agency psychologists have less autonomy in their work or have greater exposure to patients who display difficult behaviors (Yang & Hayes, 2020).

Burnout among psychotherapists tends to decrease with age (Nissen-Lie et al., 2021; Yang & Hayes, 2020). Perhaps psychologists learn better self-care skills as they mature, or perhaps some distressed psychologists leave the profession, or perhaps older psychologists just left their agency jobs and took positions where they can screen out many patients with difficult behaviors (Nissen-Lie et al., 2021).

Social support reduces self-reported burnout (Rupert et al., 2015; Yang & Hayes, 2020). This conclusion is consistent with research on loneliness in general, which finds that those with the most social support tend to report higher quality of lives (Holt-Lunstad, 2021).

Studies on burnout and gender have found mixed results, although any finding of a correlation may occur because a higher percentage of women psychologists are early career psychologists, who are more likely to feel stress. We found no studies looking at burnout rates among LGBTQ+ psychologists or psychologists of color, although one might assume that they have more stress because most of them are also early in their careers, and many experience *minority stress*. LGBTQ+ graduate students and graduate students of color reported more burnout than heterosexual and White students (Hobaica et al., 2021).

Yang and Hayes (2020) found a link between well-being, self-efficacy, extraversion, emotional coping skills, and mindfulness. Among psychology trainees, burnout was linked to an *unrelenting standards* schema ("perfectionistic and rigid expectations of the self around performance and responsibility"; Kaeding et al., 2017, p. 1783). Among psychologists, burnout was linked to unrelenting standards and *self-sacrifice* schemas ("the tendency of psychologists to sacrifice their own needs, seek approval from supervisors and colleagues and set high self-internalized expectations"; Simpson et al., 2019, p. 41). Having a history of early trauma also increases a psychotherapist's sense of personal burden (Nissen-Lie et al., 2021).

Confronting Professional Stressors

Bad things can happen in the life of a professional psychologist. For example, Leitzel and Knapp (2021) found that, in 2020, 6% of psychologists reported the death of at least one patient by suicide and 29% reported that at least one patient attempted suicide while in treatment. These events usually trigger sadness, grief, and guilt, and the impact may be especially difficult for psychology trainees (Gill, 2012).

Assaults against health professionals rarely occur, and those that do occur are usually in inpatient facilities or prisons, where the risk of encountering violent persons is higher. Stalking and harassment are more common. Kivisto et al. (2015) reported that one in four psychologists were harassed at some point in their careers; one in seven were stalked; and one in five were threatened. Stalking behaviors could include unwanted phone calls; unsolicited texts, emails, or letters; unwanted approaches; being spied on or followed; or having patients show up around home, work, or other places frequented by the psychologist (A. J. Kivisto & Kivisto, 2018).

CASE EXAMPLE: A FRIGHTENING SITUATION

The female patient of a psychologist was furious when he referred her to another provider. Although the referral was therapeutically indicated and handled tactfully, the psychologist found that his car was vandalized, a rock was thrown through his office window, and his wife received a letter falsely accusing him of having an affair with another woman.

Upon consultation with an expert, the psychologist changed his daily routine, installed an alarm in his house, notified family members to be wary of anyone who appeared to be watching them, and consulted an attorney about legal options.

Psychologists can reduce the risk of stalking by maintaining clear boundaries and addressing inappropriate behaviors early in psychotherapy. However, patients become stalkers for different reasons (A. J. Kivisto & Kivisto, 2018), and some patients will end up stalking psychologists who keep impeccable boundaries and have excellent interpersonal skills. Most stalkers eventually stop on their own and few go on to physically attack their victims. Nonetheless, it is hard to predict with any certainty which stalkers will just go away and which will become aggressive.

Psychologists who have been victims of stalking should remember that stalking can be very emotionally upsetting. They should seek emotional support for themselves, and take measures to ensure their safety, such as installing alarms in their offices or homes and changing their usual habits of shopping, driving to work, or places where they exercise (Erickson Cornish et al., 2019). Psychologists should document all encounters and seek advice on their legal options. Attorneys with experience in domestic violence or mental health may be the most knowledgeable.

Loss of Professional Competence

Standard 2.06a, Personal Problems and Conflicts, restricts psychologists from taking on activities when their personal problems prevent them from performing competently. In addition, state licensing laws make health-related loss of competence (impairment), in and of itself, grounds for disciplinary actions. Psychologists who know or should know that they are impaired must withdraw from their work or seek supervision to ensure the quality of their work.

Moreover, consultants including myself (Samuel J. Knapp) who have worked with psychologists who have been disciplined have noted that many psychologists appeared to have committed their misdeeds in the context of some personal crisis or severe stress. Perhaps they retained competence in many areas of their practices, but these observations suggest psychologists could prevent many ethical violations if they engaged in adequate self-care.

Some psychologists, either through the stress of their personal work, personal problems, or some combination of both, may lose the ability to fulfill the minimum responsibilities of the profession. Traditionally this loss of competence has been referred to as *impairment,* although *loss of professional competence* may better describe the phenomenon (Elman & Forrest, 2007). The estimates of competence loss due to health problems among psychologists vary because researchers differ on how they have defined and operationalized the term.

However, many psychologists will, at some time in their careers, have a mental or physical disability that prevents them from performing the functions of their profession adequately. We (Samuel J. Knapp and Randy Fingerhut) have consulted with psychologists who have had to curtail their professional work due to serious illnesses such as cancer, and most were able to return to full-time work after treatment. Psychologists who know their limitations, seek consultations, and adjust their caseloads accordingly are protecting themselves and their patients and incur little risk of a disciplinary action.

Other psychologists may have untreated or inadequately treated mental illnesses or substance misuse or lack insight into the impact of their illness on their performance. These psychologists may continue to practice and jeopardize the well-being of their patients. They have a high risk of disciplinary actions.

Fortunately, psychologists respond well to mental health treatment, just as other patients do. Among psychologists who had completed psychotherapy, 90% believed it was helpful and half believed that it made them better psychologists (Norcross, 2005). Bearse et al. (2013) reported that 84% of psychologists found it helpful (at least 4 on a 5-point scale). Also, many state and provincial psychological associations offer CE programs, publish articles, present workshops, and otherwise disseminate information on how psychologists can help reduce distress and prevent health-related loss of competence. These efforts encourage psychologists to focus on general self-care, which includes anticipating and learning to handle profession-specific stressors.

CASE EXAMPLE: A POSITIVE OUTCOME

A psychologist received two DUIs within a year and was sentenced to prison for 30 days (suspended if he entered treatment). Upon an agreement with the impaired professional program, the psychologist was allowed to continue to practice under supervision if he attended Alcoholics Anonymous meetings, participated in psychotherapy, took medications, and underwent periodic drug monitoring. After 3 years of sobriety, he returned to fully independent practice. He has been sober for the last 15 years and publicly speaks about his addiction and recovery.

Ideally, graduate programs monitor their students closely enough so they can identify those students who show signs of reduced competence, help them address their problems, or remove them from the training program. Standard 7.04, Student Disclosure of Personal Information, of the APA Ethics Code permits training programs to require personal disclosures on the part of students who appear to be impaired.

Flourishing as a Psychologist

Despite these profession-specific stressors, most psychologists value their careers, would choose psychology as a career again, and flourish as professionals. Certain attitudes and activities help them to optimize their enthusiasm for their day-to-day work. Although it is important to discuss the risk of health-related competence loss, it is equally important to discuss how all psychologists can improve their self-care, well-being, and functioning.

To *flourish* means to "live within an optimal range of human functioning, one that connotes goodness, generativity, growth, and resilience" (Fredrickson & Losada, 2005, p. 678). It appears that psychologists who live up to their highest ideals as competent practitioners, teachers, and researchers are those who are flourishing, which means, among other things, they have a life characterized by a high ratio of positive to negative emotions and behaviors that contribute to the welfare of others. Of course, no psychologist can avoid many of the difficult, stressful, and painful situations described previously. However, psychologists will function more effectively if they attempt to maximize positive emotions such as love, appreciation, gratitude, joy, and curiosity as much as possible, consistent with their professional duties.

The factors contributing to well-being, resilience, and flourishing in general have been discussed by many writers and are not repeated here, except for noting features that are especially salient for psychologists. There is an understandable gap between knowing about self-care and practicing it. We know, for example, that graduate students who have good sleep hygiene, receive social support, know how to regulate their emotions, and experience mindful self-acceptance tend to have good mental health (Myers et al., 2012). We also know that certain lifestyle behaviors incorporating mindfulness, spirituality, and positive psychology can enhance our personal lives (Wise et al., 2012). Translating these insights into actual behaviors might be easier if psychologists embed themselves in a caring community where people watch out for each other (W. B. Johnson et al., 2013).

This emphasis on a caring community is consistent with the comments of Norcross (2000), who urged psychologists to place themselves in an environment that reinforces behaviors that promote personal and patient welfare. The environment should provide a feedback loop that allows psychologists to continually reflect on their procedures and outcomes. The various forms of external feedback include, but are not limited to, consultation, study groups, gathering systematic data on patient outcomes or satisfaction, and informal conversations with colleagues, as discussed earlier in this chapter.

Social support appears especially important when working as a professional psychologist. As Sternlieb (2011) noted, "The practice of psychotherapy is an emotional contact sport . . . not only do we impact our patients, our patients impact us" (p. 17). Those who experience pain in their professional work can "share the burden" or involve others in making critical decisions. Just the opportunity to express one's dismay can have healing effects and reduce stress. Those who experience a joy in their professional work can double that joy by sharing it with others. Clinically, those psychologists who receive regular consultation from others will benefit from their shared clinical expertise and be able to deliver a high standard of care (as Sternlieb, 2013, noted, "You have to share it to bear it"; p. 21). Indeed, Coster and Schwebel (1997) found that social support was rated as one of the key components of success among psychologists who were nominated by their peers as being "well-functioning," and Dlugos and Friedlander (2001) found that peer-nominated, passionately committed psychologists continually sought feedback and supervision.

6

Informed Consent or Empowered Collaboration

Informed consent is the legal and ethical obligation to give information to patients or research participants before they initiate assessment, treatment, or participation in a study. Informed consent procedures reflect respect for patient autonomy (Beauchamp & Childress, 2019). It is assumed that patients can make, or at least have the right to make, decisions in their best interests when they have been given relevant information. Psychologists should respect the autonomy of their patients except for very narrow circumstances, such as when patients are incapable of giving consent or the lives of individuals are at stake. We discuss these exceptions in more detail later in this chapter. To the extent that a thorough informed consent process facilitates good patient outcomes, one could also justify informed consent on the basis of beneficence and nonmaleficence.

The American Psychological Association's (APA's; 2017a) *Ethical Principles of Psychologists and Code of Conduct* (APA Ethics Code) outlines the minimum standards of informed consent. The key or foundational standard states that psychologists "obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons" (APA Ethics Code, Standard 3.10a, Informed Consent). Other ethical standards expand on the requirements of informed consent or delineate exceptions.

Malpractice courts have used the "reasonable person" standard to determine what information health care providers should give to their patients. That is, courts ask, "What would a reasonable person want to know about the medical

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procedure before agreeing to it?" The standards of informed consent were developed primarily from physical medicine or surgery, but for reasons discussed later, they need to be modified to make them appropriate for mental health treatment. In addition, the informed consent process was altered in 2003, when the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (U.S. Department of Health and Human Services, 2002) went into effect and required covered entities to give privacy notices to patients (see Chapter 8).

Informed consent procedures are also part of maintaining good practice. The informed consent procedures should anticipate questions that most reasonable patients would have in order to prevent future misunderstandings and disappointments. If implemented properly, informed consent procedures promote open exchanges between psychologists and their patients. These exchanges ensure that psychologists and their patients have a shared set of expectations of their professional relationship. Informed consent is essential for building and maintaining trust between health professionals and their patients. Patients who trust their health care professionals are more likely to seek treatment and to cooperate when they are in treatment.

However, informed consent can be seen as part of a larger effort of psychologists to respect patient autonomy and decision making. The phrase *empowered collaboration* probably better reflects the underlying goals (Pomerantz, 2012). This requires psychologists to explain, listen, involve, and ask. Not only should psychologists ensure that patients understand the nature of the proposed treatment in the informed consent process, they should also listen carefully to their patients' viewpoints, involve them in treatment decisions, and ask them what they think about treatment and how they are responding to it (Knapp, 2022). As described in Chapter 9, when there is a risk of a treatment failure, it is often useful to revisit the extent to which psychologists have involved their patients in important decisions.

In this chapter, we review basic information about informed consent and special issues that may arise in couples, family, or group therapy or in supervised services. We describe some ways that psychotherapists can embed respect for patient autonomy beyond the traditional informed consent process. We also cover the desirability of obtaining assent (i.e., agreement) to promote greater participation from individuals who are not legally capable of giving informed consent. In addition, we consider options when patients appear unable to participate in decisions about treatment. Chapters 10, 15, and 16 also cover aspects of informed consent in forensic work, supervision, and research, respectively. Chapter 11 covers informed consent when doing forensic evaluations or when treating patients who are court ordered for treatment, and Chapter 13 covers the implications of the No Surprise Act for billing.

ENSURING SHARED DECISION MAKING

The early references to informed consent in the legal literature concerned the nature and type of information that patients should receive before agreeing to undergo medical procedures such as surgery. The historical *medicolegal model*

of informed consent had three salient characteristics—namely, that informed consent was a passive, one-time event in which the client either could or could not provide it—that are in contrast to the newer *participatory model*, which views informed consent as an ongoing process in which the patient is actively involved.

First, the medicolegal model saw informed consent as a passive activity in that the patient had a "right to determine what shall be *done with* [emphasis added] his own body" (*Canterbury v. Spence,* 1972, p. 772). Although a receptive or passive attitude may be appropriate for surgery, it may not be the optimal attitude to have when involved in an interactive and participatory relationship such as psychotherapy. A medicolegal model of informed consent as applied to psychotherapy may be misleading because it could imply that the patient is passively consenting to something presented by the psychologist (Beahrs & Guthiel, 2001).

Second, the medicolegal model considered informed consent as a specific event, typically occurring before the start of treatment. In contrast, a participatory model that views consent as occurring throughout the course of treatment may be more appropriate for psychotherapy and other psychological services. Furthermore, from a practical perspective, psychologists might not be able to give patients all the information that they may want to know about treatment, such as reasonable estimates on the length of treatment or the nature of the treatment plan, until several sessions have passed (Pomerantz, 2005).

Third, the medicolegal model assumed that patients either did or did not have the ability to give informed consent after receiving basic information. It considered the ability to give consent as a fixed trait. In contrast, the participatory model assumes that the ability of patients to participate fully in treatment decisions varies according to their emotional needs, interpersonal influences, and the content of the information given to them.

Despite its limitations, the medicolegal model emphasizes the ability of the patient to give meaningful consent, requires sharing of some information, and requires that the information be given at an understandable level. Nonetheless, because mental health treatment is most effective when patients have an internal motivation for change (McAleavey et al., 2019), we believe that the participatory model, which encourages autonomy and self-determination, is appropriate for most psychological services.

The very process by which psychologists engage patients in treatment is part of the treatment itself. The initial information sharing process is an opportunity to do more than inform patients about the therapeutic process. For example, including a treatment rationale during informed consent discussions may, in and of itself, improve patient expectations for treatment, patient engagement in treatment, and the likelihood of success (Trachsel & grosse Holtforth, 2019). Furthermore, the informed consent process creates an opportunity for psychotherapists and patients to start discussions on the goals and methods of treatment. The participatory model also invites patients to cocreate the elements of their treatment. It involves patients in numerous treatment

decisions, such as whether to involve other family members, to seek an evaluation for psychotropic medications, or to use complementary medical treatments. A participatory model is consistent with theories of motivation that emphasize the therapeutic aspects of encouraging autonomy and self-determination (Ryan & Deci, 2008).

A participatory model of treatment is also embedded in APA's definition of evidence-based practice, which includes empirical support for treatments, clinical judgment, and consideration of patients' cultural identities, preferences, and needs (APA Task Force on Psychological Processes With Sexual Minority Persons, 2021). Indeed, patients respond better to treatment when psychotherapists personalize their treatments and accommodate patient preferences (Norcross & Cooper, 2021). For example, dropout rates were cut in half when patients had their psychotherapy matched to their preferences, and they were significantly more likely to have treatment success (Swift et al., 2019). In their review of evidence-supported relationships, Norcross and Lambert (2018) found that patients had better outcomes and greater satisfaction when they collaborated with their psychotherapists on treatment goals. Furthermore, a study of participants in the National Health Service in the United Kingdom found that patients who did not have their preferences for treatment met were less satisfied with treatment compared with patients who had their preferences met (Williams et al., 2016).

One source concerning the benefits of accommodating patient preferences comes from the principles of change literature. Castonguay et al. (2019) developed principles of change as evidence-based, brief, and transtheoretical statements about what works in psychotherapy. Several of these principles recognize the importance of accommodating patient preferences for the psychotherapists' cultural identity or gender, accommodating treatment to the religious and spiritual preferences of patients, and otherwise tailoring treatment to the unique needs of patients.

At times, patients may enter psychotherapy feeling discouraged or demoralized and may defer to their psychologists to select their treatment goals for them. Nonetheless, these psychotherapist-generated goals should be seen only as interim goals, which should be revisited with the patient periodically. Although psychologists may be experts at psychotherapy, the patients are still the experts in their own lives (e.g., Jobes, 2016).

The first part of involving patients in treatment is to listen carefully to their concerns and try hard to understand what is on their minds. Then, psychologists will be better able to propose a treatment plan that addresses their needs. When it comes to treating children, psychologists can directly ask their patients or guardians during or at the end of the information-gathering stage, whether they understand their goals and agree with the treatment plan. Such end-of-session questions could include the following: "What do you think of the proposed treatment plan?" "Do you think that the treatment plan addresses your concerns?" "How do you think therapy will help your child and your family?" "Do you have concerns about how the treatment will progress or how your

child will respond?" and "Is there anything we haven't spoken about that you think is important to know?" (Perle, 2015, p. 368).

PARAMETERS OF CONSENT

Some psychologists may see informed consent as a static, fixed, or pro forma process where they give patients a standard form to sign or a scripted discussion and then expect all of them to passively accept it. If we want to ascribe to the highest ethical ideal, however, we should go beyond this approach and encourage patient input into how the psychological services can best work for them.

Nonetheless, the psychologist will typically present a structure for the patient to follow, usually involving an intake interview and weekly psychotherapy sessions and specifying whether these would be individual, group, or family sessions. In this respect, the informed consent could involve a version of what Thaler and Sunstein (2008) referred to as *nudges*, or presentations of options that encourage people in certain directions but ultimately allow them choices. Nudges attempt to balance respect for patient decision making with beneficence. For example, the psychologist who asks their patient, "What time would you like to meet next week?" is structuring a response likely to include an appointment next week, although it is possible for the patient to ask for two appointments next week, or an appointment in 2 weeks, or some other modification of the schedule. If the psychologist believes that once-a-week individual psychotherapy is indicated, it is a nudge to ask the question in such a manner as to elicit a once-a-week scheduling response ("What time would you like to meet next week?") as opposed to presenting an open-ended question ("When would you like to meet again?"). The example shows that most psychologists have at some time or other used nudges whether they called them nudges or not.

Some critics argue that nudges undercut patient autonomy (see comments by Cohen, 2013) and that health care practitioners should facilitate rational patient decision making instead of setting up nudges. We suggest a more nuanced approach wherein nudges are appropriate for routine decisions regarding the parameters of treatment (how often to meet, length of sessions), but in other treatment decisions, such as agreeing to treatment itself or setting the goals of treatment, psychologists should use a more open-ended process.

Psychologists can influence their patients in several ways. They can make direct suggestions to patients ("I think you need marital therapy"), make appeals to their values ("Most Christians would want to save their marriages"), appeal to community norms ("Most patients in your situation would choose marital therapy"), or frame options in a manner to influence the choices ("In situations such as yours, individual therapy will fail 30% of the time"; Blumenthal-Barby et al., 2013). The general rule, however, is to use such influence tactics selectively. They can be justified when the degree of danger to patients is high or patients have, for whatever reason, factors that at least temporarily compromise their ability to think clearly and independently.

WHO CAN PARTICIPATE IN THE DECISION?

Service recipients can only truly give informed consent when they have the legal or cognitive capacity to do so. Generally speaking, any adult has the legal right to give consent for themselves or their children. Also, many states allow exceptions whereby minors may give legal consent for treatment under certain circumstances, such as during an emergency or if they have reached a certain age. Of course, even if minors can legally consent to treatment on their own, most psychologists believe it is usually clinically indicated to have at least one parent involved in treatment, especially because parents have the potential to be major allies in assisting the patient in moving toward psychological health.

However, most minors are not legally allowed to consent to treatment. Also, some adults have had their guardianship or decision-making powers for health care granted to another individual, usually a family member, through a court order or other legally binding process. Even in those situations, psychologists should try to get patient's assent or agreement to treatment and to consider their preferences (Standard 3.10b, Informed Consent). The general goal is to maximize patients' control over treatment decisions and the treatment process as much as possible under the circumstances.

Some psychologists use a *shifting standard* with adolescent patients in which they vary the standard they use to obtain assent depending on the outcomes at stake (Howe, 200l). If there are life-endangering qualities, or if the welfare of the patient is seriously jeopardized, then these psychologists err on the side of insisting on treatment. That is, they temporarily allow beneficence or nonmaleficence (i.e., the need to protect the welfare of the patient and to avoid harm to the patient) to override respect for patient autonomy. Of course, they always attempt to get the assent of their adolescent patients, but they do not allow the lack of assent to stop treatment if necessary to prevent serious harm. However, they defer more to the wishes of the adolescent if the potential for harm is low.

CASE EXAMPLE: A SENSITIVE PSYCHOLOGIST

A psychologist often established an "agreement" with her reluctant low-risk adolescent patients. She told them they had to come in at least three times, and after that, she would respect their wishes concerning future treatment. The patients appreciated her efforts to consider their preferences and almost always preferred to continue in treatment after the three sessions were over.

Throughout her sessions, the psychologist continually involved her adolescent patients in all treatment decisions as much as was reasonable or clinically indicated. When treatment ended, she routinely asked her adolescent patients for constructive feedback. She would state, "I talk to a lot of teenagers, and it would be helpful for me to know what was helpful for you and what was not so helpful."

Sometimes psychologists encounter potential patients who have the legal authority to give consent but appear to lack the cognitive abilities necessary to do so (e.g., patients with dementia or intellectual disabilities). However, such patients are considered legally competent to give consent unless a court has held otherwise.

The issue is further complicated by the fact that the psychologist may not be able to ascertain the patient's ability to understand the nature of the services being offered until they have started or even completed the evaluation. A patient who initially presented as alert and intelligent may appear more and more cognitively impaired as the evaluation continues. Also, the ability of the patient to give consent may vary over time. A patient may appear alert and competent one day but disoriented and confused the next. Psychologists who feel uncertain about a patient's ability to give informed consent should proceed with caution.

Nevertheless, even persons with serious limitations may be able to understand the process if sufficient time is given for the explanation or if they have time to ask questions or consult with others. Sometimes creative educational approaches can be helpful. For example, psychologists can arrange to have the patient talk with persons who have already had the treatment, or they can ask family members to help explain concepts. In addition, psychologists can sometimes titrate the information given to patients. That is, they present the patient with a limited amount of information, determine how well the patient is able to understand and integrate that information, and then provide additional information as needed.

CASE EXAMPLE: A PRUDENT PSYCHOLOGIST

A distraught patient contacted a psychologist requesting couples therapy. It was not clear at the initial session whether couples therapy would be therapeutically indicated. The psychologist met with the patient several times to help her clarify her goals and assess the likelihood that couples therapy would help her to reach her goals. In this case, the psychologist suggested that the patient should not decide about couples therapy until she gained control over her emotional turmoil and could think through her future goals.

Furthermore, psychologists should not ignore the role of subtle factors that can influence the informed consent process. When it appears that an individual is not capable of giving meaningful consent, we urge psychologists to document their explanations to the patient carefully and, with the patient's permission, to consult with the patient's family or other surrogate decision makers. Even if patients have not yet been adjudicated incompetent, informing their relatives reduces misunderstandings as well as the likelihood that they will perceive the psychologist as having initiated health care unnecessarily

(Adams & Boyd, 2010). Consultation with colleagues or with other professionals treating the patient may sometimes be helpful. The psychologist can ask consultants if they know of additional ways to assess the capacity of the patient to understand the procedures and the benefits or risks of participating in treatment.

WHAT INFORMATION SHOULD BE GIVEN AS PART OF DECISION MAKING?

It is necessary for patients to have basic information about the psychotherapeutic process before they can give informed consent. The content of the specific communication should include legally mandated items, including what is required in the HIPAA Privacy Rule and the APA Ethics Code. A few states mandate specific ingredients in mandated informed consent forms, but regardless of these requirements, psychologists should give information that would generally be helpful to most patients. In addition, a 2022 "No Surprises Act" requires psychologists and other health care professionals to give information to some patients about the expected cost of the course of treatment before it begins (APA, 2022d). Chapter 13 discusses this issue in more detail. Of course, psychologists can give additional information depending on the patient's needs. The question is "What would the average patient want to know about treatment?" Fortunately, researchers have asked patients that question (Braaten & Handelsman, 1997), and we present salient features from their findings in the following sections. Psychotherapists can give much of the factual information to patients in the form of a psychotherapy brochure or consent agreement. Some psychologists include this information on their websites or even include a brief video where they present some of the essential ingredients about informed consent.

Information Required by the APA Ethics Code

Standard 3.10, Informed Consent, requires that psychologists obtain the consent of their service recipients using language that is reasonably understandable. Psychologists must also discuss the limits of confidentiality (Standards 4.02, Discussing the Limits of Confidentiality; and 6.02b, Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work), obtain consent for audio or video recording (Standard 4.03, Recording), and give information about fees (Standard 6.04, Fees and Financial Arrangements). Furthermore, as applied to psychotherapy, "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" (Standard 10.01a, Informed Consent to Therapy).

The APA Ethics Code expands on informed consent procedures when they involve new or experimental therapies (Standard 10.0lb, Informed Consent to Therapy), when supervisees provide services (Standard 10.01c,

Informed Consent to Therapy), when conducting family or couples therapy (Standard 10.02, Therapy Involving Couples or Families), and when conducting group therapy (Standard 10.03, Group Therapy).

Psychologists who provide new, experimental, or innovative psychotherapies must inform prospective patients of the experimental nature of the treatment, the potential risks involved, other more standardized alternative treatments that may be available, and the voluntary nature of their participation. Chapter 5 discusses new, experimental, or innovative psychotherapies in more detail.

When treating couples or families, psychologists need to clarify their roles, their relationships with all parties, and the probable use of services and information provided. Two issues that commonly arise regarding the use of information concern the role of secrets in family or couples therapy and the rules for confidentiality with minors. Chapter 8 discusses keeping secrets in family therapy and confidentiality in the treatment of adolescents in more detail.

CASE EXAMPLE: IMPACT ON THIRD PARTIES

A 30-year-old married woman called and requested treatment for depression and dissatisfaction with her marriage. In the first interview, she revealed that she was a survivor of sexual trauma as an adolescent, and it appeared that her depression and some of her marital problems were linked to this trauma.

Here, the informed consent process needed to address the possible impact of treatment on the spouse and the marriage. Traumas often lead to disrupted relationships with spouses or significant others because of emotional detachment, lack of intimacy, and impaired sexual relationships. In this case, the psychologist spoke candidly with the patient and asked her to consider how her trauma impacted her current relationship.

When psychologists provide group therapy, they need to "describe at the outset the roles and responsibilities of all parties and the limits of confidentiality" (Standard 10.03, Group Therapy). Psychologists need to ensure that patients in the group will understand their roles and respect the privacy of other group members. At the first meeting, it is desirable to discuss the terms of participation, the purposes of the group therapy, and the kinds of sharing that will occur. Whether the group is time-limited or ongoing should also be discussed. If ongoing, then the procedures for leaving the group should be described, although all patients have the right to leave at any time and for any reason. Although it is not a requirement of the APA Ethics Code, psychologists may reinforce these concepts by having all group members sign an agreement promising to hold in confidence all matters discussed in the group and agreeing to a policy regarding extra group interactions.

Psychologists should also tell patients how they will handle confidentiality if patients are seen in both individual and group therapy. Of course,

psychologists should avoid disclosing private or secret information about one patient to another patient in the group sessions. Disclosures should be limited to what the patient has chosen to reveal within the group sessions. Fortunately, Burlingame et al. (2011) reported that pregroup preparation and efforts to establish good group cohesion at the start of treatment tended to facilitate outcomes in group therapy. Chapter 8 presents more information on confidentiality in group therapy.

Patients have a right to know if they are receiving services from a supervisee (Standard 10.01c, Informed Consent to Therapy), the name of the supervisor, and the fact that the supervisor has access to all patient information. Consent is especially important when the trainee is in the early stages of training because patients may elect not to receive the service under these conditions. Knowledge of the supervised status of the trainee may also protect the supervisor. It is preferable that the patient speaks to a supervisor with a concern early in treatment rather than having the supervisor learn about the discontent of the patient through an informal or formal complaint. Furthermore, the trainee or supervisee status may be relevant to insurance reimbursement. Chapter 15 contains more information on informed consent with supervisees.

Psychologists who provide telehealth services need to ensure that their patients understand the limits of telehealth services and any relevant threats to confidentiality (Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013). Chapter 5 discusses these services in more detail.

Information Required by the Health Insurance Portability and Accountability Act Privacy Rule

The HIPAA Privacy Rule applies to all psychologists providing health care who transmit information electronically (except for those covered by the Family Educational Rights and Privacy Act of 1974 [FERPA]). The Privacy Rule applies to some employment evaluations, some forensic services, and has some limited applicability to services provided in correctional facilities.

The HIPAA Privacy Rule requires every covered entity to give patients a privacy notice, which contains information such as the general exceptions to confidentiality, how to file a grievance, and rights to inspect records. It must be shared at the start of treatment, although reasonable delays may be permitted, such as in emergencies (U.S. Department of Health and Human Services, 2002). Chapter 8 discusses HIPAA in more detail.

Use of Electronic Communications

Many patients wish to text or email their psychologists. Some psychologists have practices with older adults where such requests rarely occur. Other psychologists have practices with teenagers or adults who frequently want to communicate electronically. Psychologists should think through their policies

regarding the use of electronic communications ahead of time. Some psychologists may, for example, accept email only for routine scheduling. Others may use email selectively for some clinical interventions. Although each of these approaches may have advantages and disadvantages, psychologists should tell their patients ahead of time how they will respond to electronic communications. Also, psychologists can caution their patients that no form of electronic communication is ever completely secure. Chapter 5 discusses telehealth and electronic communications in more detail.

Other Information That Patients Should Know

Some patients want information on the personal characteristics and competencies of their psychotherapists, general information about confidentiality and exceptions, the nature and anticipated course of psychotherapy, and an opportunity to ask questions and receive answers (Braaten & Handelsman, 1997; Martindale et al., 2009). The exact information that should be given to patients will depend on their needs and expectations. For example, Rudd et al. (2009) suggested that patients at a high risk for suicide should be given accurate information about the likelihood that the psychotherapy may involve the processing of painful emotions and that many will consider suicide during the course of treatment. Of course, this information should be presented in the context of an overall empowering and hope-generating informed consent process. Nonetheless, the candor allows for the opportunity for discussing suicide risks openly with the patient.

Informed consent discussions also provide an opportunity to go over billing questions such as cancellation policies, acceptance of credit cards, and so on. Chapter 13 contains more information on billing. Practical information such as psychotherapist emergency numbers can be given here as well.

KEEPING PATIENTS INVOLVED

As discussed earlier in this chapter, the participatory model assumes that consent is ongoing throughout treatment. The information provided at the beginning of treatment may be insufficient as treatment progresses, treatment plans change, or new clinical issues unfold. Ongoing discussions regarding treatment, therefore, may be warranted. For example, practitioners of dialectical behavior therapy have a structured pretreatment phase before treatment begins and subsequently conduct mini orientation sessions before introducing new psychotherapy techniques (Koerner, 2012).

Although the APA Ethics Code does not require patients to give consent in writing, many insurers require written consent forms. Also, written information or signed consent forms may supplement the dialogue between psychologists and their patients. Unfortunately, a review of consent forms used by mental health professionals in Colorado revealed a readability scale at the level of a

CASE EXAMPLE: CONTRASTING INFORMED CONSENT STYLES

A psychologist gave his patients an informed consent form to sign and did nothing to review or discuss it. When he charged one of his patients for a missed appointment, he explained, "It was all explained in the brochure I gave you, which you agreed to read." The patient was offended by the bill and dropped out of treatment prematurely.

Another psychologist discussed essential features of informed consent with patients at the first meeting and then handed them a brochure and asked them to read it. In the next session, he briefly went over the main features in the brochure and asked them if they had any questions. He seldom had misunderstandings with patients about the issues covered in the brochure.

The second psychologist understood that consent is a process that depends on open communication between psychologists and patients. He wanted his patients to understand the issues ahead of time and to feel free to ask questions or express concerns. He did not view informed consent as a legal formality, and he did not want patients to commit prematurely to a process that they did not fully understand. Indeed, for patients who feel demoralized or helpless, the informed consent process itself may have therapeutic elements in that it reinforces the idea that patients have some agency or control over their lives.

college senior (Handelsman et al., 1995). This level of difficulty may discourage some patients from reading the forms in their entirety and creates the possibility that some patients may not understand everything in the informed consent form.

The most useful consent forms use colloquial language and avoid legalese. Extensive discussions about the law surrounding the limits to confidentiality may have a chilling effect on patients and leave them confused and frustrated. Special emphasis on the exceptions to confidentiality necessitated by a child protective services law, for example, may be appropriate when first meeting with a family with a background of excessive physical discipline. However, for many patients, such detailed information would distract them from their primary goals of psychotherapy and raise concerns about the judgment or priorities of the psychologist.

Even after the necessary forms have been signed and the necessary information given to patients early in treatment, prudent psychologists ensure that they involve patients in important treatment decisions and monitor the extent to which psychotherapy is moving patients toward their goals. Because informed consent is a dynamic process, it may be necessary to revisit goals and progress with the patient periodically. Even in routine treatments, it is common for psychologists and patients to differ on their perceptions of the extent to which specific therapeutic interventions were helpful or hindering (Castonguay et al., 2010). Finally, when the risk of a treatment failure is high, psychologists can

evaluate how well they have involved patients in important decisions about their treatment (see Chapter 9).

There is no substitute for periodically asking patients what they think about treatment, what is helping them, if they believe that they are making progress, and if they are able to talk about what is important to them in psychotherapy (Sparks & Duncan, 2018). Psychologists can supplement these direct questions with standardized outcome measures or, with the permission of their patients, reports from family members or significant others. Seeking patient feedback on psychotherapy, such as through routine outpatient monitoring, appears to improve patient outcomes (McAleavey et al., 2019).

7

Multiple Relationships and Professional Boundaries

The term *boundaries* refers to the rules of the professional relationship that set it apart from other relationships. The rules clarify which behaviors are appropriate and inappropriate in psychotherapy and other professional services compared with those behaviors that are appropriate or inappropriate in other settings. Boundaries set limits, provide structure, and thereby prevent harm to patients. They create an atmosphere of safety that allows a relationship to develop so the patient can reflect on personal experiences without worrying about the needs of the psychologist. Boundaries support the notion that the primary purpose of psychotherapy and other services usually is to promote the welfare of the patient (Sommers-Flanagan, 2012).

Gutheil and Gabbard (1998) distinguished between *boundary crossings* and *boundary violations*. A boundary crossing involves "a deviation from the usual verbal behavior" (p. 410) that does not harm or exploit a patient. A boundary violation is a boundary crossing that creates a reasonable risk of harming or exploiting a patient.

Some psychotherapist behaviors, such as sex with a patient, are always boundary violations. Other behaviors, such as psychotherapist self-disclosure, may be violations, benign boundary crossings, or even helpful to the patient, depending on the circumstances. To a certain extent, the theoretical orientation of the psychologist may influence how they handle these boundary crossings. For example, humanistic or eclectic psychotherapists may allow themselves more flexibility in their boundaries than psychoanalytic psychotherapists

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(Williams, 1997). The challenge to the psychologist then is to determine when the circumstances warrant bending or holding firm on boundaries (Sommers-Flanagan, 2012). Consequently, psychologists need to do more than just learn a list of "thou shalt nots." Instead, they need to consider the purposes and goals of general rules and to understand how to implement them to meet the needs of a patient.

For example, sports psychologists need flexibility with their boundaries because they may need to eat, travel, or even share accommodations with their clients or hold consultations in semipublic locations such as hotel lobbies, sports facilities, or parking lots (Stapleton et al., 2010). On the other hand, psychologists who work with high-conflict families need to monitor their roles and boundaries vigilantly because the perception of boundary betrayal could cause them to lose credibility with one or both parents.

Small boundary crossings may be the first step down a "slippery slope" to a highly exploitative relationship. However, the fact that exploitative psychologists may cross boundaries does not mean that all boundary crossings are harmful, unethical, exploitative, or the first step down a slippery slope (Gottlieb & Younggren, 2009). For instance, it may be therapeutically indicated for a psychologist to accept Christmas or Hanukkah cookies from a patient or to talk about sports with treatment-resistant adolescents to help them feel comfortable in psychotherapy. Psychologists need not develop rigid stances, but they should use their clinical judgment to determine when such boundary crossings may be therapeutically indicated (Gutheil & Gabbard, 1993, 1998).

Psychologists need to consider boundary crossings carefully because of the power differential inherent in the psychologist–patient relationship. Several factors contribute to this power differential. Psychologists have professional status, knowledge of interpersonal influences, and personal knowledge of the patient. Patients may be emotionally dependent or vulnerable as a result of a mental illness or situational stresses.

The current standards for boundaries have evolved over time. During the early days of psychoanalysis, Freud expressed concern when he learned that some analysts were getting romantically involved with their analysands. He doubted the wisdom of such involvement and was concerned about scandals harming the public acceptance of psychoanalysis (Baur, 1997). Over the years, clinical lore and empirical data have informed standards on proper professional boundaries.

The rules regarding boundaries can be found in the American Psychological Association's (APA's; 2017a) *Ethical Principles of Psychologists and Code of Conduct* (APA Ethics Code), in the regulations or ethics codes of state boards of psychology, and decisions issued by malpractice courts. In addition, several states have criminalized sexual contact between mental health providers and their patients.

Boundary violations consistently represent one of the top causes of being disciplined by licensing boards (Association of State and Provincial Psychology Boards, 2021) and are sometimes the basis for malpractice suits. Most of the

violations involved sexual contact between a psychologist and a patient, and about 80% of violations involved sexual contact between a male psychologist and female patient. However, nonsexual multiple relationships (e.g., concurrent business and professional relationships) were the cause of numerous other complaints.

The overarching ethical principles guiding decisions about boundaries are nonmaleficence (i.e., do no harm) and beneficence (i.e., work to promote the welfare of others). In addition, respect for patient autonomy and fidelity to the psychologist–patient relationship are also relevant because psychologists should not undercut patient autonomy to create dependency or use the power differential inherent in the professional relationship to exploit their patients.

In this chapter, we review the definitions of boundaries in concurrent and consecutive relationships, unavoidable multiple relationships, subtle boundary crossings (e.g., self-disclosure, gift-giving, touching, hugging), sexual relationships, and other issues. Chapter 11 covers multiple relationships in forensic settings and Chapters 14 and 15 consider multiple relationships between educators and students, and supervisors and supervisees.

CONCURRENT OR CONSECUTIVE MULTIPLE RELATIONSHIPS

Standard 3.05, Multiple Relationships, of the APA Ethics Code defines a multiple relationship as occurring

> 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.

In concurrent multiple relationships, psychologists have a social or business relationship with patients or people closely related to them at the same time they have a professional relationship. In a consecutive multiple relationship, the psychologists have had a social or business relationship with patients or people closely related to them either before or after the professional relationship.

Even though Standard 3.04, Avoiding Harm, does not prohibit all multiple relationships, it is a general rule of thumb to avoid treating patients when a multiple relationship exists or could be reasonably foreseen. However, we present two exceptions to this general rule. First, in some small towns or small communities, patients may have no other option than to seek services from a mental health professional with whom they have, or could be expected to have, some kind of multiple relationship. In those circumstances, services referred means services are denied. Even in a moderately sized community, a psychologist may be the only one with expertise in a particular content area. For example, a gay psychologist may be sought out by other members of their

local LGBTQ+ community because of their expertise in dealing with problems unique to this community. Since telehealth has become more widespread, patients have more options for seeking psychotherapists, but, as described in Chapter 5, telehealth services are not always the optimal mode of intervention for patients. Similarly, an exception may occur when working with members of specific cultural groups. For example, traditional Chinese society tends to be an "acquaintance culture" where it is assumed that one gets better care if one knows the professional personally or through an acquaintance (Zhao et al., 2011).

Nonetheless, even when treating acquaintances or members of a psychologist's community in these unusual situations, psychologists can take steps to minimize harm. They can ensure that their informed consent process includes ways to handle overlapping relationships, clarify boundaries and expectations within psychotherapy, and pay particular attention to confidentiality issues (Schank et al., 2010).

Concurrent Relationships

Standard 3.05a, Multiple Relationships, explicitly states that not every multiple relationship is necessarily harmful: "Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical." The issue is whether a reasonable psychologist would be aware of factors that would make harm or exploitation foreseeable.

Self-interest can blind psychologists to the dangers of entering into a multiple relationship. All persons run the risk of ignoring how their own welfare or self-interests influence their interpersonal relationships. "One must always assume that a compromise in one's objectivity might reach beyond one's awareness" (Younggren & Gottlieb, 2004, p. 257). Nonetheless, the welfare of patients always comes first.

A multiple relationship that causes harm to the patient could result in a claim of misconduct in a malpractice court. Examples have been brought to our attention in which psychotherapists have, among other things, used the psychotherapy to discuss personal problems, gossiped about other patients, or hired patients to work around their offices.

Patients or prospective patients may push boundaries out of ignorance, pathology, or both. This finding should not be surprising because nonsexual dual relationships are common among clients or patients of physicians, accountants, lawyers, and others. Popular television shows (e.g., *Frasier*) and movies (e.g., *Good Will Hunting*) reflect this misunderstanding when the plot lines normalize psychotherapists crossing boundaries with their patients.

Positive limit setting may benefit these patients. Positive limit setting refers to "responding to the client's request while, at the same time, reframing the response in a way that meets a legitimate underlying need" (Koocher & Keith-Spiegel, 2008, p. 269). That is, a psychologist may decline a patient's social invitation but recognize the legitimate need for the patient to develop other social relationships. Consider the following example.

CASE EXAMPLE: AN APPRECIATIVE PATIENT

A patient who made significant gains in her treatment tried to give her psychologist a holiday bonus. When the psychologist refused, the patient said that she had given a similar gift to her massage therapist, who accepted it. The psychologist validated the patient's desire to express her appreciation but also used the moment as an opportunity to discuss differences between the psychotherapeutic and other relationships, specifically how the psychotherapy relationship is centered more explicitly on the patient's rather than the therapist's needs.

Some patients push boundaries as a function of their pathology. They may view psychologists as rescuers or potential lovers. When boundaries are set, these patients may retaliate with anger. However, they are better off with psychologists who maintain boundaries than with ones who are intimidated into breaking them. Often psychologists can use the patient's behavior to illustrate issues or themes in the patient's lives in a productive manner. Consider this other example.

CASE EXAMPLE: AN APPROPRIATE RESPONSE

A male psychologist escorted a young patient into his office and then excused himself temporarily to address an issue with his administrative assistant. When he returned, he saw that his patient had undressed herself. He said, "I am leaving the room and returning in 3 minutes, and I want you to put your clothes back on."

The patient was embarrassed by the apparent rejection, but they took this opportunity to discuss other situations outside of psychotherapy in which she had used sexuality to express appreciation, affection, or other positive emotions.

Of course, sometimes contacts with patients outside of the office are clinically indicated. For example, it could be appropriate for psychologists to use treatment procedures such as in vivo exposure outside of the office (Gola et al., 2016). Sometimes cleaning obsessions and compulsions are best treated through response prevention when some of the sessions occur in the patient's home. In addition, it may be acceptable in unusual circumstances for psychologists to accept invitations from some patients for certain special events, such as weddings or funerals, as long as the psychologist has determined that it is not clinically contraindicated and that confidentiality issues have been addressed with the patient.

Consecutive Relationships

Other multiple relationships are consecutive in that a social or business relationship developed before the professional relationship started or after it ended. Psychologists should consider the consequences of a consecutive relationship on a former patient on the basis of the patient's particular vulnerabilities. This may require psychologists to weigh several factors when considering posttherapy relationships, including the power differential (from the standpoint of the patient), which may be influenced by the duration of treatment and the clarity of the termination (Gottlieb, 1993). Psychologists should also consider the possibility that the patient may need to return to psychotherapy. Some patients remain vulnerable to exploitation even after termination; the patient or psychologist may have strong feelings generated by psychotherapy; psychologists may not retain objectivity in the posttherapy relationship; the trustworthiness of psychologists in general may be threatened when such relationships become public; or former patients may be harmed if the relationship ends badly (Pipes, 1997).

CASE EXAMPLE: A STRAINED RELATIONSHIP

A psychologist borrowed several thousand dollars from a former patient to open a business. The business failed, prompting the former patient to request the return on his lost investment. When the psychologist balked at the request, the patient complained that the psychologist exploited the goodwill generated by their treatment relationship to induce him to invest in an ill-conceived enterprise.

The psychologist initially minimized the extent of his interpersonal influence over his former patient. However, upon receiving legal consultation, he was advised that a disciplinary board might view the situation differently. The psychologist managed to repay his former patient.

UNAVOIDABLE CONTACTS

Although they do not often result in long-term multiple relationships, psychologists may unexpectedly encounter their patients outside of psychotherapy. One psychologist left her office during a break in the day to go to the gym where she had maintained a membership for years. While she was taking her shower, she turned around and faced the patient who had just left her office an hour earlier. Another psychologist found that her dog was competing with a patient's pet in a dog show. Another psychologist came home one night to see a patient working on the plumbing in the addition to the psychologist's new house; apparently the contractor had subcontracted to a business that employed the patient. Still another psychologist sat beside a patient for half an hour in the waiting room of a local physician. Another psychologist arrived

at the office of her physician to see that a former patient was the technician responsible for completing the mammogram.

Incidental contacts for psychologists in small towns or rural areas appear to be especially likely (Helbok et al., 2006). As the size of a community shrinks, the likelihood of such encounters expands (Roberts et al., 1999). In very rural communities, psychologists may depend on their patients to sell them groceries or repair their appliances. Often psychologists in rural areas must schedule patients so that neighbors do not encounter each other in the waiting room.

In addition, the family of the psychologist may encounter patients in any of the previously mentioned situations. The patient of one psychologist asked him how his wife liked her new car—he had sold her the car earlier that week, although the wife had no idea that the car dealer was her husband's patient. Sandifer (1989) wrote that a psychologist and spouse found out on the first day of school that their child's new fifth-grade teacher was a former patient. Another psychologist found that his daughter's softball coach was the spouse of a former patient. The ex-patient had reported that her husband had substantial anger management problems. Still another psychologist responded to the doorbell only to see a young woman patient at the door. She appeared as surprised as the psychologist, having no idea that the young man with whom she had a date was the psychologist's adult son (the two had different surnames).

Although these small-world hazards are more common in rural areas, they are not restricted to rural areas. Unavoidable contacts can also occur in smaller communities in urban areas, such as defined social groups. For example, professionals who have social activities such as mountain bike riding or long-distance running may have relatively defined social circles even in urban areas and may encounter patients in that context (L. S. Brown, 2011). Encounters with patients through religious organizations are also common (Lamb et al., 2004).

According to Standard 3.05b, Multiple Relationships:

> 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.

As part of the informed consent process, psychologists who anticipate random meetings with their patients can use the *you first* rule by which patients retain control of whether they will recognize their psychologist in a nontherapeutic context (Knapp & VandeCreek, 2003). According to this rule, patients decide whether to acknowledge the psychologist first, thus ensuring patients' control over the social situation. They may or may not want to speak to or acknowledge the psychologist, depending on the circumstances (e.g., their companions, the setting, their degree of comfort).

Often psychologists feel surprised, uncertain, or uncomfortable in these situations (Sharkin & Birky, 1992). Psychologists who anticipate encounters with a patient do well to address the issue proactively and revisit it as often as

is needed. Barnett (1999) described how he handled an unavoidable multiple relationship. After agreeing to start psychotherapy with a mother, he encountered her at a soccer practice involving their children. They discussed the likelihood of future encounters and preserved a working therapeutic relationship. Nonetheless, "we did revisit these issues several times during treatment to be sure there was no adverse impact on the patient or the treatment relationship" (p. 20).

CASE EXAMPLE: AN UNAVOIDABLE MULTIPLE RELATIONSHIP

A child psychologist had a policy of never treating children who went to the same school district as her children. One child patient, however, transferred into her son's school district during the middle of psychotherapy. The patient was in the same classroom as her son.

The psychologist appropriately discussed the rules of confidentiality with the patient's parents as soon as she was aware of the situation. However, the child patient recognized the relationship and told the psychologist's son that he was a patient of his mother. This revelation led to a frank discussion between mother and son about the role of a psychologist and the need to protect patient privacy.

SUBTLE BOUNDARY CROSSING

Boundary crossings can be overt, such as concurrent or consecutive business or social relationships with a patient. They can also be subtle in instances in which the boundaries are crossed by just-noticeable gradients of behavior. Common subtle boundary crossings are touching or hugging, gift-giving (or receiving), psychotherapist self-disclosure, or intrusive advocacy (i.e., using psychotherapy to advocate for a social cause; Knapp & VandeCreek, 2003). Many psychologists are flexible in their boundaries and, depending on the needs of the patient and the context of psychotherapy, may cross these boundaries and touch a patient, accept token gifts, disclose personal information, extend psychotherapy beyond the scheduled time, or engage in social amenities such as the discussion of current events. Psychologists should be aware of the potential for harm from subtle boundary crossings, which on the whole would give a reasonable person the impression that the psychologist was attempting to transform the relationship from a professional to a personal one. However, isolated, clinically reasonable, and nonexploitative boundary crossings on the part of psychologists can be acceptable or even appreciated (Knapp & VandeCreek, 2003).

Even some crossings that do not move the treatment relationship into a social one could, nonetheless, reduce the quality of treatment. A subtle boundary crossing may cause harm if the patient misunderstands it, such as when a patient views the self-disclosure of the psychologist as an invitation to create

a social relationship. A slippery slope may occur whereby even small boundary crossings may establish precedents that cause patients to expect more movement away from a professional role (Gottlieb & Younggren, 2009). Sensitive psychologists are alert to problems or feelings of discomfort created by subtle boundary crossings.

Although these subtle boundary crossings are usually harmless or even helpful, judicious psychologists think carefully about them. When evaluating the potential impact of subtle boundary crossings, it is helpful to consider the clinical purpose and likely outcome of the boundary crossing and the degree to which it creates the possibility of future entanglements. Sometimes it is helpful for psychologists to ask whether the boundary crossing is benefitting the patients or themselves.

Every intentional boundary crossing needs to have a therapeutic rationale. Decisions about boundaries should be informed by the needs of the patient and the likely outcome in terms of risks and benefits. Psychologists should not underestimate the ability of some patients to misconstrue seemingly innocuous events, such as being scheduled as the last appointment of the day or receiving clinically relevant telephone calls between sessions.

CASE EXAMPLE: AN UNEXPECTED OUTCOME

A psychologist was treating a woman with a long history of interpersonal stressors. The psychologist brought a small cake to one session so that they could "celebrate" her birthday together. The psychologist used some moderate self-disclosure for therapeutic purposes. She promised the patient that she would always be there for her and would never abandon her. Yet as psychotherapy progressed, it became clearer that the patient needed more intense services, perhaps a day hospital program, than the psychologist could provide. When the psychologist discussed the possibility of a transfer, the patient alleged that the psychologist had "groomed" her for a social relationship and was now abandoning her.

Although the psychologist might have done nothing that would warrant a disciplinary action, in hindsight she had made some mistakes. The patient misinterpreted (or alleged to have misinterpreted) the birthday cake, the self-disclosure, and the promise to "always be there" as a license for her to engage in numerous boundary challenges without any consequences.

Of course, psychologists who deliver services in the homes or residences of their patients need to be especially vigilant that their presence there does not activate a *guest schema* on the part of the patients. That is, in such situations the patients may be more likely to cross boundaries and provide refreshments, engage in social conversations, or otherwise treat the psychologist more as a social guest than a treating professional (Knapp & Slattery, 2004).

Keeping strict boundaries should not be seen as making the psychologist rigid, distant, or cold (Gutheil, 1994). Boundaries allow psychologists to be warm and supportive toward patients, and patients should not fear that their psychologist will turn the relationship to their own advantage. According to the professional acculturation model, integrated psychologists demonstrate a balance of personal compassion and professional boundaries (see Chapter 2). They neither show the same degree of self-disclosure or emotional involvement as found in friendships (as would a professional using the *separated strategy*, wherein they show personal concern for their patients but fail to follow well-established professional rules), nor are they cold and distant (as might be a professional using the *assimilated strategy*, wherein they carefully follow well-established professional rules but fail to express sufficient warmth or personal concern for their patients). Finally, psychologists should be cautious about any boundary crossing that would result in mixing roles to the extent that the boundary crossing loses its clinical rationale or results in a relationship whose outcome cannot be predicted. Psychologists can explain the rationale for the boundaries and how they benefit the patient in the long run. Framing the discussion in terms of patient well-being may enhance the treatment relationship and demonstrate empathy and concern for the patient. It is also important to convey an understanding of the patient's behavior in terms of their history and not as a "manipulative" or hostile act.

Self-Disclosure

All psychologists disclose some information as soon as the patient sets eyes on them. The psychologist's age, gender, physical appearance, including clothing and jewelry, accent, choice of words, last name, and the decor of their offices all disclose something about them as people. Often these disclosures are subtle. Once, I (Samuel J. Knapp) conducted a workshop on spirituality and psychotherapy and asked the participants if their patients ever discussed religion or spiritual issues in psychotherapy. Some psychologists said rarely, yet another psychologist, who wore a cross around her neck as part of tasteful jewelry, said her patients often raised religious issues without her prompting them. I wondered if the mere presence of her jewelry conveyed to them that she would feel open to their discussions of religion. This suggests that psychologists can use their public self-disclosures to a psychotherapeutic advantage. For example, some psychologists we know, who work close to military bases, will place a small American flag on their desks, which conveys an atmosphere that helps the service members feel more at home.

Also, psychologists should freely disclose their areas of proficiency and other relevant credentials. However, in this context, *self-disclosure* refers to other non-public (i.e., private) information about psychologists.

Psychologists differ on how they handle the self-disclosure of private information. Some, especially those trained in an analytic tradition, eschew all self-disclosure. Others, especially those trained in humanistic or existential

traditions, believe that self-disclosure can be clinically indicated in certain situations. Although individual feminist psychologists may vary in the extent to which they self-disclose, some share personal information such as sexual orientation, religious background, or political beliefs as part of the informed consent process or to equalize the relationship between the psychologist and the patient (Mahalik et al., 2000). Some psychologists treating patients with eating disorders have found that limited self-disclosure of their personal background with eating disorders has been helpful (Patmore, 2020). Some psychologists from marginalized backgrounds have found it helpful to discuss their own history of discrimination with their patients from similar backgrounds (Sunderani & Moodley, 2020).

However, it is desirable for psychologists to think through their feelings and clinical perspectives on self-disclosure and they should not feel compelled to disclose anything that gives them discomfort. Often patients attempt to elicit self-disclosures. Glickauf-Hughes (1998) recommended that psychologists look for the motivations and clinical needs that prompt these questions and not just respond (or fail to respond) to the surface meaning.

CASE EXAMPLE: AN HONEST QUESTION

A psychologist was treating a woman with depression. In the middle of the first session, the patient asked, "Are you a Christian?" The psychologist responded not to the question but to the implied concern of the patient. The psychologist said, "Perhaps you want to know if I have the ability to understand you or appreciate your values. Let me assure you that I will be very respectful of your religious beliefs."

Good psychologists anticipate such questions. This psychologist had anticipated such questions about her religious beliefs, especially when she was conducting psychotherapy with highly religious patients, and she had thought through her responses. This psychologist did not believe that self-disclosure at this time would serve a clinical purpose or achieve a desirable clinical outcome. She was also aware that if she answered this one question, then she might be opening the door for greater entanglement by which the patient would ask more and more personal questions. Other psychologists may adopt a slightly different position and make a limited disclosure about their religious affiliation. A few even advertise that their psychotherapy is religiously informed. However, even these psychologists recognize that they need to limit their self-disclosure to avoid having psychotherapy devolve into discussions or disclosures unrelated to patient needs.

The decision to self-disclose may be viewed from a consequentialist perspective or one that focuses on the well-being of the patient (Hill et al., 2018). When making decisions about self-disclosure, we recommend that psychologists consider the following: (a) disclose infrequently; (b) consider intentional

self-disclosures to normalize, model, or strengthen the therapeutic alliance; (c) ensure that self-disclosures focus on the needs of the patient; (d) observe how patients respond to self-disclosures; (e) decide to self-disclose on the basis of the impact on the patient, recognizing that some patients respond well to self-disclosure and others do not (e.g., consider carefully self-disclosures for patients who have trouble forming therapeutic relationships); and, if the self-disclosures appear to be problematic, then (f) document self-disclosures and the clinical rationale behind them (see Hill et al., 2018).

American society has seen great turmoil in recent years caused by political polarization as well as COVID-19 and the subsequent economic uncertainty. The mental health of Americans has declined substantially in recent years. If psychotherapists are to respond to the needs of their patients, then they should allow patients to discuss what really upsets them, including their politics. Indeed, differences in politics have been known to disrupt family relationships and friendships. One survey published in 2019 found that 87% of patients discussed politics in their sessions and 21% of psychotherapists explicitly revealed their political leanings to some extent (Solomonov & Barber, 2019). Although such disclosures may be indicated in some situations, psychologists need to ensure that their disclosures meet the criteria described previously.

Facebook and Other Social Media

A variation of self-disclosure can occur when patients acquire information about psychologists through the internet. For example, psychologists may receive requests from patients to friend them on Facebook or other social media. The response of the psychologist should rest on clinical decisions about maintaining appropriate boundaries. It is hard to generalize about social media, which vary in terms of information disclosed. Some psychologists may have professionally focused Facebook pages that advertise their practices and include only professional information (e.g., education, areas of specialty) that would be appropriate for patients or prospective patients to see. However, publicly viewed pages should not include information generally reserved for family members or friends because giving patients access to that information may move the relationship toward a social relationship as opposed to a professional one. Generally, psychologists should ensure that they have appropriate privacy settings for their pages and refuse requests from patients to friend them. As with other boundary challenges, psychologists should show consideration for the feelings of their patients when they turn down such requests by focusing on the importance of the psychologist–patient relationship and affirming their commitment to the well-being of their patients (Knox et al., 2020).

Given the pervasiveness of the internet in American society, it is appropriate for psychologists to conduct an internet search of their names to determine if the sites included personal material that they would not want known. I (Randy Fingerhut) regularly assign my students to do an internet search of themselves. Students are often shocked at what they discover. One student

realized that her wedding registry was public. Another student saw that her house was listed with its appraisal value. A third student found an article he had written in his high school newspaper that could be misconstrued if read out of context. Sometimes it is not possible to remove online information but other times, psychologists can remove website content that they wish to keep private. They may also want to double-check their privacy settings on social media to ensure that they are controlling who has access to their personal information.

At times psychologists may view the internet postings of their patients. At times it might be clinically indicated to accept a patient's invitation to view their online presence if that is consistent with their treatment goals. For example, one patient described how a particular Facebook posting offended her. Instead of trying to explain the posting and comments from memory, she found it easier to quickly take out her phone and show the postings and comments to her psychologist. Furthermore, psychologists who conduct forensic evaluations may inform their clients that they will conduct internet searches as one element of their evaluation.

However, viewing internet content about patients without their consent raises ethical issues. Such internet searches without the knowledge or consent of patients are neither illegal nor prohibited by the APA Ethics Code. However, a question arises as to whether doing so is consistent with the overarching ethical principles of beneficence or respect for patient autonomy.

Some may argue that the additional information they get from such Internet searches can help them make an accurate assessment or formulate an effective treatment plan. Others would counter that the information on the internet might not be accurate. Also, barring some highly unusual life-endangering circumstances, psychologists should respect patients' autonomy and allow them to disclose information at their pace. Furthermore, if the internet contains such important information, then psychologists can discuss the patients' social media presence with them during treatment and, if clinically indicated, solicit their permission to view clinically relevant material (Tao, 2014).

Gift Giving or Receiving

The proper attitude to have about gifts, as with other boundary issues, is to focus on the welfare of the patient. Some psychologists reject all gifts and use the offer as an opportunity to discuss its implications for the psychotherapeutic relationship. Others accept small or token gifts. As with self-disclosure, we recommend that psychologists analyze their feelings and clinical rationales ahead of time so that they can respond thoughtfully when the event occurs.

Most gifts are tokens of nominal value and are appropriate for a special occasion—for example, when a patient brings in holiday cookies or a child patient brings in a hand-drawn picture. Although their theoretical orientation may dictate how they respond to such gifts, most psychologists would accept a nominal gift with the appropriate appreciation and let it go at that. They are

merely courteous social conventions. Psychologists should also consider the meaning of the gift in the context of the patient's culture. For example, among some Native American tribes, gift giving is a sign of respect and may strengthen a relationship (Lettenberger-Klein et al., 2013).

Other gifts, however, raise concerns about the nature of the psychologist–patient relationship. We know of psychologists who have been offered a chair, an expensive pen and pencil set, a VCR, intimate and erotic sleepwear, erotic wood prints, wine, cocaine, pornographic magazines, and an all-expenses-paid vacation.

Ordinarily, these gifts would have to be refused because they are emotion laden, intimate, or involve a substantial amount of money. In addition to refusing these gifts, a psychologist may need to inquire about how the patient perceives the therapeutic relationship. Gift giving may be a well-meaning but ill-advised effort to express appreciation, level the power balance between the psychologist and the patient, set the groundwork for soliciting special favors, or to encourage the psychologist to step into committing an ethical transgression. Other patients may view such gifts as a form of bartering and expect the psychologist to reciprocate with a reduced fee or other monetary consideration.

Psychologists who accept such gifts risk exploiting the dependency of the patient during a period of vulnerability. Furthermore, the quality or objectivity of treatment could be impaired if the psychologist were to accept the gift and feel a need to reciprocate in some fashion.

CASE EXAMPLE: AN INAPPROPRIATE OFFER

The husband of a prospective patient called a psychologist to arrange treatment for his wife. He said, "I am the director of a managed care network, and I will see to it that you get in the network." The psychologist turned down the referral immediately and told the husband that any such offer, however good the intention, could imply that the psychologist owed something to the husband, thus compromising his commitment to the welfare of the wife. He suggested that the wife call another psychologist herself or, if the husband called, to get a psychologist outside of the network, so there could be no implied obligation to the husband.

Touching and Hugging

Social attitudes about touching and hugging vary. Some people are "huggers" or "touchers" and feel little reluctance to put their hands on other people in the course of conversations. Others reserve hugging for romantic or special occasions and would never touch a nonrelative except under the most unusual circumstances. Patients with a history of involvement in Alcoholics Anonymous may expect hugs as part of the treatment because hugs are commonly given at the close of Alcoholics Anonymous meetings. Attitudes toward touching

and hugging also vary according to culture and the particular age or gender mix. One American psychologist who was working in Panama was surprised when a married couple entered his office and both the husband and wife greeted him with a kiss. Although such behavior may be atypical in the United States, it was normative in Panama. Conversely, psychologists may encounter patients from other cultures that would frown upon the mere touching of a member of the other sex.

For some patients, a touch or a hug could be clinically useful. For example, to a grieving patient, a gentle touch can convey a thousand sympathetic words. On the other hand, some patients may feel uncomfortable with touching and hugging, especially when combined with the intense emotional affect that often occurs within psychotherapy. However, a patient with a history of eroticizing relationships who insists on an intense hug may be challenging appropriate boundaries and trying to foster a social relationship. Or patients who have had a history of sexual or physical abuse could misinterpret a touch or hug from an authority figure as a step toward sexual exploitation. Consequently, psychologists should touch or hug patients with discretion. They should consider their own motivations for wanting to touch patients and the way that attitudes toward touching may vary according to the gender and age of the psychologist and patient. Psychologists should consider the purpose of the touch (e.g., to console), the likely outcome (e.g., will it assist the patient's recovery?), and the possibility of future entanglements (e.g., will it set a precedent for behavior that could be clinically contraindicated?).

Advocacy

Intrusive advocacy refers to using psychotherapy to enlist patients for social causes, no matter how worthy (Pope & Brown, 1996). Advocacy with patients can be justified on the principle of general beneficence if there is an immediate threat to the safety of a third party or society, the advocacy benefits the patient, and if the psychologist avoids harming the psychotherapeutic relationship. Often, however, advocacy with patients can become contraindicated if it overrides respect for patient autonomy.

For example, some psychotherapists have pressured survivors of childhood abuse to confront or sue the alleged perpetrators. They may have argued that their patients have a social responsibility to punish all child abusers. However, the role of psychotherapists is to help patients make these decisions for themselves, not to pressure them into adopting the psychotherapist's political positions. Generally, there should be no problem if the psychotherapist raised the issue without pushing it, but even then, there may be some cases where even raising the possibility would be contraindicated.

Also, one could wonder if pressuring patients to go public with sexual abuse claims would further social justice in the long run. Reluctant patients may be poor litigants and are at risk for dropping the suits when the litigation gets uncomfortable. Furthermore, if the public perceived that psychologists would

exploit them to pursue goals outside of their wishes, members of the public might be less likely to seek psychological treatment.

One may evaluate these situations from the standpoint of the ethics acculturation model. Psychologists working with a separated process may believe so strongly in the need to reduce sexual abuse that they put their personal value system above that of their professional obligations. However, psychologists working within an integrated process recognize that they have professional obligations that transcend their personal beliefs. Other examples could be given where there are risks that the psychologist's advocacy may intrude into the psychotherapeutic relationship. For example, well-trained psychologists who incorporate religious practices into psychotherapy appropriately keep a focus on the therapeutic goals and avoid using psychotherapy to promote their own religious worldviews (Tjeltveit, 2012).

CASE EXAMPLE: A SUBTLE BOUNDARY ISSUE

Shortly before the 2020 Presidential election, an intern held her regularly scheduled psychotherapy group, which consisted primarily of women of Latina background. Many of them were worried about the outcome of the election and an escalation in anti-Latina harassment and discrimination. They decided in the group to campaign for their preferred candidate. It was unclear if some of the group members would be campaigning together.

Upon discussion of this session with her supervisor, the psychology intern concluded that the women's experience of harassment was a legitimate topic for group psychotherapy and active involvement could be a healthy way to address those concerns. However, she also asked herself if the group momentum may have pressured some women to volunteer who would not have otherwise done so, if campaigning together would involve some members in out-of-group activities that could lead to the development of cliques or unique friendships that could change the dynamics of the group, and if some members of the group had needs other than dealing with harassment and discrimination and the campaign might detract them from those other goals. She knew that she needed to address these issues in the next meeting.

ROLE CONFLICTS IN TREATING INDIVIDUALS FROM THE SAME FAMILY OR SOCIAL NETWORK

Nothing is inherently wrong with treating members of the same family or social network at the same time (Knauss & Knauss, 2012). In fact, the reputation of the psychologist and background information about the family may help facilitate trust and ensure a good treatment outcome, and often the psychologist can be placed in a unique position to provide special help to all parties.

However, problems may arise if the relatives or friends have incompatible treatment agendas. For example, a psychologist may see a couple for marital therapy and then decide that they both need individual psychotherapy. It can be a role conflict if the psychologist treats the wife for assistance in how to end the marriage while seeing the husband for assistance in how to keep the marriage going. Similar role conflicts occur when a psychologist treats the mother whose goal is to become emotionally closer to her daughter while also treating the daughter whose goal is to set limits with her intrusive mother. Role conflicts can occur any time psychologists treat patients who are friends or who otherwise know each other. Finally, multiple patients do not have obligations of confidentiality with each other. Psychologists cannot prevent patients from talking to each other.

Psychologists should be aware of when their previous psychotherapy relationship could affect their judgment in a new role. For example, psychologists might see an individual for psychotherapy and then decide to work with that patient and their spouse in couple's therapy. Psychologists have a greater likelihood of success as a couple's therapist if they recognize that they may have a bias in the role of couple's therapist because they received information that was filtered through the perspective of their individual patient. Also, the spouse may not feel like they have entered couples counseling on an equal footing because of the previous relationship with individual psychotherapists. The decision on whether to transition from an individual psychotherapist to a couple's therapist depends on many factors including the nature of the couple's problems and the length and depth of the individual treatment. In many circumstances, psychologists will decline to transition to a couple's therapist and refer the patients elsewhere.

MULTIPLE RELATIONSHIPS WITH SUPERVISEES, TRAINEES, OR STUDENTS

The relationship between psychologists and their supervisees, trainees, and students is not completely analogous to that between psychologists and patients. Nonetheless, abuses can occur, and faculty need to use discretion in their personal relationships with students (Rosenberg & Heimberg, 2009).

Multiple roles between faculty and students are inevitable. Faculty members may be instructors, supervisors, advisors, researchers, and/or mentors for students. Also, they have dual allegiances when dealing with students. For example, faculty members who train future psychologists have obligations not only to promote the welfare of their students but also to protect the public from incompetent practitioners. Furthermore, the relationship between faculty members and students is not stagnant; students start as neophytes but mature to advanced students and then to colleagues (Biaggio et al., 1997; Keller et al., 2012).

Students often benefit from contact with faculty members outside the narrow constraints of the classroom. Faculty members can advise students on academic

or career choices, provide emotional support, and offer advice on personal matters. In the ordinary give-and-take of personal relationships, small favors may be asked, such as giving a ride home, and friendships can develop. Faculty members need to be aware that students may not feel the option of saying no to even minor requests (e.g., "Can you babysit Friday night?" "Can you cover a class for me next week?").

Although faculty can have multiple roles with students, they need to avoid harmful multiple relationships.

CASE EXAMPLE: AN OVERLY DEMANDING SUPERVISOR

A faculty member who did not yet have tenure "encouraged" his graduate assistant to help him write articles that would help prepare him for tenure. He prodded the graduate assistant to work far in excess of his required workload and often called him at home late at night to discuss details of article preparation.

Furthermore, faculty members need to ask themselves whether they give preferential treatment to students with whom they have multiple relationships or whether they are equally available to advise and mentor other students (Biaggio et al., 1997). Of course, sexual relationships with students over whom faculty members have evaluative authority are harmful and wrong (see the section Sexual Relationships With Students and Supervisees later in this chapter). Issues related to multiple relationships between students and faculty are also discussed in Chapter 14.

SEXUAL RELATIONSHIPS

According to Standard 10.05, Sexual Intimacies With Current Therapy Clients/Patients, "Psychologists do not engage in sexual intimacies with current therapy clients/patients." This is one of the few absolute statements in the APA Ethics Code. The standard has no qualifiers or recommendations to use clinical judgment in deciding whether to engage in sexual relationships with patients.

Courts have traditionally viewed sexual relationships with patients as grounds for malpractice. According to *Roy v. Hartogs* (1975), "There is a public policy to protect a patient from the deliberate and malicious abuse of power and breach of trust by a psychiatrist" (p. 297). Subsequent courts have invariably adopted similar positions.

Despite isolated stories of happy marriages between psychologists and their patients, sexual contact usually harms patients, and sometimes the harm is severe (see reviews by Pope, 1994; Sonne, 2012). A number of studies with varying methodologies, samples, and definitions of sexual contact have found

that the frequency of lifetime sexual contact between mental health professionals and their patients ranged between less than 1% to 3% for female psychotherapists and approximately 4% to 16% for male psychotherapists (Sonne, 2012). Sexual contact with former patients is more frequent than sexual contact with current patients. Although this generalization has many exceptions, the most common pattern is for an older male psychotherapist to have sexual relations with a younger female patient. In addition to the harm to individual patients, sexual contact between psychologists and patients harms the public image of psychologists in general and may deter some people from seeking help.

The power differential between psychologists and their patients means that the ability of patients to enter a romantic relationship voluntarily is seriously compromised. One patient, who was also a graduate student in psychology, reflected on why she engaged in a romantic relationship with her psychotherapist. She wrote, "I was in the midst of treatment for breast cancer and my judgment was clouded by pain, medication, and the fear of death" (Anonymous Psychology Student, 2006, p. 7).

The pain that sexualized encounters can cause patients should not be underestimated. Another patient, who was also a psychologist herself, described how her treating psychologist exploited her vulnerability while she was in "an emotional hell" (Anonymous, 2002, p. 8). She described how "therapy sessions billed to my insurance were now closed-door romantic interludes combined with EMDR techniques" (p. 8). When thinking back about this "psychotherapy experience," she wrote, "The shame I struggle with is enormous" (p. 8). She wrote that "the damage from the destructive therapy is by far the worst trauma I have ever experienced in my life" (p. 8).

Data suggest that the frequency of patient–therapist sexual contact may be decreasing in recent years, although several methodological factors make it impossible to reach this conclusion with certainty (Sonne, 2012). If such contact is decreasing, it may be because several states have criminalized this behavior, the number of female psychologists (who have lower rates of exploitation) has increased, and/or the educational and preventative efforts by training institutions and psychological associations have been effective.

Sexual Relationships With Former Therapy Patients

According to Standard 10.08a, Sexual Intimacies With Former Therapy Clients/Patients, "Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy." In addition, psychologists may not engage in sexual intimacies with former patients even after 2 years, except in highly unusual circumstances. According to Standard 10.08b, if they do have sexual intimacies with former patients, psychologists have

> 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.

Thus, the APA Ethics Code almost always prohibits sexual relationships with former patients. This standard does not mean "two years and a green light." It means "two years and a flashing red light. . . . It is an 'almost never' standard" (Knapp & VandeCreek, 2003, p. 156).

Former patients are vulnerable to exploitation. Although psychotherapy may be over, a former psychologist still has influence and information that can be used to keep the relationship going. Even before the explicit prohibition against sexual relationships with former patients appeared in previous versions of the APA Ethics Code, APA commonly disciplined psychologists who terminated psychotherapy to enter into a sexual relationship with a patient.

Sexual Relationships With Close Relatives or Friends of Patients

In addition to the problems that develop with sexual contact with patients, students, and former patients, psychologists can also cause harm by having romantic relationships with close relatives or friends of patients. For example, a psychologist who initiates a romantic relationship with the mother of a child patient is entering into a potentially harmful relationship with that child and betraying the primary fiduciary relationship to that child.

Sexual Relationships With Students and Supervisees

The APA Ethics Code prohibits sexual relationships with students and supervisees (Standard 7.07, Sexual Relationships With Students and Supervisees). Although educators or supervisors do not have as much influence over supervisees as psychologists have over their patients, they still have substantial control and influence. Teachers have control over students through grades, letters of recommendation, and, for graduate assistants, the quality of their work life. Faculty and supervisors cannot be objective if they are having sexual relationships with students or supervisees (Sullivan & Ogloff, 1998). Although sexual relationships between supervisors or faculty and students are always forbidden, even nonsexual multiple relationships must be avoided if they impair objectivity or are exploitative (Standard 3.05, Multiple Relationships).

A majority of these inappropriate relationships are between older male psychologist-educators and younger female students. Respondents to a survey on these sexual relationships tended to view them as exploitative and harmful (Hammel et al., 1996).

The sexual exploitation of students or supervisees is not grounds for malpractice because no psychologist–patient relationship exists. However, it could be grounds for disciplinary action by a licensing board, ethics committee, or educational institution, or grounds for a sexual harassment lawsuit.

In addition to the harm that may come to the supervisee, some evidence suggests that supervisees who have had sexual relationships with supervisors during training were more likely to have sexual relationships with patients later in their careers, although the data for this are mixed (Lamb et al., 2003).

Protecting Patients From Sexual Exploitation

The sexual exploitation of patients is probably multidetermined. Nonetheless, several factors have emerged in the study of psychotherapists who have engaged in sexual misconduct. On the basis of his experience in treating professionals accused of boundary violations, Schoener (2002) described great diversity among these offenders. For example, sometimes the exploiting psychologists have long-standing personality or sexual disorders (e.g., pedophilia, sexual sadism). Others are impaired either through the abuse of drugs or alcohol or from a serious mental illness. Often, the offending psychologists are "lovesick" (i.e., believe themselves to be in love) and ignore or overlook their role as a psychologist. Some poorly trained psychologists have not learned to recognize or manage the feelings engendered by psychotherapy or the boundary issues in psychotherapy. Schoener noted that there are other categories of offenders, and many cases have multiple determinants.

Several surveys have produced results that are consistent with and expand on Schoener's (2002) description. Some psychologists had relationships with patients during periods of personal distress (Jackson & Nuttall, 2001; Lamb et al., 2003) or were inexperienced or lonely (Hamilton & Spruill, 1999). Others had a background of being sexually abused as children (Jackson & Nuttall, 2001). It is very difficult to prevent sexual exploitation by psychologists with long-standing personality or sexual disorders. However, the profession can do more to prevent misconduct by psychotherapists who are undertrained or temporarily impaired.

Gabbard (1996) argued that it is inappropriate to view sexual misconduct from an "us versus them" perspective. It is true that some mental health professionals who engage in sexual misconduct have serious character flaws and should never have been admitted into the profession. However, many transgressions occur because of a confluence of clinical error, poor training, and personal vulnerabilities.

According to Gabbard (1996),

> The majority of those that I have seen over the years are more similar to the rest of us than different. Many have felt that they were in love with their patients, others have self-destructively surrendered to demands for demonstrations of caring, and still others have been desperately needy and situationally vulnerable because of impoverished personal lives or acute stressors like divorce or the death of a loved one. (p. 312)

Psychologists, like other humans, are sexual beings. Sexual feelings permeate people's everyday lives, and sexual behaviors often reflect more pervasive personality traits. As stated by Glenmullen (1993), "The sexual arena is a distillation, a shorthand in which psychological motifs can often be seen more

readily than they can in more complex social interactions" (p. 245). In addition, the emotional intensity of the treatment relationship commonly activates sexual needs and fantasies on the part of both the psychologist and the patient. These sexual feelings can create discomfort, guilt, and anxiety on the part of the psychologist (Rodgers, 2011).

From the standpoint of both the patient and psychologist, sometimes the intensity of feelings is fueled by unresolved issues and reflects a means to gain control, express appreciation, or solicit affection. Sometimes the seduction may be overt; at other times it is subtle or unconscious.

Reframing the Sexual Exploitation Issue in Terms of Optimizing Treatments

Sexual attraction should be viewed as an occupational hazard for psychologists. The problem is not the presence of sexual feelings but the way those feelings are handled. As a profession, we can do a better job of reducing sexual exploitation by appropriately recognizing the sexual feelings that may emerge in psychotherapy. Typically, the issue of sex with patients is framed in terms of stopping sexual exploitation. However, it may be better to frame the problem in terms of improving the overall quality of the therapeutic relationship. Specifically, how should psychologists handle sexual feelings that develop in psychotherapy in a manner that fulfills the moral principles (i.e., beneficence, nonmaleficence, fidelity, justice, and respect for patient autonomy) that should guide treatment?

Reframing of the sex-with-patients issue becomes especially important from the standpoint of education and prevention. Efforts that focus only on stopping sexual exploitation may send a message that it is desirable to suppress or minimize sexual feelings. However, efforts that focus on acknowledging and understanding sexual feelings send a message that it is desirable for psychologists to be alert to their feelings, including sexual feelings, so that they can have more productive treatment relationships with patients. In that sense, sexual feelings do not differ from other strong feelings, such as fear, disgust, anger, protectiveness, or deep affection that may arise during the course of psychotherapy and which, because of their intensity, can derail the course of treatment or lead to less-than-optimal outcomes.

We propose several steps that should help reduce the likelihood of sexual exploitation that are informed by Hayes (2014) and Hayes et al. (2018). First, students and psychologists should understand that sexual feelings are common and normative. Second, students and psychologists should focus on maintaining appropriate boundaries, which may mean looking at boundaries from the standpoint of the ethics acculturation model. Finally, students and psychologists should seek supervision or get consultations when needed, understand the dynamics involved in sexual exploitation, and practice good self-care.

Sexual Feelings Are Common and Normal

Because sexual feelings are common and inevitable, Moursund (2001) encouraged students to anticipate sexual attraction and their reactions:

> You will handle such situations much better if you've thought in advance about what you might say and do with them. Moreover, thinking about these issues now gives you a chance to set your own internal radar screen, to be sensitive to your own feelings and to the out-of-awareness messages you may be sending to an attractive client. (p. 53)

Sexual topics are very sensitive, and intense sexual feelings are typically not discussed except in the most intimate situations. However, psychologists who focus on understanding themselves may be better able to acknowledge and understand their sexual feelings and to provide a higher level of service to all of their patients, rather than just abstaining from sexual relationships with them. The goal is not just to minimize the harm that can occur because of sexual exploitation.

Understanding Boundaries From the Ethics Acculturation Model

Psychology students and psychologists should focus on keeping appropriate boundaries. A psychologist may mean one thing by giving a patient a hug, but the patient may interpret it as something different. Hamilton and Spruill (1999) noted that psychologists who were more likely to engage in a sexual boundary violation had a background of volunteering or working in a social service position before entering training in psychology. This fact raises the question of whether these psychologists' socialization into the profession was adequate. The ability to work within boundaries can be conceptualized according to the acculturation model presented in Chapter 2. That is, students may handle boundaries most appropriately if they have integrated professional ethics into a well-founded sense of personal ethics. Students who have poorly integrated their personal ethics into their professional ethics have a greater risk for boundary violations (see Table 7.1).

Students who are using integrated strategies successfully combine good personal ethics with the spirit and rules surrounding professional boundaries. As such, they are more likely to have anticipated their reactions to boundary issues and to have developed a response based on clinically relevant standards implemented within a caring personal style. Depending on their personal orientation, for example, they may or may not self-disclose or accept small gifts from patients. But whatever they do is done from an understanding of professional roles and a genuine concern for the patient.

Students who are high on personal ethics but low on professional ethics (i.e., using separated strategies) may not understand the importance of keeping professional roles distinct from personal roles. They may be more willing to loan money to a patient, give advice, self-disclose personal information, and give or receive gifts, as they might do with a personal friend. They may allow momentary feelings of compassion to trump professional ethics and become too

TABLE 7.1. Boundaries Viewed From an Acculturation Model

Personal ethics	Professional ethics	
	High	**Low**
High	Follows professional rules and personal values such as compassion guide behavior in gray areas. Integrated Likelihood of exploitation is very low.	Personal values or intuitions guide behavior and override professional rules. Overinvolved Likelihood of exploitation is low but may be involved in "rescuing."
Low	Follows professional rules but lacks a well-developed personal moral code to guide behavior in gray areas. Rigid Likelihood of exploitation is low but may come across as distant.	Does not respect professional rules and lacks a well-developed personal code to guide behavior. Dangerous Likelihood of exploitation is high.

involved and seek to rescue their patients. These students (or psychologists) are at lower risk for sexual offenses, and when those offenses occur, they are probably the result of a rescue fantasy.

Students who are low on personal ethics but high on professional ethics (i.e., using assimilated strategies) may attend to the letter of the APA Ethics Code but fail to understand the meanings behind it. They only feel guided by the APA Ethics Code when it gives them a clear direction on a particular issue. As a result, they may be inclined to adopt a legalistic or rigid stance. For example, they may fail to touch the hand of a grieving patient, even though doing so would be compassionate and clearly clinically indicated. They are at a low risk for sexual offenses, but their relationships with patients may be less than optimal because they come across as too distant or uninvolved.

The most dangerous trainees are those who are low on both professional ethics and personal ethics. They are motivated primarily by self-interest and not by concern for their patients. Of the four groups, they present the highest risk for sexual exploitation of patients.

Fortunately, many graduate training programs address these issues (Samuel & Gorton, 1998). One of the primary goals of training in the context of multiple relationships is to encourage future psychologists to seek consultation and possibly personal psychotherapy whenever sexual feelings toward a patient appear to interfere with the quality of treatment.

Get Supervision or Consultation

If psychologists feel more than mild and transitory sexual attraction to a patient, or if psychologists are the recipients of sexual attraction from a patient, then they should seek consultation to ensure that they are handling the experience

in the optimal manner. Although almost all internship directors believe that they should teach their interns about boundaries, they may underestimate the extent to which their interns are likely to experience eroticized transference or countertransference (Samuel & Gorton, 1998). Supervisors who openly discuss the reality of sexual attraction can help their trainees acquire the objectivity needed to deal with these emotions constructively. However, this needs to be done tactfully. Because supervisors have a degree of control over the career paths of their supervisees, the trainees may be naturally reluctant to discuss these "forbidden feelings." According to Gabbard (1996), "Those aspects of their thoughts, feelings, or actions that they would most like to keep secret from the supervisor are precisely the issues that should be openly discussed in supervision" (p. 317).

Supervisors can initiate the process by selectively self-disclosing their own sexual feelings and how they are handled. As stated by Baur (1997):

> The supervisors who guide psychotherapists need to be able to discuss their own, real experiences of powerful sexual attraction. If they cannot tell all, then the therapists coming to them will not trust them with their embarrassing secret feelings while there is still time to avoid an affair. (p. 7)

Supervisors need to disclose this information tactfully and discretely with the goal of helping trainees better understand how to identify and handle their own sexual feelings in psychotherapy. Supervisors may have to be explicit as to why the disclosure was made and how it relates to the training of the supervisees.

Finally, supervision is important to help trainees handle unwanted or unsolicited sexual advances by patients. About one half of female psychologists have received such advances. Supervision can help psychologists or psychology trainees handle such behaviors within sessions or identify antecedents or motivations behind such advances (Hartl et al., 2007). Many students feel unprepared for sexual advances by patients and uncertain as to how to respond in a professionally appropriate manner (Sonne & Jochai, 2014).

Surveys suggest that about 60% to 70% of psychologists who have experienced sexual attraction to patients sought consultation, supervision, or discussed these issues in their personal psychotherapy (Rodolfa et al., 1994; Stake & Oliver, 1991). However, that means that between 30% and 40% of psychologists did not. It is interesting to note that those who sought consultation were significantly less likely to believe that they would act on the sexual feelings (Rodolfa et al., 1994).

Understanding the Dynamics of Attraction

Training programs have developed curricula, including training exercises and vignettes, to sensitize students and practitioners to sexual attraction in the therapeutic relationship (Samuel & Gorton, 1998; Schoener, 1999). Samuel and Gorton (1998) recommended introducing the curricula on boundary violations early in the educational program and then having it developed, reinforced, and integrated throughout the training program. First-person accounts of individuals

who have been sexually exploited can be especially useful in helping students to appreciate the harm that may occur. Training in how to handle sexual issues should involve not only sexual attraction in psychotherapy but also basic information on human sexuality (Ford & Hendrick, 2003). Students who have the best understanding of the ethical issues involved in sexual feelings that arise in psychotherapy are more likely to discuss patient attraction with their supervisors (Housman & Stake, 1999).

Schoener (1999) described a number of educational programs, videos, and exercises on boundaries in general but also on sexual feelings. One structured exercise is "How to Seduce a Client," in which the participants state what they would do to set up the emotional seduction of a patient, and the group leader lists the responses on a chalkboard or chart. After the list is reviewed, the leader can ask participants to note which ones are inherently unethical. Few of these actions are inherently unethical. The mere process of listening to the intimate details of another person's life can create a sense of intimacy and generate intense feelings.

Another exercise asks students to create two lists, one for the characteristics of a friend and the other for the characteristics of a professional. The friend may, for example, loan money, exchange gifts, or engage in mutual self-disclosure. A psychologist, however, would do none of those. This exercise is important because it helps differentiate social from professional roles and social from professional ways of expressing care and moral behavior.

Practice Self-Care

We have already discussed the need for self-care, which involves conscientiously monitoring one's feelings and embedding oneself in a protective social network that provides regular, honest, and caring feedback. However, the need for self-care is heightened by awareness that personal distress, recent personal losses, job stress, or poor self-concept are related to sexual misconduct. Even psychologists who do not exploit patients sexually may have less than optimal outcomes if they feel distress. It is harder to be aware of personal feelings that emerge in a therapeutic relationship when those feelings are masked by a background of general dysphoria or anxiety. It is therefore helpful to engage in ongoing self-examination of feelings toward patients (Hayes, 2014).

8

Confidentiality, Privileged Communications, and Record Keeping

The terms *confidentiality* and *privileged communications* refer to different, albeit overlapping, concepts. Confidentiality is a general term that refers to the obligations of psychologists to protect the privacy of patient information. Privileged communications is a specialized term that refers to the legal right of patients to withhold evidence from courts under certain circumstances.

Confidentiality rules can be found in the state licensing laws for psychologists and in other statutes or regulations. In addition, courts have found psychologists and other health care professionals culpable for malpractice, defamation, or other torts for the unauthorized release of patient information. Breaches of confidentiality could be the basis of complaints before licensing boards, malpractice courts, and the Ethics Committee of the American Psychological Association (APA), although it is not one of the common sources of complaints.

Nonetheless, confidentiality remains a significant concern for professional psychologists. In critical incident surveys, psychologists reported that confidentiality was the most frequently encountered cause of dilemmas that they faced in practice (Pope & Vetter, 1992). Over half of psychologists reported that they have unintentionally violated confidentiality (Pope et al., 1987).

Furthermore, rules regarding the privacy of persons receiving health care are now included in federal law through the Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA; U.S. Department of Health and Human Services [USDHHS], 2002). Separate confidentiality laws apply to

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schools and institutions of higher learning through the Federal Educational Rights and Privacy Act (FERPA) and to federally funded drug and alcohol treatment facilities through federal law (commonly referred to as 42 CFR Part 2, referring to its location in the federal statutes).

Confidentiality rules are based on the moral principles of beneficence, in that psychologists will act to promote patient welfare; nonmaleficence, in that psychologists avoid actions that could harm patients; integrity (i.e., fidelity), in that psychologists keep their promises; and respect for patient autonomy, to the extent that patients have control over the release of the information generated from patient services. Confidentiality rules have a utilitarian aspect as well. It is assumed that patients will be more open in their communications if they have an assurance of confidentiality.

In this chapter, we review confidentiality (including the HIPAA Privacy Rule), privileged communications, record creation and disposal, patient access to records, and common exceptions to confidentiality. Chapter 9 covers confidentiality with life-endangering patients.

At first glance, it would appear difficult to strive for moral excellence in the area of confidentiality. It would seem that the rules of confidentiality (e.g., not to release patient records without the consent of the patient unless done under one of the narrow circumstances set by law) allow no room for moral excellence. However, it may be instructive to look at the goals that the rules are intended to support. Confidentiality rules function in a manner similar to the rules regarding psychotherapy boundaries; they are established to ensure that patients feel enough safety and trust to share information. For example, fear of having one's confidentiality broken is one of the reasons that suicidal patients might withhold information about suicidal thoughts (Farber et al., 2019). The question for the psychologist then becomes, "How can I facilitate that safe environment?"

In part, psychologists can create a safe environment through the quality of their relationships and the sensitivity that they show to the revelations of the patient. Psychologists can earn that trust by being meticulous about keeping patient information confidential. They can also earn that trust by taking special care to inform patients of the limits of confidentiality before treatment begins and about the ways that they handle information in gray areas in which therapeutic discretion is required, such as when psychologists are treating families or adolescents.

THE HIPAA PRIVACY RULE

Since April 14, 2003, all health care professionals, facilities, and insurers who transmit protected health information electronically in connection with specified transactions, such as submitting claims to third-party payers, have had to comply with the HIPAA Privacy Rule (USDHHS, 2002). The Privacy Rule does not apply to educational records, which are covered by FERPA. The rules applying to correctional facilities are complex, but a thumbnail description is

that some HIPAA rules apply to services in correctional facilities and to some forensic services if provided by an otherwise covered entity.

In this section, we briefly overview the most salient points of the HIPAA Privacy Rule. The Privacy Rule is difficult to understand because the interplay of state and federal laws regarding confidentiality can be complex and the USDHHS (the federal agency responsible for the implementation of HIPAA) has not yet clarified some issues. Because this is only an overview, we urge readers to seek more detailed information about the interplay of HIPAA with the laws in their own states, to keep abreast of changes in the interpretation and applicability of HIPAA, and to seek consultation on its more technical issues.

Even those health care psychologists who are not covered by HIPAA may want to consider complying with its standards. First, if a psychologist who is not required to be HIPAA-compliant were to start billing electronically—even once—then all of the practice must comply completely with HIPAA at that time. Second, over time the standards found in HIPAA may represent the standard of practice throughout the entire health care industry. It is conceivable that future courts could determine that psychologists who fail to provide the notices and other requirements of HIPAA are practicing below the minimum standards of their profession.

The HIPAA Privacy Rule mandates that covered entities have to meet certain minimal standards of patient privacy, including (a) giving a privacy notice to all patients, (b) following certain rules on what information they can disclose and to whom, (c) ensuring that they include certain types of information on all patient authorizations (i.e., release of information forms required for certain disclosures), (d) having agreements with business associates to ensure they protect patient privacy, and (e) appointing a privacy officer for every covered practice. Further information and copies of the forms required for HIPAA compliance can be obtained from APA or from commercial vendors.

State laws preempt the HIPAA Privacy Rule when they are more protective of privacy from the standpoint of the patient. For example, HIPAA permits health care personnel to give information to police investigating crimes; state laws, however, typically permit no such exceptions for psychologists, so these state laws override HIPAA. Because state laws regarding mental health generally strongly protect patient privacy, most rules regarding the day-to-day handling of confidential patient information by psychologists have changed very little as a result of the HIPAA Privacy Rule.

Furthermore, the HIPAA Privacy Rule is scalable, which means that individuals or organizations may modify the requirements for compliance according to their size. For example, whereas a large hospital may have to develop a detailed and formal complaint process, psychologists in solo practices may use a simple form and meet with their patients themselves if a complaint arises. Whereas a large hospital may have to employ a full-time privacy officer, psychologists in solo practices can serve as their own privacy officers. Whereas a large hospital may need to have a full-time training director for all new employees, psychologists in solo practices may train their own employees.

The Privacy Notice

The privacy notice was discussed briefly in Chapter 6. Every covered health care provider must give patients a privacy statement that reviews the relevant limitations on privacy, information on disclosures and authorizations (i.e., release of information forms), and the patient's right to review and copy records. Psychologists may provide the privacy notice at the same time they present an informed consent or service brochure to patients, although they may not combine the two forms. The privacy notice may be, but does not have to be, layered (i.e., have a brief summary on top followed by more detailed information).

Every covered entity must give all patients a privacy notice at their first encounter, except in emergencies. Phone contacts to schedule appointments are not considered the first encounter. Providers who fail to get the patient's signature on the notice form are not penalized as long as they make good faith efforts to do so and document such efforts. In addition to giving the privacy notice to each patient, psychologists must post it where patients or future patients can see it. Those health care professionals who have a website must have a copy of the privacy notice there (USDHHS, 2002). Only one privacy notice is required for an organized entity delivering service. For example, each provider within the same facility would not have to give a patient a separate privacy notice.

Psychotherapy Notes

HIPAA requirements (USDHHS, 2002) distinguish between psychotherapy notes and other *protected health information* (PHI). This distinction is relevant for two reasons. First, HIPAA requires that patients have access to their PHI but not to psychotherapy notes. However, as noted previously in this chapter, state laws may preempt this and other portions of the HIPAA Privacy Rule if they are more protective of patient privacy from the standpoint of the patient or provide patients with greater access to records. Second, third-party payers may not condition payment on the basis of the receipt of copies of psychotherapy notes.

The Privacy Rule defines PHI as

> information, including demographic data that relates to the individual's past, present or future physical or mental health or condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. (USDHHS, 2002, 45 C.F.R. 164.501)

Psychotherapy notes are defined in the HIPAA Privacy Rule as

> 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. (USDHHS, 2002, 45 C.F.R. 164.501)

The definition of psychotherapy notes in the Privacy Rule specifically 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. (USDHHS, 2002, 45 C.F.R. 164.501)

The practical implication of these distinctions is that insurers or patients may be able to have access to protected health care information such as treatment summaries, assessment results, and notes on medications, but they may not have access to their psychotherapy notes unless permitted by state law.

Accidental Releases of Information

Accidental releases of information without legal justification or the permission of the patient could trigger a variety of consequences for the psychologist, such as a licensing board complaint. In addition, HIPAA also establishes certain procedures to follow when health care providers release patient information by accident or error. These unauthorized disclosures are called *breaches*. A breach is "the acquisition, access, use, or disclosure of protected health information in a manner not permitted . . . which compromises the security or privacy of the protected health information" (USDHHS, 45 C.F.R. §164.402).

A breach triggers a notification process, which is too detailed to cover here. Nonetheless, psychologists can take steps to avoid compromises in confidentiality by encrypting their patient records if they store them electronically, being scrupulous when releasing materials, and ensuring that they train staff on the rules surrounding confidentiality.

PROTECTING CONFIDENTIALITY

Effective treatment requires an atmosphere of trust and openness. To a large extent, psychologists can generate trust through a warm and reassuring interpersonal style. All of these efforts to engender trust can be shattered, however, if psychologists do not ensure the privacy of patient information. Prudent psychologists review their office procedures, their actions, and the actions of their staff members to ensure that confidentiality leaks do not occur.

Psychologists are responsible for training members of their office staff and professional supervisees in the rules of confidentiality. Most staff members accept their responsibilities conscientiously. They refrain from talking about patients in public places, protect patient charts, and take other steps to protect patient confidentiality. However, the most effective way to prevent breaches of confidentiality is to ensure a culture of safety in which everyone views confidentiality as their responsibility. Clerical workers should feel free to tell professional staff members when they see threats to patient confidentiality. The information flow should not be one-way. It can be helpful to attend to small

details concerning accidental breaches of information. For example, psychologists need to ensure that voices or messages from the answering machine do not carry from a treatment room into the reception area or waiting room. Clerical staff members can be crucial in informing psychologists about the effectiveness of soundproofing, carpeting, or music in reducing sound overflow.

CASE EXAMPLE: AN EFFECTIVE SOUND CONTROL SYSTEM

The clerical staff at a midsize professional practice commonly kept the radio in the waiting room playing so that it would reduce the likelihood of their voices being heard while they phoned patients or insurance companies. Occasionally, a patient would turn off the radio, thus subverting this measure. The clerical staff placed a sign on the radio that read, "Please do not turn off."

Other breaches of confidentiality can occur as well. Consider the following example.

CASE EXAMPLE: A HURRIED PSYCHOLOGIST

A psychologist who was in a rush picked up the chart of the patient whom he was to see for the first time that day. He looked at the name on the chart and said, "Well, Mr. Newton, how are you today?" However, the psychologist had picked up the wrong chart, and the name of the patient was Leibniz.

How could this miscalculation have been avoided? Could the secretary have been more careful about the charts? Should the psychologist have been more alert to the possibility of errors when in a hurry? Careful psychologists try to determine how these slips can be avoided. Similarly, simple prudence and caution can prevent other confidentiality breaches, such as faxing information to the wrong number or leaving the charts of other patients on their desks where patients might see their names.

Special confidentiality or boundary issues may occur when psychologists locate their offices in their homes, where family members may inadvertently acquire identifying information on patients or where patients may acquire private information about their psychologists. Family members may see patients entering the office portion of the house or see return addresses on mail addressed to the office. Cases have even occurred in which patients have wandered into the residential portion of the house or unruly children have intruded on psychotherapy sessions.

Nonetheless, conscientious psychologists have considered these possible problems ahead of time and address them proactively. For example, a physical barrier between the office and the rest of the house (including having a separate

and marked entrance for the office) can steer patients away from the living area of the psychologist. The work and home areas can be securely sound proofed so that conversations in psychotherapy do not bleed into the living area or vice versa. They may also have different business and home phones.

Some psychologists may wish to accept or receive text messages or emails from patients for routine matters, such as scheduling appointments. We recommend that psychologists who email or text patients get permission to do so from the patients at the beginning of treatment or as soon as possible. In addition, psychologists can disguise client names in their cell phone contact lists so that they are not identified when they receive text messages.

Psychologists who deliver telehealth services need to inform their patients of the limits of confidentiality through these forms of communications, although the confidentiality issues are less salient now that some services are compliant with the security provisions of HIPAA and sign business associate agreements. Although it is theoretically possible for messages to be hijacked electronically through these secure services, a more likely threat to confidentiality could occur when another person (e.g., family member, employer) has access to the computer at home and could, for example, read the e-mails that the patient intended to be confidential. Chapter 5 gives more information on telepsychology.

Exceptions to Confidentiality

Psychologists may release patient information if the patient has signed a release of information form, the psychologist has received a court order, or a law permits or requires the release. Psychologists should require a signed release (i.e., consent or authorization) from their patients before disclosing or sending out information except in emergencies, in mandated or discretionary reporting situations, or in response to a court order. State and federal laws may specify the required contents of the form. APA's (2017a) *Ethical Principles of Psychologists and Code of Conduct* (APA Ethics Code), Standard 4.06, Consultations, permits professional consultations as long as psychologists do not disclose identifying information and disclose only the information needed for the consultation.

At the beginning of psychotherapy, psychologists should inform their patients of the relevant exceptions to confidentiality (see especially Chapters 6 and 12). In addition, family and group therapy and the treatment of adolescents or adults with serious and persistent mental illnesses have unique aspects. Treating patients who have been court ordered for treatment also creates unusual confidentiality issues, which are discussed in Chapter 11.

Confidentiality in Family Therapy

The APA Ethics Code requires psychologists to explain the rules of confidentiality at the outset of psychotherapy (see Standards 4.02, Discussing the Limits of Confidentiality; 10.01, Informed Consent to Therapy; 10.02, Therapy Involving Couples or Families; and 10.03, Group Therapy). Before starting family therapy,

psychologists should inform patients about how they will handle information obtained through private conversations with individual family members.

Some of the information obtained from private conversations deals with other family members, other information deals only with the individual. A patient who speaks to her family therapist alone and says her spouse is having an affair is sharing information directly relevant to the family's functioning. A patient who speaks to her family therapist alone and says that she is having conflict with a coworker is sharing information that is less directly related (or perhaps irrelevant) to the family's functioning. Sometimes, family members reveal information privately because they do not wish to anger or embarrass other family members but believe that the psychologist needs to know this information. At other times, they want to develop a special alliance with the psychologist to increase their influence within psychotherapy. Psychologists disagree on how to handle these kinds of situations. Some receive and use information from private conversations; others do not. Many clinicians adopt a no-secrets policy, which means that they have the option to share any information relevant to family or couples' treatment that was obtained individually (Harway et al., 2012). The APA Ethics Code only requires psychologists to clarify their policy at the outset of psychotherapy.

In addition, psychologists may sometimes mix individual and couples or family therapy. They may, for example, start in individual psychotherapy with one patient and then invite the spouse in as a collateral contact to assist the patient in their individual psychotherapy. Alternatively, they may invite the spouse to engage in couples therapy with their relationship as the focus of treatment. As a third possibility, a psychologist may start and finish couples therapy and then, sometime in the future, accept one of the members of the couple in individual psychotherapy. In each of these situations, psychologists need to be clear about who is the patient (and holds the right to release information) and how records will be kept (Harway et al., 2012).

Confidentiality in Group Psychotherapy

Psychologists have more difficulty protecting patient privacy in group therapy than individual therapy because a larger number of persons have access to the information shared in psychotherapy. Nonetheless, psychologists can take precautions to reduce breaches. L. K. Knauss and Knauss (2012) recommended addressing confidentiality through an open discussion with the group to help members become aware of the importance of protecting the confidentiality of others. Psychologists can inform patients at the outset of psychotherapy of the need to respect the privacy of other patients and can promote a sense of responsibility by urging group members to see themselves as cotherapists with the other group members. They can also ask patients to sign statements promising that they will respect the privacy of the other members of the group, and they can make further participation in the group contingent on maintaining that privacy.

Confidentiality in Integrated Care Settings

Integrated care settings provide unique challenges to confidentiality because the psychologists or other behavioral health professionals need to communicate freely with the physicians and other professionals providing physical health care. In some settings, the health care entity employs the psychologist directly, in which case a designee of the entity can inform the patient of the rules regarding the integration of behavioral health and physical health treatment (and the exchanges of information between professional staff) as part of the initial consent form. At other times, the behavioral health professional may be colocated in the office of the physician yet is a separate legal entity. In those cases, the traditional rules regarding patient authorizations for the release of information apply.

Some physicians may prefer to give a "warm handoff" to a patient, meaning that they may actually physically escort the patient to the office of the psychologist down the hall and introduce them personally. These warm handoffs can effectively facilitate a transition to behavioral health treatment. Nonetheless, they do not negate the importance of informed consent regarding the sharing of information. Informed consent should include a discussion of which medical providers have access to patient health information; what information, if any, is protected; and emergency situations that would necessitate the breaking of confidentiality. It is possible that the warm handoff may involve only the introduction of names and other nonclinical information until the patient has been informed of the confidentiality issues involved (Hudgins et al., 2013).

Confidentiality With Adolescents

The general rule is that parents control the ability of their children to seek health care treatment. However, many states make exceptions and allow some children to seek psychotherapy without parental consent, depending on their age or other circumstances. For example, some states permit mental health professionals to treat a minor for a specified number of sessions or in an emergency without the knowledge of the parents.

Although it may not be explicitly stated in any state statute or regulation, the ability to authorize or consent to treatment implies the ability to control the release of information generated from that treatment. Consequently, if parental consent is needed to obtain treatment, it usually follows that the parents have a right to obtain the information generated from such treatment. However, a policy of sharing all information with the parents may dissuade some children from being candid in psychotherapy.

The best way for psychologists to handle the issue of confidentiality with adolescents is to discuss it openly with all parties at the start of psychotherapy (L. K. Knauss & Knauss, 2012). In those states in which adolescents cannot legally control their confidentiality, psychologists may, if clinically indicated, often establish private agreements wherein parents agree to withhold their requests for information to allow the adolescent a greater sense of privacy and thus encourage a stronger therapeutic alliance.

Psychologists should inform parents that they will share information if the life or safety of the adolescent or a third party is imminently endangered and disclosure is necessary to diffuse that danger. In addition, psychologists need to clarify with parents their confidentiality policy when adolescents disclose sensitive information, such as the use of drugs or sexual activity. Often, psychologists add other narrow exceptions to confidentiality, such as information as to whether the child is using the time productively or whether the child has a problem that exceeds the competence of the psychologist.

It is important to get the parents, the child, and the psychotherapist on the same page when it comes to information sharing. Parents may send their children into psychotherapy with widely different expectations of what should be shared. Cultural factors may be relevant here. For example, parents from more collectivist or interdependent cultures may expect to have greater involvement in their children's psychotherapy (Yao et al., 2021).

Nonetheless, when parental consent to treatment is legally required, the parents have traditionally been able to insist on obtaining the information generated within psychotherapy. However, the HIPAA Privacy Rule elevates the status of private agreements between parents, children, and psychotherapists. If the parents have signed a written agreement of confidentiality, it can be legally binding, and the parents might not have access to the confidential information about their children covered in the confidentiality agreement.

The determination of what threatens life or safety requires discretion on the part of the psychologist. Behaviors such as smoking cigarettes and sexual contact present varying degrees of danger. Many psychologists establish the standard to include imminent danger to self or others, to avoid the situation in which the parents expect a report on a wide range of activities in which such danger is remote (L. K. Knauss & Knauss, 2012). Nonetheless, psychologists may have to reflect or consult when the degree of danger is not clear.

For example, a 16-year-old in treatment revealed that she was having sexual relationships with a number of young men. They often, but not always, used condoms. The psychologist asked himself if the danger created from these unprotected sexual relationships rose to the level of danger to self that would require notification of the parents. Another psychologist treated a 15-year-old who drank alcohol to the point of passing out. Another treated a 17-year-old who often rode in cars with drunk drivers. Another psychologist treated a 14-year-old who associated with a gang whose members were known for their delinquent behaviors and aggression.

No simple answer can be given to the psychologists in these cases. The response should depend on a comprehensive assessment that considers weighing the nature and frequency, intensity, and duration of the high-risk behavior; the likelihood that psychotherapy will be successful in changing the behavior (and reducing the threat of harm to the adolescent); and the harm to the relationship if the parents are told without the consent of the child.

Psychologists often can be most effective when they resist the inclination to dichotomize their options (e.g., "Either I tell the parents or I don't tell

them"). An alternative option is to get the adolescent's consent to disclose high-risk behaviors with their parents. The process of discussing danger with the adolescent may reveal information about the family dynamics or the concerns of the adolescent that will facilitate considerable growth and communication within the family. One conscientious psychologist said he almost never had to reveal dangerous behavior to a parent without the consent of the adolescent.

According to principle-based ethics (see Chapter 2), psychologists generally adhere to moral principles such as fidelity (i.e., keeping promises of confidentiality), respect for patient autonomy, and beneficence (i.e., working to protect the welfare of patients). However, when moral principles collide, moral agents may allow one ethical principle to override another. When the decision is made to override an ethical principle, efforts should be made to minimize the harm to the offended ethical principle. Consequently, when psychologists decide to override the autonomy of their child patients, they should nonetheless take reasonable steps to minimize harm to the offended ethical principle. For example, they may allow the patients some control over the manner in which the disclosure to their parents is made. The adolescents could choose whether their psychotherapists disclose the information themselves, or if preferred, the psychotherapists could schedule a family session where the behavior is discussed with all parties present.

Other confidentiality concerns may arise when treating children. The person who is legally allowed to consent to treatment must sign the release of information form. Even when parents control the course of psychotherapy, it sometimes may be clinically indicated to ask a mature minor to also sign a release of information form. While it would be legally meaningless, it communicates a respect for the patient's autonomy.

The treatment of adolescents, like younger children, often requires coordination of services with schools, probation departments, or other agencies. Consequently, psychologists may need to communicate with a wider number of parties than they would when treating adults. Even if consent is not legally required from adolescents, it is often therapeutically wise to review with the adolescent the nature of the information that is to be shared.

CASE EXAMPLE: A PSYCHOLOGIST WITH FORESIGHT

A psychologist needed to send information to the probation officer of an adolescent patient. Although the patient was doing well, the psychologist was aware of the sensitivity of the issues that were being discussed. Consequently, the psychologist shared a near final draft of his letter to the probation officer with the adolescent patient. This action helped to ensure the trust of the patient and the accuracy of the information sent out.

Confidentiality With Adults With Serious and Persistent Mental Illnesses

Patients with serious and persistent mental illnesses present unique ethical challenges for psychologists. Although the patients may be adults, they often depend on their parents or other relatives for caretaker services. Their effective treatment usually requires contact with a treating psychopharmacologist and the family members who are in a caretaker role.

The rules of confidentiality apply to these adults as they do to other patients, and it is advisable to get a patient's permission before talking to family members. Very often these family members already have been involved in their relative's psychotherapy and would be a regular part of a psychotherapist–family dialogue anyway. Except in rare circumstances, such as psychiatric emergencies, the psychologist should work cooperatively with the patients to ensure that they share common goals concerning the paths to recovery, including the extent to which family members or other health professionals are involved in their treatment (see Chapter 6).

PRIVILEGED COMMUNICATIONS

Privileged communication is a legal term that allows patients to prevent information from being introduced into courtroom proceedings under certain circumstances. Although some privileges were developed through common law (i.e., the judge-made legal tradition that is part of the Anglo American legal heritage), most privileged communication laws are now based on state statutes (i.e., laws passed by state legislatures) or federal privileged communication laws (adopted by the U.S. Congress and interpreted by the Supreme Court of the United States).[1] Privileged communication statutes run counter to the common law tradition that courts need to have access to all relevant information to help them make accurate decisions. Consequently, most courts interpret privileged communication laws strictly because they are reluctant to exclude evidence relevant to the issues before them (Knapp & VandeCreek, 1987).

Most legal scholars justify privileged communication laws on utilitarian grounds. They may argue, for example, that society benefits when privacy is ensured in the psychologist–patient relationship because marriages are more likely to be saved, suicides are more likely to be prevented, and mental illnesses are more likely to be treated successfully. Although some information is lost to the courts when privilege laws are present, that loss is counterbalanced by the overall benefit to society (Knapp & VandeCreek, 1987).

[1]State privileged communication laws apply to state courts, which adjudicate cases involving state laws. Federal privileged communication laws apply to federal courts, which adjudicate cases involving federal law or litigation between citizens of different states.

All states have privileged communication statutes for attorney–client, husband–wife, clergy–penitent, and psychologist–patient relationships. Most states have a social worker–client privilege, and some states have privileged communication laws for family, sexual abuse, domestic abuse, and mental health counselors as well. Many states have physician–patient privileges, although these are often limited in scope.

Most of the legal cases in which psychologists become involved occur in state courts where state law determines the admission of evidence, including the rules for privileged communication. Federal courts are also required to accept a psychologist–patient privilege (*Jaffee v. Redmond*, 1996).

Privileged communication statutes only apply to information acquired within a professional relationship. Casual conversations between acquaintances, business contacts, or friends are not privileged. The patient, not the psychologist, owns the privilege. That is, the patient or the patient's legal representative decides when to invoke or waive the privilege. Psychologists do not have the legal standing to waive the privilege against the wishes of their patients, and they may only invoke the privilege on behalf of their patients when patients are not aware of the desire to access their records. Psychologists may not invoke the privilege against the expressed wishes of their patients.

Patients or their representatives may waive their privilege whenever they choose. In addition, patients automatically waive their privilege if they enter their mental health as an issue in court, such as through a psychological malpractice claim, a personal injury case with claims for emotional damage, or an insanity plea. The privilege does not apply to court-ordered examinations (Knapp & VandeCreek, 1987).

Once parties waive their privilege, they waive it completely. In malpractice suits against psychologists, for example, patients may not enter selected facts about their mental health that would help their cases but then try to withhold other facts that would hurt their cases. In sum, they cannot use privilege as both a shield and a sword.

Subpoenas

A *subpoena* is a request for documents usually filled out and served by the attorney seeking the information. Sometimes attorneys use a record-copying service to secure those documents. Often subpoenas are expected. Psychologists may know that their patients are in litigation, and they may have talked about the case (and their potential testimony) ahead of time. At other times, the subpoenas are unexpected. They may come from an attorney representing a party with interests adversarial to those of the patient, or the patient may have left psychotherapy several years ago and the psychologist has no information about the lawsuit.

Psychologists who receive a subpoena need to talk with their patient and the patient's attorney to learn how to proceed. If patients want to enter their records into court, then psychologists need to obtain a release from their patients before

sending the records. Before obtaining that release, however, psychologists need to be frank about the general contents of the records or what they would say if called into court. It is better for their patients and their patients' attorney to know this information before the records are sent out. Perhaps the patients and the patients' attorney will determine that the information will harm their case and will withdraw the request for information, or they will modify their complaints so that the patients' mental health is no longer an issue in litigation.

CASE EXAMPLE: A STRESSFUL ENCOUNTER

A psychologist received a subpoena from an unknown attorney about a patient she had seen several years earlier. The psychologist called the attorney to say that she did not have an authorization from the patient and could not release the information. The attorney angrily responded that the subpoena was valid, the psychologist had an obligation to send the information, and failure to do so could result in contempt of court charges.

Situations like this were once common, although less so today. Here, the attorney was giving the psychologist inaccurate information. A subpoena from an attorney does not override the statutory rights of the patient to confidentiality. In these situations, psychologists may feel at a disadvantage because they do not have the legal expertise of attorneys and may feel intimidated by the confrontational style of some attorneys. Nonetheless, psychologists have the responsibility to understand their legal obligations. If the psychologist had sent the records in response to the subpoena without permission from the patient, then the psychologist would have committed an ethical violation. In this case, the psychologist only had the obligation to acknowledge the receipt of the subpoena and the reason for noncompliance.

At times the records of the psychologist contain information that is potentially embarrassing to the patient or is irrelevant to the case before the court. In those situations, the patient's attorney can ask the judge to review the records *in camera* (i.e., in the judge's chamber, outside the view of the parties) and remove portions of the records that are not directly related to the question before the court. However, there is no guarantee that the judge will agree to that arrangement.

Court Orders

A court order differs from a subpoena in that a judge signed it. Psychologists must comply with a court order and turn over information or testify, depending on the request. However, if the psychologist believes that the court order violates a privileged communication law or otherwise harms a party unnecessarily, then the psychologist may ask the judge to reconsider the order.

CASE EXAMPLE: A CAUTIOUS PSYCHOLOGIST

A court ordered a psychologist to present information on his psychotherapy sessions with a child under the protection of children and youth services. The psychologist wrote a respectful letter to the judge noting that they would comply with the order of the court if necessary but asked the judge to reconsider the court order. They briefly described why the disclosure of this information would not be in the best interests of the child. The judge rescinded the court order because she believed that she could get the essential information from other sources.

Chapter 10 covers information on protecting copyrighted test information in response to a court order.

RECORD KEEPING

Records remind psychologists of what has happened in the past. Often the very process of writing notes helps psychologists to clarify their perceptions of a case. Records also justify the medical necessity of treatment to third-party payers (although the HIPAA Privacy Rule has placed substantial limits on the access of health insurers to psychotherapy notes). Furthermore, records provide useful information about treatment if the patient transfers to another health professional, are a source of data for archival research, and can protect the psychologist in the event of a charge of negligence. A common axiom in risk management is that if it is not written down, it did not occur. Courts tend to give great deference to psychotherapy records and will assume that whatever is recorded in them is accurate.

Psychologists vary in the level of detail in their records. Some psychologists keep minimal notes. Sometimes they use a predetermined format that includes a checklist of possible symptoms (e.g., anxious, depressed, angry) with space for two or three sentences. Checklists can remind psychologists of factors to look for when interviewing patients, and checking a box is quicker than writing the symptoms out. On the other hand, when psychologists have checked a box, they have indicated that the patient has a symptom, and this may incur an obligation to make this symptom a focus of treatment or otherwise explain why it was not a focus of treatment.

Other psychologists write several sentences describing their perceptions of the salient events in psychotherapy. Still other therapists use a narrative approach but deliberately link the events in psychotherapy to treatment goals and include behavioral descriptors when possible. Psychologists also vary in the number of records that they keep. Some psychologists keep one set of records; other psychologists keep two sets. The diversity of record-keeping styles becomes more complex by the fact that psychologists often use the terms for records inconsistently (e.g., referring to a clinical record without defining what that term means).

We urge psychologists to make their decisions about the record-keeping methods in a manner that is consistent with patient needs and contractual or other obligations. Psychologists who have contracts with insurers or managed care companies typically have agreed to follow that company's documentation standards. Insurers may sometimes audit records for quality assurance purposes or because a patient has filed a complaint with them about the quality of services, and they will notice the extent to which psychologists followed the record keeping standards.

Psychologists who work outside of third-party reimbursement can maintain adequate records by following the recommendations found in APA's *Record Keeping Guidelines* (2007).

Some psychologists who work in nursing homes or integrated care settings have found it necessary to keep two sets of notes. One set of very brief notes contains essential information that nurses or other health care professionals need to know. A second set of notes is less available to other treatment professionals and includes more detailed and sensitive information designed to meet any record-keeping requirements that the psychologist needs to follow.

Patient Access to Records

Patient access to records is controlled by both the HIPAA Privacy Rule and state law. According to the Privacy Rule, patients generally have a right to access all of the information in their records except for psychotherapy notes (see definition earlier in this chapter). However, state laws that give patients greater access to their records may preempt the Privacy Rule. Many states require psychologists to give patients access to their records, although some statutes make exceptions if the disclosure would harm the patient. Consequently, the state laws that require access to psychotherapy notes override the Privacy Rule.

Patients' requests to view their records often represent hidden clinical questions and concerns. The patient may wonder, "What is wrong with me?" or "What does my therapist think of me?" For this reason, many information requests can be reframed to explore the motivation for the record request. If the records are written precisely and sensitively, it will often be clinically acceptable or even desirable to show them to the patient. It may be an opportunity for the psychologist to engage patients more fully in the treatment process and focus them on treatment procedures and goals.

CASE EXAMPLE: A USEFUL DECISION

A patient requested that she receive a copy of her psychotherapy notes. The psychologist agreed to give her a copy but first read the note from the last session aloud to her, so she could get a general sense of what is typically contained in psychotherapy notes. They then engaged in a productive discussion of why the patient wanted to see the notes.

For most patients, the content of the psychotherapy notes should contain few surprises, because psychologists and patients should be openly discussing the goals and methods of treatment well ahead of time. Under some circumstances, however, it may be contraindicated for patients to see their records. If these patients insist on seeing the records, then the psychologist may attempt to balance respect for patient autonomy with nonmaleficence. For example, if the patient agrees, the psychologist may honor the request for information (without showing the patient harmful information) by writing a summary of the records, using lay terms. Usually, but not always, this will satisfy the patient.

If the decision is made to show the records to a patient, then it is desirable that the patient review the records with the psychologist present. Patients may misconstrue the technical terms found in the records unless the treating psychologist is there in person to interpret or translate.

Record Retention and Disposal

State and territorial licensing boards or state laws usually determine the length of time to keep records. In those few states or territories where the time period of retaining records is not explicit, APA recommends keeping adult patient records for 7 years after the last service contact; for minors, records should be kept for 7 years or 3 years after the minor reaches the age of majority, whichever is later (APA, 2007). After that time has expired, psychologists may legally destroy their records. However, psychologists may want to keep some records longer. Psychologists may need older records if they are the target of a malpractice suit or a complaint before a licensing board. Although the statute of limitations on a malpractice suit varies from state to state, it is typically 2 years or 2 years after the patient turns 18 years of age. Furthermore, some patients may have legitimate needs for old records. For example, a patient with a serious developmental disability may need old records to demonstrate the lifelong history of that disability.

Psychologists should take reasonable measures to protect their records in anticipation of retirement, disability, or death. Ideally, the retired psychologist can handle requests for records as they arise. In the event of death, the records can be given to a colleague who can handle those requests. Unfortunately, situations have occurred in which grieving spouses either have given out records without verifying the status of the individual asking for a copy of the records or have refused to give out records even when the patient had signed a valid authorization.

For records that legally cannot be destroyed, psychologists or their executors can write a letter to the last known address of patients, informing them that the psychologist has retired or died and that they may request that the records be sent to another health care provider of their choice or that the records will be destroyed after a specified period of time, consistent with state law.

Many psychologists plan for the disposal of their records upon their death or disability by specifying what is to be done with their records in a document, sometimes called a professional will. This document can specify where records

are kept, how long they should be kept, and who should maintain custody of them, including access to passwords and digital account information (Lustgarten et al., 2020).

Before the age of computers, issues of record storage were relatively straightforward in that psychologists needed to keep their paper files in a safe location, such as in a locked file in a locked room. However, electronic record storage raises its own questions concerning security. It is difficult to establish hard and fixed rules concerning security in a technological world that is continually changing. Nonetheless, we encourage psychologists who store records electronically to review the security of electronic storage mechanisms carefully. Some psychologists store records in the "cloud" using companies that provide HIPAA compliance, tight security, encryption of information, and backup provisions, encourage strong passwords, and take other measures to protect the confidentiality of the information, such as training staff in good "cyber hygiene." Although hackers generally target large hospital systems, we have known some health care professionals (including one psychologist) with small practices who have had their records held for ransom by cyber hackers.

Content of Psychotherapy Records

Many state and territorial licensing laws and regulations establish minimum record keeping standards, although they typically leave much discretion to the treating psychologist. In the absence of regulations from the state or territorial licensing board, psychologists should follow APA's record keeping guidelines (2007). These standards provide the ethical floor for psychologists but give little direction on the content of the records.

CASE EXAMPLE: A CHALLENGING PATIENT

A patient agreed to enter psychotherapy only if the psychologist agreed to take no notes. The patient explained that he was involved in litigation and was afraid that something he said eventually could be used against him. The psychologist refused and explained the legal requirements and benefits of keeping notes. The patient then asked the psychologist to promise that the notes would never be released. Again, the psychologist refused, noting the exceptions to confidentiality, which are rare but nonetheless do exist.

The psychologist acted appropriately in refusing the patient's request to not take notes. In addition to being a legal requirement, properly kept notes promote the quality of care and protect the psychologist. The psychologist also acted appropriately in refusing to give a blanket guarantee of confidentiality. Although confidentiality protections are strong, they are not absolute, and the psychologist could not promise what kinds of situations (e.g., child abuse, duty to warn or protect) might occur in the future that could create an exception to confidentiality.

To a large extent, the content of psychotherapy records is determined by the nature of the clientele, type of work, and the theoretical orientation of the psychologist. However, the content may also be influenced by the requirements of third-party payers, such as Medicare, Medicaid, or commercial insurers. Nonetheless, we suggest that good records be comprehensive, objective, consistent, retrievable, and securely stored. Comprehensive records include the elements found in the APA record-keeping guidelines or required by state laws generally include: the name of the patient; fee arrangements; dates and substance of each service event, including test results; results of formal consultations; correspondence; release of information (i.e., authorization) forms; copies of reports; notations of phone calls and other therapeutic contacts; and any documentation required by the HIPAA Privacy Rule (if applicable).

Psychologists should document or include in the record any clinically relevant electronic communication from a patient. It is probably not necessary to include or store a routine email from a patient noting that they expect to be 5 minutes late for the appointment (although one could imagine a situation where a patient was routinely late and the communication was part of a pattern that should be noted). However, psychologists should document or keep text messages, emails, or other communications that have clinical relevance. Some psychologists keep a copy of the patient's email in a computer file on their hard drive.

Ordinarily, psychologists are advised to attempt to secure previous treatment records of patients. Good records include the patient's diagnosis (or presenting problem), the treatment plan, and how those determinations were made. Generally, psychologists who read past records better understand the nature of the presenting problem and prior treatment.

However, some patients will present seemingly good reasons for refusing to allow the release of past records, such as past abuse on the part of the previous psychotherapist. At times these reports by a patient may be accurate, but they also may represent falsehoods designed to hide an accurate report of the patient's past manipulative behaviors. Reports by patients of past misconduct by previous psychotherapists should not be a barrier to attempting to retrieve the records. Even if the patient's report of abuse is accurate, the records of previous psychotherapists may still contain some useful clinical information.

Comprehensive records also record the significant events in treatment as well as the psychologist's process of ethical decision making. For example, it is important to document high-risk situations carefully, such as when the psychologist suspects child abuse, a patient threatens violence toward others, or serious boundary problems emerge during treatment. Prudent psychologists establish a standard procedure for assessing the clinical situation with life-endangering patients. When a patient threatens a third party, for example, it is desirable to record the assessment of the likelihood of the threat and to include reasons why it should or should not be considered imminent. Chapter 9 reviews this topic in more detail.

CASE EXAMPLE: GOOD INTENTIONS, BAD OUTCOMES

A psychologist acted on the presumption that the less written about a patient, the better. She mistakenly believed that detailed records would compromise her patient's confidentiality and could be used against her in the event of a charge of negligence. Consequently, she kept skimpy records that primarily repeated a set of 10 or 15 stock phrases such as "patient feels better" or "relevant concerns were discussed."

This psychologist misunderstood the purpose of psychotherapy records. On the whole, the more details, the better, as long as these details promote the care of the patient and risk management system of the psychologist.

Conscientious psychologists strive for objectivity in their records, although the psychotherapeutic process is in and of itself subjective. Psychologists should show sensitivity in what they place in patient records, exclude any gratuitous remarks, and use behavioral descriptions whenever possible. Although the records belong to the psychologist, patients may have a right to see them under the laws of some states. Consequently, psychologists should create records with the expectation that the patient will see them someday. Pejorative remarks, if seen by the patient, could provoke anger or a perception of the psychologist as uncaring or insensitive.

Psychologists should strive for internal consistency in their records. That is to say, the records should chronicle that the treatment plan is being implemented as intended. Of course, psychologists can change their treatment plan or diagnosis. Patients commonly change their treatment goals over the course of treatment as new information comes to light, or they are better able to articulate their goals. However, psychologists should document these changes. Psychologists may comment on previous notes and include clarifications, but under no circumstances should they alter or destroy a previous note.

Finally, records should be retrievable, which means readable (at least to the writer). Although it is not unethical to be inefficient, a good filing system saves time and reduces the risk of losing a record or part of a record. This means more than just placing charts in alphabetical order; it also means having a specific location in every chart (or a specific paper color) in the chart for intake forms, release of information forms (authorizations), psychotherapy notes, and other information.

USE OF INFORMATION FOR DIDACTIC PURPOSES

Standard 4.07, Use of Confidential Information for Didactic or Other Purposes, permits psychologists to use information about patients for didactic purposes (e.g., professional writings, teaching) if the consent of the patient has been

obtained or if the identifiable information has been removed. Although the letter of the APA Ethics Code can be met if the patient's identity is disguised, psychologists need to be sensitive to the potential impact of the writing on patients, who may, for example, believe that the psychologist did not adequately disguise their identity. It may be relatively easy to disguise very short vignettes, but it becomes harder to disguise detailed case studies. For that reason, some writers have created composite vignettes based on the experiences of many individuals. Also, patients may feel hurt or offended by the description contained in the writing.

Fischer (2012) urged psychologists to involve patients in the process of creating didactic vignettes as much as possible, including ways to protect their confidentiality and ways to phrase the descriptive wording about them. She noted that clients who are consulted about the process almost always cooperate and appreciate the respect shown to them.

A psychiatrist described his experience of writing about a patient with Asperger's syndrome (now considered part of the autism spectrum; Brendel, 2003). The psychiatrist had exaggerated the Asperger's qualities to emphasize certain features unique to that syndrome. The minimal ethical imperatives had been met (i.e., the patient had given consent and his identity had been adequately disguised), but when the patient read the article written about him, he "reacted with horror and dismay" (Carter, 2003, p. 97) at the descriptions given of him. Much to his credit, the psychiatrist worked closely with the patient to ameliorate the damage and the anger. He also used his experiences to write about what he had learned (Brendel, 2003), and the patient, writing under a pseudonym, also wrote about the experience from his standpoint (Carter, 2003).

9

Life-Endangering Patients

Virtually every professional psychologist will encounter patients who threaten, attempt, or die from suicide. Psychologists may also encounter patients who threaten or actually harm identifiable third parties, including their spouses or children. Some threaten the psychologists themselves. Leitzel and Knapp (2021) found that, in 2020, 6% of psychologists reported that they had at least one patient die from suicide and 29% had at least one patient attempt suicide while in treatment. These can be some of the most upsetting events in a psychologist's career (e.g., Sandford et al., 2021).

The overarching ethical principle of general beneficence compels psychologists to act to protect third parties from patients who threaten them. Also, the principle of beneficence compels psychologists to act to protect patients who threaten themselves or identifiable third parties, under the assumption that assaulting others harms the perpetrators as well as the victims. Finally, the principle of nonmaleficence compels psychologists to protect the lives of their patients from self-harm. Because of the high stakes involved, the principles of general beneficence, beneficence, and nonmaleficence may temporarily override respect for patient autonomy.

Risk management or quality enhancement principles become especially important when dealing with life-endangering patients. Patient suicides or deaths by patient assaults are rare but high-impact events. Often the death of a patient or a third party will precipitate a malpractice suit. Consequently, psychologists should pay close attention to risk management or quality enhancement

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principles when working with life-endangering patients. That is, they need to be competent (i.e., know how to treat patients with life-endangering features and how to document their interventions clearly) and sensitive to the welfare of both patients and third parties. They need to know the relevant laws in their state, and they need to keep their emotional balance to avoid impulsive decisions. The last factor needs a special comment. Sometimes, to reduce the substantial distress experienced by dealing with dangerous patients, psychologists may temporarily reduce their anxiety by settling on the first just-good-enough solution that occurs to them. However, a just-good-enough solution may allow too much room for error in a life-endangering situation.

The American Psychological Association's (APA's; 2017a) *Ethical Principles of Psychologists and Code of Conduct* (APA Ethics Code) says little about life-endangering patients except to permit exceptions to confidentiality if necessary to protect others. Most of the guidance in this area comes from state statutes or malpractice court decisions (Benjamin et al., 2009). For example, whereas many states have statutes or precedent-setting court cases that require psychologists to warn or take protective action when a patient presents an imminent danger to harm an identifiable third party, a few states expressly prohibit psychologists from warning others. Courts have established the criteria for evaluating psychologists who were allegedly negligent in treating patients who later killed themselves.

In addition, all states have statutes that require psychologists to report suspected child abuse. Many states have statutes that require or permit psychologists to report the abuse of older adults or vulnerable adults (e.g., adults with severe and pervasive mental illnesses or severe intellectual disabilities). A few states require psychologists to report impaired drivers. The Health Insurance Portability and Accountability Act's Privacy Rule (HIPAA; U.S. Department of Health and Human Services, 2002) does not override state laws that permit or require exceptions to confidentiality to prevent harm to others.

In this chapter, we review the responsibilities of psychologists when dealing with patients who are at risk of harming themselves or others. For each of these areas, we describe the applicable standards and recommend courses of action for psychologists. We use the five-step model for determining the optimal response (see Chapter 4) and introduce ethically based quality enhancement principles based on the Harris-Younggren model of individualized risk management (Knapp et al., 2013).

AGGRESSIVE PATIENTS

The review of the ethical responsibilities of psychologists dealing with life-endangering patients begins with the 1976 *Tarasoff* ruling by the California Supreme Court (*Tarasoff v. Regents of the University of California et al.*, 1976). Subsequent court decisions have similarly considered the legal responsibilities of psychotherapists when their patients present an imminent danger to inflict

serious physical harm on identifiable others. To clarify the responsibilities of psychotherapists, numerous state legislatures have passed duty-to-warn or duty-to-protect statutes that instruct psychotherapists on what they must, must not, or may do when treating dangerous patients (Benjamin et al., 2009). In other states, it is the courts that have established the duty to warn or protect laws.

Psychologists who are practicing across state lines using telehealth must follow the laws where the patient is physically located. Consequently, differences in state duty to warn or protect laws become important. So, for example, the law in one state may require psychologists to warn or act to protect when an identifiable third party has been threatened. However, the law in another state may require psychologists to warn or act to protect when an identifiable class or group of people (e.g., "those neighbors of mine" or "the people at the school I used to attend") have been threatened.

The Facts of the *Tarasoff* Case

More details on this tragic event can be found by reading the actual civil case or an account by Blum (1986), which included some fictionalized dialogue but is otherwise accurate. Only the essential facts are presented here. Prosenjit Poddar, an exchange student from India, was attending the University of California, Berkeley, when he met and fell in love with Tatiana Tarasoff. When she did not return his affections, Mr. Poddar deteriorated mentally. A friend strongly encouraged Mr. Poddar to seek treatment and even accompanied him to his first psychotherapy appointment with Dr. Lawrence Moore at the university counseling center. During a session in August 1969, Mr. Poddar confided to Dr. Moore his intent to kill Ms. Tarasoff when she returned from Brazil. The psychologist took the threats seriously and asked the campus police to involuntarily commit Mr. Poddar.

The campus police interviewed Mr. Poddar but did not commit him because he appeared rational and promised to avoid Ms. Tarasoff. Mr. Poddar discontinued psychotherapy after the failed commitment attempt. Subsequently, Dr. Moore's supervising psychiatrist ordered him to destroy his psychotherapy notes and instructed him to make no further attempts to commit Mr. Poddar. That fall, Ms. Tarasoff returned from Brazil unaware of the danger to her. On October 27, 1969, Mr. Poddar went to Ms. Tarasoff's house, shot and stabbed her repeatedly, and killed her.

The *Tarasoff* Decision

Ms. Tarasoff's parents initiated a wrongful death suit against the Regents of the University of California, the treating psychologist, the supervising psychiatrist, and the police officers who were involved in the abortive commitment attempt. The court concluded that the defendants were not liable for the failure to commit Mr. Poddar. The court noted the California statute that exempts public

employees from liabilities for injuries resulting from decisions to release psychiatric patients. The defendants, however, were liable for their failure to warn Ms. Tarasoff of the danger to her or to protect her.

Although the court noted that determining dangerousness is difficult and confidentiality needs to be given a very high priority, it held that the difficulty in predicting dangerousness does not remove the obligation to protect others when such a prediction is made. The court clarified that psychotherapists are not required to issue a warning every time a patient reveals an urge or fantasy to harm someone. Instead, psychotherapists need to establish the degree of dangerousness, using the standards of the profession to do so. For the duty to protect or warn to arise, the psychotherapist needs to identify the victim and to determine that the threatened harm is substantial and imminent. Identifiable means that the psychotherapist should be able to identify the intended victim "at a moment's notice." It does not require the psychotherapist to do investigative work to ascertain the identity of the victim. The harm must be substantial, meaning that the danger to life or health is more than transitory discomfort or pain. Imminent harm is harm that is likely to occur in the near future, absent some intervention. Of course, no court can anticipate all possible situations and any psychotherapist can envision some middle or borderline situation where they need to use their judgment in determining how substantial or how imminent the danger might be.

Although it has sometimes been phrased in terms of a "new" legal duty, the *Tarasoff* case actually applied old legal principles regarding tort liability and negligence to a new context. The tradition within Anglo American law does not require one person to come to the aid of another. However, that tradition has made exceptions for "special relationships" or public callings, such as innkeepers, who have an affirmative duty to protect their guests, or public carriers, who have a duty to protect their passengers.

Later, courts expanded the concept of "special relationship" to psychiatric hospitals, which have a duty to use reasonable care to prevent the escape of dangerous patients. In addition, physicians are liable to third parties if they negligently fail to diagnose contagious diseases or if they diagnose the disease but negligently fail to warn foreseeable recipients of the infection. According to the *Tarasoff* case, the psychologist had a special relationship with Mr. Poddar, which created the obligation to act to protect an identifiable victim. The Tarasoff decision simply took the traditional idea of a "special relationship" and applied it to an outpatient psychotherapist.

Legal and Ethical Requirements When There Is Imminent Danger to Third Parties

The legal requirements under the *Tarasoff* case appear consistent with conclusions that could be reached through principle-based ethical decision making. Professional psychologists generally respect patient autonomy and acknowledge patient control over the direction and major events of psychotherapy. However,

under rare circumstances, such as when a patient presents an imminent danger to harm others, psychologists may have to consider whether to temporarily invoke the principle of general beneficence (and perhaps break confidentiality and notify an intended victim) to override the principle of respect for patient autonomy.

Using the process of balancing ethical principles described in Chapter 4, psychologists can ask themselves several questions before deciding to override a prima facie ethical principle. Applying those questions to a homicidal patient, psychologists should ask themselves, "Will breaking confidentiality have a realistic chance of protecting the life of the third party?" "Is there any other alternative to breaking confidentiality?" "How can I infringe on confidentiality as little as possible to ensure the safety of the patient?" and "Can I minimize the harm caused by the breach of confidentiality?"

Psychologists can minimize the infringement of autonomy and maximize the involvement of patients by selecting interventions designed to reduce the likelihood of harm to others. For example, if the desired intervention requires notifying the intended victim, then the psychologist can ask the patient, "How should we go about ensuring that you will not harm this intended victim?" "Would it be helpful if I cautioned them to stay away from you?" and "Do you want to be present when I share the information?" When speaking to the intended victim directly, the psychologist should give only the minimal amount of information necessary to achieve the goal.

However, the desired intervention may include options other than breaching confidentiality. Depending on the circumstances, interventions could include a voluntary hospitalization, an increase in the frequency or duration of outpatient appointments, or the involvement of a family member who might be able to diffuse the situation. Of course, in some cases, no one can predict the optimal manner to respond. As consultants, we have encountered situations in which the clinical realities did not fit nicely with the general rules delineated in this section. The following section contains clinical recommendations that could help psychologists with practical issues that arise from the duty to warn or protect.

Regrettably, some state laws require certain actions (e.g., warning an intended victim) to ensure immunity from liability even when these actions do not appear to represent the best course of action. For example, the law may require a psychologist to report a threat made by a patient, even if the likelihood that the patient would act on the threat is minimal or nil. Such laws place a burden on psychologists to justify why they took an action that state law did not specifically identify (Benjamin et al., 2009), and represent the bad law, bad social science, and bad policy referenced by Bersoff (2014). They harm the treatment relationship while doing nothing to protect the public.

The Five-Step Model Applied to Aggressive Patients

When faced with a decision on how to protect a third party, psychologists can use the five-step decision-making model.

Step 1: Identify or Scrutinize the Problem

In duty-to-warn-or-protect situations, the basic ethical conflict is between general beneficence and respect for patient autonomy. That is, the psychologist has the sometimes incompatible obligations both to protect the public and the welfare of patients who are likely to act aggressively and to respect the autonomy of patients to make their own decisions.

From a practical standpoint, the clarification of the first step hinges on the determination of dangerousness by the psychologist. The assessment of dangerousness is an ongoing process, not a one-time event. From the first session in which patients express an intent to harm another person, psychologists should inquire about and keep alert for signs that violence may occur. They need to assess the patient's violent ideation, intent, plans (if any), and the means and opportunity for the violence to occur (Wortzel et al., 2020). Typically, patients threaten a specific person, usually a family member, former lover, or other acquaintance, although sometimes patients may threaten a group or class of people.

Although no formula can predict dangerousness with great accuracy, actuarial, historical, and clinical information can guide psychologists in their decision making. For example, Swanson et al. (2002) found that past exposure to violence, violence in the surrounding environment, and substance abuse were associated with violent behavior among persons with serious mental illness. When all three risk factors were present, the risk of violent behavior increased substantially. Subsequent studies have confirmed that alcohol misuse increases the risk of aggression (e.g., Jones et al., 2022), and aggression is more likely to occur among persons who have problems in self-regulation or who hold beliefs that make violence acceptable (Stefanile et al., 2021). Of course, psychologists also need to consider contextual factors that could increase the risk of violence (e.g., recent negative life events) and factors that could decrease the risk of violence (e.g., strong ties to one's family or community; E. Johnson & Moyer, 2021).

Although the duty to warn or protect usually conjures up images of a patient threatening a nonfamily person, most of the violent patients encountered by psychologists threaten current or former lovers or family members. In that sense, the *Tarasoff* case is a good exemplar because it dealt with violence that occurred as a consequence of a failed romance. Nearly one out of four women and one out of 10 men have experienced physical or sexual violence from a partner sometime in their lives and many have also experienced psychological abuse. About one third of women and one tenth of men who experienced partner violence sustained a physical injury (Centers for Disease Control and Prevention, 2022). Consequently, psychologists should be alert to the presence of domestic abuse, routinely include questions about partner abuse in intake interviews (e.g., "Do you feel safe in your home?"), and be prepared to respond clinically when abuse is identified.

In most domestic abuse situations that psychologists encounter, the spouse has already been assaulted or threatened directly. However, that spouse may

not be aware of the severity of the danger or the fact that women who leave their abusive partners are at an increased risk of being harmed (Riggs et al., 2000). Consequently, a psychologist may need to warn the intended victim of the increase in danger even if the victim has already been threatened directly. For example, in *Emerich v. Philadelphia Center for Human Development* (1998), a patient threatened to kill his girlfriend if she attempted to move her belongings out of their apartment. The psychotherapist cautioned the intended victim over the phone not to return to their apartment, but she ignored the warning and was subsequently killed. The allegation in the subsequent suit was that the warning was not adequate. The court, however, exonerated the psychotherapist from any liability because it determined that the warning to the intended victim was sufficiently explicit.

CASE EXAMPLE: A THOROUGH PSYCHOLOGIST

A psychologist accepted a couple into therapy. According to his standard practice, he initially interviewed each partner separately. The wife initially denied any abuse. However, the psychologist followed up with specific questions about the manner in which they handled their disagreements. The questions gradually elicited more and more detail, such as the presence of pushing, threats, and thrown objects. The wife, who had grown up in a household with extreme violence, did not interpret pushing or throwing objects as "abuse" and emphasized that her husband never punched or choked her.

The psychologist understood that some abused individuals may deny the presence of abuse out of embarrassment, a desire to protect their partner, or an idiosyncratic definition of what constitutes abuse. If the psychologist had not followed up carefully, he might have missed an important aspect of their marital conflict.

Step 2: Develop Alternatives or Hypothesize Solutions

Step 2 in the five-step model considers options likely to reduce the danger. When danger to others is imminent, decisions about the treatment plan can focus on incapacitating the patient (e.g., through a hospitalization), hardening the target (e.g., through warning the intended victim), or intensifying treatment (Monahan, 1993). As much as possible, it is desirable to involve the patient in considering treatment options. Some states have statutes or case law that limit the options available in Step 2 because they do not permit warning the intended victim. In those states, the statutes limit the psychotherapists to either incapacitating the patient, such as through a hospitalization, or intensifying treatment.

Even in states that allow a full range of therapeutic interventions to diffuse the risk of harm, determining the optimal intervention can be difficult. Every situation contains unique contextual factors, and no one can give psychologists a precise decision tree to follow. Instead, psychologists must use the totality of

information available to them to make the optimal intervention. Although warning the intended victim may make sense in some situations, in other situations the warning might be unnecessary or may even precipitate the violence that the psychologist is trying to prevent.

Although common sense may suggest that notifying the police is an acceptable way to discharge duties to third parties at risk of harm, Huber et al. (2000) found that many police departments do not have experience with *Tarasoff*-type warnings or do not even have policies in place if they receive such a warning. Consequently, the ability of the police to diffuse danger may depend on the police force in one's local community.

Sometimes patients who threaten violence may qualify for an involuntary psychiatric hospitalization. However, this is rare because many violent persons do not have a serious and persistent mental illness, or otherwise fail to meet the criteria for hospitalization according to the laws of their state.

In making these decisions, psychologists need to attend to their emotional reactions. As described in Chapter 4, strong emotions may influence how psychologists will process or interpret information. Their fear that someone may be harmed may cloud their judgment. In these situations, psychologists may do well to monitor their feelings and seek consultation.

Step 3: Evaluate or Analyze Options

Psychologists may develop the optimal treatment plan through *theory knitting*, or adopting the intervention that incorporates the most advantages and excludes the most disadvantages of the options generated in Step 2.

CASE EXAMPLE: A SKILLFUL INTERVENTION

A patient made a serious threat to kill the man who had an affair with his wife. The psychologist determined that the danger was not imminent (the intended victim had learned of the threat and temporarily moved out of town) and developed a treatment plan involving marital therapy that focused on strengthening the spousal relationship. As the relationship improved, the homicidal thoughts decreased substantially.

In this situation, the psychologist was fortunate that the victim was temporarily safe (i.e., he was working out of town). The psychologist used the time wisely to focus on lifting the patient's depression and strengthening the marriage, thereby diffusing the risk of violence.

Step 4: Act or Perform

Psychologists must implement the intervention in a reasonable manner. Inadequately implemented interventions have led to tragedies. In the *Tarasoff* case, the murder occurred because the treating psychologist failed to implement the intervention as intended. The psychologist correctly predicted the danger

and developed a treatment plan (i.e., an involuntary commitment) calculated to protect the identifiable victim. The murder occurred, however, after the attempted commitment failed. The police did not follow through with the commitment, and the supervisor of the psychologist ordered him to take no further actions to protect Ms. Tarasoff.

Psychologists should attempt to involve the patient in the treatment plan as much as possible. For example, if possible, they can issue the warning with the consent of the patient or even with the patient present. Patients who participate in the decision to warn and who are informed of the need to protect an identifiable third party are more likely to continue in treatment (Binder & McNiel, 1996).

It is best to attempt to involve the patients in all decisions, if possible. For example, if a hospitalization is considered, psychologists may possibly persuade (e.g., "It is to your benefit to enter the hospital because . . .") or induce (e.g., "If you enter the hospital voluntarily, you will retain the option of signing yourself out at any time") patients to agree to the treatment plan. Psychologists should avoid threats of involuntary hospitalizations unless the danger is imminent, no other option to diffuse the danger is available, and the patient likely qualifies for an involuntary hospitalization.

If the patient is hospitalized, then the psychologist should clearly communicate the nature of the danger to the hospital and especially to the attending physician. A danger always exists that the information can be lost when multiple treatment providers (as in a hospital or nonhospital residential facility) are involved. For example, the emergency room personnel may not convey the severity of the dangerousness to the attending physician (VandeCreek & Knapp, 2001).

Most of the time when a warning is made, the intended victims had already suspected danger to themselves (Binder & McNiel, 1996). Typically, the potential victims expressed appreciation and an intent to modify their behavior. Some, however, denied the danger. In such situations, psychologists may consider sending the intended victim an email, fax, or certified letter reiterating the danger. The letter can help reinforce the verbal warning, and the paper trail documents the efforts of the psychologist to diffuse the danger.

Step 5: Look Back or Evaluate

The psychologist should continually look back at or evaluate the impact of every intervention with life-endangering patients. The psychologist should assess dangerousness periodically throughout the treatment process and modify the treatment plan as the clinical realities and external circumstances of the patient change (e.g., the patient is noncompliant with the original treatment plan). A program of intensive outpatient treatment may be sufficient to fulfill the duty to protect at one point in time but not later.

Of course, at all stages of the decision-making process, psychologists need to ensure that their documentation reflects their reasoning and decision making. As discussed in Chapter 8, psychologists should document their important

decisions including the rationale for making them. In a matter similar to a good mathematics student, psychologists should "show their work" so that any third party looking at their notes could discern the reasons behind their decisions.

SUICIDAL PATIENTS

Most psychologists will treat suicidal patients during their career, and many psychologists will have a patient die from suicide sometime during their career. While the mortality rates for most leading causes of death in the United States continue to decline, the rate of suicide within the United States increased by 30% from 1998 through 2020 (Garnett et al., 2022). Losing a patient to suicide is one of the most stressful experiences that psychologists will encounter. Every practicing psychologist should have supervised experience and coursework in dealing with suicidal patients. Unfortunately, many mental health training programs, including psychology programs, traditionally offered little training in suicide prevention (Mitchell et al., 2020), although evidence suggests that psychology programs have been doing better in recent years (Monahan & Karver, 2021).

Fortunately, several interventions have strong evidence of effectiveness in treating suicidal behavior, including cognitive behavior therapy (Bryan & Rudd, 2018), the collaborative management and assessment of suicide (Jobes, 2016), and dialectical behavior therapy (Linehan et al., 2015). Acceptance and commitment therapy, mentalization therapy, attachment therapy, and other therapies also have evidence supporting their effectiveness (Calati & Courtet, 2016). Furthermore, more specific interventions such as collaboratively based safety planning (Nuij et al., 2021) and lethal means counseling (see Chapter 3; Anestis et al., 2021) are effective in saving lives as well. It is not our intent in this chapter to review all of the information that psychologists need to conduct an adequate suicide assessment or to manage such patients. Nonetheless, psychologists should know the common errors in the management of suicidal patients, including an overreliance on safety agreements, medication, or hospitalizations, and an underreliance on collaboratively based assessments and suicide-focused interventions with known efficacy.

Quality Enhancement Strategies

Psychologists can reduce the risk of an adverse outcome or a treatment failure by using quality enhancement or risk management strategies. These are based on the premise that the best risk management strategies focus on providing and documenting good patient care (Knapp et al., 2013). Some of these strategies increase the amount of information available to them and others ensure that they process this information correctly.

These quality enhancement (or risk reduction) strategies can be distinguished from *false risk management strategies* that sacrifice public or patient well-being

in an effort to deter allegations of misconduct. An example of a false risk management strategy would be to always get suicidal patients to sign safety contracts. Often the false risk management strategies are framed in absolutist terms such as *always* and *never*, leave no room for individual discretion based on unique case or context factors, and are not based on overarching ethical principles. Knapp et al. (2013) warned that "any purported risk management strategy that tells you to do something that appears to harm a patient or violates a moral principle needs to be reconsidered" (p. 32).

The four quality enhancement strategies are: (a) maximizing patient involvement (informed consent or empowered collaboration), (b) expanding resources (consultation), (c) creating good documentation, and (d) checking one's work (redundant protection). Attention to these quality enhancement strategies should increase whenever the risk of harm to the patient or the public increases or a deeply held moral principle is threatened.

Maximizing Patient Involvement: Informed Consent or Empowered Collaboration

Psychologists have an obligation to seek consent or assent from all patients (see Chapter 6). For example, they should explain the general nature of the treatment, the involvement of third parties, and any exceptions to confidentiality as required by the APA Ethics Code. However, in high-risk situations, it may be especially important for psychologists to ensure that patients are involved in treatment decisions and processes as much as possible (Knapp, 2022).

For example, when treating a patient with a high risk of harming herself, a psychologist went to great lengths to involve the patient in treatment, including soliciting her understanding of the rationale for therapeutic assignments and processes. One of the big shifts in the treatment of suicidal patients has been the movement away from restrictive interventions and toward interventions that elicit patient cooperation, such as collaboratively developed safety plans.

Sometimes, especially in the past, psychologists asked suicidal patients to sign a no-suicide, no-harm, or safety contract or agreement. The term *contract* is a misnomer; such a document is not a legal contract. Nonetheless, these prewritten agreements are written in a legalistic manner in which patients agree not to kill themselves. The problem with no-suicide contracts is that patients are not involved in their development, and they are only told what they cannot do. Also, some psychologists introduced these contracts in an aggressive manner, even though excessive efforts to get patients to sign such contracts may convey that these psychologists had more concern about their own legal liability than the welfare of their patients. Finally, no-suicide contracts have not been demonstrated to be effective in saving people's lives (Edwards & Sachmann, 2010).

Collaboratively developed safety plans represent a process based on respect for patient decision making that stands in sharp contrast to no-suicide contracts. Instead of just telling patients what they cannot do ("Don't kill yourself"), these safety plans contain recommendations to help patients manage their current

distress. Instead of being a prewritten document, safety plans are created collaboratively with psychologists and their patients (Rudd et al., 2006). Furthermore, patients can revise these plans as they wish as more information comes to light. Finally, these safety plans are highly effective in reducing suicide attempts (Nuij et al., 2021).

CASE EXAMPLE: A HELPFUL AGREEMENT

It appeared that a patient with strong suicidal ideation could be safely treated as an outpatient. However, the patient feared that some unanticipated event would cause her to slip into a deep depression and that she might harm herself impulsively. The psychologist suggested she write down instructions to herself (a safety plan) in the event that her hopeful attitude became threatened between the current and the next appointment. The patient and her psychologist created a safety agreement that included the unique words and language that the patient used in her self-talk.

A portion of the brief safety agreement read as follows:

> Sometimes when I feel depressed and suicidal, I forget about the hopeful attitude that I have now. When I start feeling that way, I need to read this reminder. I can calm myself by listening to Taylor Swift, journaling my thoughts and feelings, or I can call mom or my friend S (555-555-1212), and if that doesn't work, I can always call my psychologist (555-555-1234), National Suicide Prevention Lifeline (988), or the local crisis line (555-555-9999).

The psychologist made three copies of the safety agreement (i.e., one for her office, one that the patient kept in her room, and one that the patient put in her book bag). The patient also purchased a "hope bracelet," which she wore to remind herself that her hopeful attitude would eventually come back.

Expanding Resources: Consultation

Of course, it is desirable that psychologists deliver all professional services competently. However, when psychologists are in the middle of treating an actual patient, they seldom have enough time to find what is needed through reading or continuing education. Instead, seeking consultation appears to be the optimal manner to identify blind spots in one's thinking, gather more information, or receive different perspectives to help the patient. Psychologists can also use the consultation to help them take a step back and rethink or better manage their emotional reactions to a patient. Even outstanding psychologists can have second thoughts or doubts when treating a highly complex patient.

Documented consultations reflect an intention to ensure the highest possible services to patients. We cannot overstate the importance of seeking consultations in difficult situations. They are especially needed if patients are

treatment-resistant, either because they failed to respond to medications or because of deep-seated personality disorders.

In high-risk situations, the professional receiving the consultation should document the fact of the consultation and the general issues discussed. Professionals may also document their reasons for not following the recommendations given. The legal liability to the consultant is minimal, and there is usually no legal or risk management requirement for the consultant to document the contact.

Creating Good Documentation

Although documentation is always important, in high-risk situations good documentation both helps professionals think through a clinical problem and provides evidence of thoughtfulness in the event that the decisions of the psychologist ever come into question. As noted in Chapter 8, psychologists should explicitly document the decision-making processes they used to identify suicidal tendencies or how to treat them.

A brief note that reads "the patient is suicidal" or that simply includes an undefined phrase such as "suicidal gesture" may confuse more than it enlightens. The reader would not know if the patient threatened suicide, attempted suicide, or if the note reflected an unsubstantiated inference on the part of the writer. Instead, notes should be specific enough to guide other professionals in their treatment and patient management decisions. Instead of writing, "The patient is suicidal," it would have been much more helpful to write, for example, "The patient wrote a suicidal note and took 30 trazadone pills but was discovered by her roommate, who called an ambulance."

From a legal perspective, the general rule is, "If it was not written down, it did not happen." Defense attorneys have told us of cases that were dismissed quickly because the professionals had good records documenting the reasonableness of their decisions, which were based on the information currently available to them at the time. Conversely, we have known dedicated and caring psychologists who delivered high-quality services but had to defend themselves in court because they kept poor records.

Records should be transparent. Should it become necessary to review the work of the psychologist, the reviewers should be able to see the information that the psychologists had available and how they used it. Ideally, even if a tragedy occurred and, for example, a patient died from a suicide, a reviewer would be able to conclude that given the information that was available at the time, the psychologist made reasonable decisions. For example, if a psychologist had to decide whether or not to recommend hospitalization for a patient, then the psychologist can document why hospitalization would be helpful, document the reasons why hospitalization would not be helpful, and document what led them to the decision that they eventually made. The DAP format (*document* the data, *analyze* the data, and document the *planned intervention*) is one way to fulfill that documentation goal.

CASE EXAMPLE: AN INSUFFICIENT RESPONSE

The work of a psychologist came under scrutiny following the death of a patient by suicide. The psychologist noted that the patient made a suicidal gesture in May but never commented on the incident further or mentioned suicide in any subsequent notes. A consulting psychologist with special skills in suicidology looking at the notes commented that the term "suicidal gesture" was never defined (see Heilbron et al., 2010) and that the failure of the treating psychologist to document future conversations about suicide gave the impression that she had inadequately monitored the patient's suicidal thoughts or urges.

Checking One's Work: Redundant Protections

The phrase *redundant protections* refers to a second source of information to assist decision making. They are what one workshop participant called "the belt and suspenders" approach. Of course, conscientious psychotherapists routinely monitor the progress of their patients and are especially vigilant about high-risk behaviors. However, when dealing with life-endangering behaviors, the risk of errors must be minimized as much as possible. Other professionals working in complex systems have developed redundant protections to prevent mistakes. Surgical teams use checklists to ensure that all necessary activities and precautions have been taken. Airplane crews double-check systems before they take off. Cruise liners have lifeboats and safety drills if problems occur.

As applied to psychological services with suicidal patients, examples of redundant protections include checklists, brief satisfaction surveys, outcome measures, contacts with other health care professionals, contacts with family members or friends, or anything else that gives a second look at the quality of care. Incorporating suicidal assessment instruments or structured interviews may help identify information that could be missed otherwise (Knapp, 2020).

The supportive and sensitive watchfulness of the family can facilitate recovery as well as provide a second source of monitoring of the patient during vulnerable times. Of course, the decision to involve the family needs to be made carefully. At times, family involvement may be therapeutically indicated, but at other times it could be contraindicated. Psychologists should defer to the wishes of the adult patient concerning the involvement of the family unless the threat of harm is so imminent that family involvement appears crucial in ensuring the patient's safety.

Mental health professionals are permitted to breach patient confidentiality if, in their opinion, it is necessary to prevent imminent harm to a patient. However, breaching patient privacy could harm the psychologist–patient relationship and in the long run hinder the treatment process.

In one highly publicized case, a staff member of the university counseling center at the Massachusetts Institute of Technology (MIT) had been treating

a sophomore for depression. She declined their request that she voluntarily hospitalize herself and later killed herself through self-immolation. Her parents sued MIT for failing to notify them of the severity of her mental illness and her suicidal ideation. Her parents claimed that they did not know that she was suicidal, even though she had been hospitalized a year earlier after a suicide attempt (Sharpe, 2002). Without detailed information about the case (which never went to trial), it is impossible to know if the mental health professionals at MIT made an error in judgment. However, even if the failure to notify was an error, errors in judgment are not necessarily grounds for liability. The standard is whether mental health professionals knew or should have known that the danger of suicide was imminent and that involving the parents would have been therapeutically helpful.

Integrating the Quality Enhancement Strategies

The four effective quality enhancement strategies overlap. For example, one could argue that the process of getting information by empowering patients could be considered a redundant protection (i.e., additional source of information). Furthermore, these quality enhancement strategies may be used in conjunction with each other and may be synergistic. For example, a consultation may lead a treating professional to institute more redundant protections with a patient, modify the manner of documenting treatment, or revisit elements of the informed consent process with the patient.

PATIENTS WHO HAVE INFECTIOUS DISEASES

State laws regarding reporting infectious diseases (e.g., COVID-19, HIV/AIDS, hepatitis C virus, monkeypox) differ considerably from those regarding patients who threaten to assault others. For COVID-19, psychologists should follow the recommendations of the Centers for Disease Control and Prevention (CDC) to the extent they are consistent with state law concerning disclosures to patients who have been exposed to the virus. Given the changing nature of the disease and the medical treatments available, CDC recommendations are likely to change over time.

Some patients who are HIV positive or present with other sexually transmitted infections create a unique concern because they may engage in behaviors that place others at risk for acquiring the infection. However, some states prohibit psychotherapists from warning identifiable victims of persons who are HIV positive.

Nonetheless, psychologists can develop effective strategies to mitigate harm if they understand infectious diseases and the characteristics of patients likely to have them. For example, assessing the degree of risk requires an understanding of the infectiousness of the patient as well as detailed information on high-risk behaviors. At times, the risk may be high and the victim easily

identifiable, such as the very rare situations when infected patients state that they intend to engage in high-risk behavior with a partner who is unaware of their infectious status. At other times, convincing evidence may be lacking. The risk may be extremely low or the evidence unclear, such as when a patient with an unknown infection status but known to have frequented sex workers is having sexual relations with a live-in partner. The five-step model may help psychologists to think through their options and identify the best course of action (Chenneville & Gabbidon, 2020).

MANDATED REPORTING LAWS

Psychologists may encounter other difficult situations in which the life or welfare of patients or third parties are at risk. This may occur when treating older adults who are dangerous drivers (Knapp & VandeCreek, 2005) or when treating vulnerable adults or older adults who are being abused. Perhaps the most common situation that psychologists encounter, however, involves suspected child abuse.

Child Abuse

Every state has a child protective services law that requires professionals to report suspected child abuse. Psychologists should know how their state defines child abuse, the conditions that activate the duty to report, and how the state defines the perpetrator of child abuse. Definitions of child abuse vary from state to state, but most include nonaccidental injuries, neglect, emotional abuse, and sexual abuse. Psychologists who practice telehealth across state lines are bound by the reporting requirements in the state where their patients are physically located, even if the psychologist does not hold a license in that state.

In some states, the duty to report under the child protective services law applies only when the child victim comes before the psychologist in a professional capacity. In other words, professionals may not have a duty to report under the child protective services law if only the alleged perpetrator has come before them in psychotherapy. In other states, psychologists may have to report abuse whenever they suspect a child was abused, even if they never saw the child in their professional capacity. Privileged communications or confidentiality laws do not exempt professionals from their duty to report suspected abuse.

Most states require that mandated reporters must report when they suspect or believe that a child was abused. They need not have proof. The child welfare agency, not the psychologist, has the responsibility to determine whether abuse occurred.

State laws vary in how they define a perpetrator. In every state, the guardians or parents of the child could qualify as perpetrators under the child protective services law. Other states include teachers, babysitters, paramours of parents,

or live-in adults in the definition. However, sometimes children reveal that they were harmed or abused by neighbors or other persons who are not guardians, parents, or perpetrators under state law. Unless state laws include these individuals in their definition of a perpetrator, the criminal justice system, not the child welfare system, will process these crimes against children.

Despite the positive goals of child abuse reporting laws, they can create a barrier to effective psychotherapy if parents view their psychologists primarily as punitive agents who must report them. Patients may lose confidence in their psychologists and discontinue psychotherapy prematurely.

Psychologists can minimize the negative influence of these laws by informing patients of the confidentiality limitations before starting treatment. Also, if possible, psychologists can discuss their initial concerns with the families in a respectful and nonjudgmental manner, using understandable language and avoiding jargon. They can give the information in small pieces and check the parents' understanding of what they are saying. They can also attend to the feelings of the parents and, depending on the circumstances, they may share their own emotional turmoil in having to make the report (Magee, 2021). It may be helpful for the psychologist to explain that the reporting decision is mandated by law and that criminal penalties can follow from a failure to do so. Of course, psychologists should carefully document their interactions with families in which child abuse is suspected.

CASE EXAMPLE: AN ILL-INFORMED PSYCHOLOGIST

A highly motivated patient revealed that he had physically abused his son several years earlier. On hearing this, the psychologist immediately reported the patient to child protective services.

The psychologist in this example was not aware that the standards for physical abuse in his state required that the abuse had to have occurred within the last 2 years. The report was unfounded, and the patient never returned for treatment. The failure to know the law in his state caused the psychologist to report behavior that should never have been reported. In this example, as in other situations, ignorance of the law can be costly.

Impaired Drivers

Psychologists may encounter older patients who are losing the ability to drive safely. Although only a few states mandate psychologists to report impaired drivers, all psychologists would want to help protect their patients and others who may be impacted by this impaired driving.

The frequency of a driving impairment increases with age. Patients with dementias have an increased risk of developing a driving impairment. However, the decline in driving ability varies considerably from person to person, and some persons can drive with relative safety for several years after being

diagnosed with dementia. Patients may have other disorders that increase their risk of impaired driving such as diabetes, seizure disorders, or orthopedic problems. However, the presence of a disorder does not necessarily mean that a patient cannot drive. When evaluating whether a patient is safe to drive, psychologists should look for functional impairments or behavioral indicators of problems, such as a recent history of traffic accidents or near accidents, traffic violations, or aggressive driving.

The options for assessing and responding to patients with driving impairments include, among other things, a referral to a physician, podiatrist, optometrist, or other health care professional to determine if medications could be causing the driving problem or if medical treatments could remediate it. Neuropsychological assessments are not usually definitive in these situations, but reports of passengers, driver simulation tests, or an actual road test may be helpful. Often patients do not have to cease driving altogether, but they can improve their driving by taking special driver education courses for older adults. Insight is especially important, as older drivers who are aware of declining skills may be able to identify compensatory strategies to ensure their safe driving (Knapp & VandeCreek, 2005). For example, older adults may be able to restrict their driving to certain times of day or locations. Or they may be able to identify a route with fewer left turns.

Assisting older adults to make decisions about driving may take time and clinical expertise. The loss of the ability to drive means a decline in the independence of older adults and represents a substantial change in their status within the families and often in their self-esteem. Ideally, older adults will have discussed driver cessation with their relatives or health care providers long before the issue becomes urgent and have thought through other ways to meet their transportation needs.

10

Psychological Testing and Assessment

Psychologists may use psychological tests or conduct assessments for many reasons, including educational placement of children, selection of job applicants, development of forensic reports, identification of neuropsychological strengths or deficits, and planning for mental health services. *Testing* refers to the use of standardized tests to assess individual psychological characteristics (American Educational Research Association [AERA] et al., 2014), whereas an *assessment* refers to a more comprehensive evaluation that may include tests but also involves integrating test results with other information (AERA et al., 2014). The American Psychological Association's (APA's; 2017a) *Ethical Principles of Psychologists and Code of Conduct* (APA Ethics Code) defines assessment data as including diagnostic information derived from clinical interviews, as well as scores on intellectual, neuropsychological, objective, or projective tests; responses to structured personality inventories; behavioral ratings; psychophysiological responses; and other samples of behavior gathered systematically.

The major source for professional standards and guidelines for assessment is the APA Ethics Code (especially Section 9, Assessment). The *APA Guidelines for Psychological Assessment and Evaluation* (APA Task Force on Psychological Assessment and Evaluation Guidelines, 2020), and *The Standards for Educational and Psychological Testing* (AERA et al., 2014) also describe recommended practices.

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Negligent assessment can be the basis for complaints to licensing boards and ethics committees and for malpractice suits. Assessments conducted at the request of third parties are especially likely to create a high risk of an allegation of misconduct because their results could damage the interests of the person being evaluated and because there is no patient–therapist relationship to mitigate the anger of the person allegedly harmed. Examples of high-risk evaluations include child custody or employment evaluations, evaluations for medical procedures such as liver transplants or bariatric surgery and for eligibility to possess lethal weapons.

In this chapter, we review ethical and risk management issues surrounding assessment, including issues of competence, informed consent, and test security. We also cover ethical issues associated with remote assessments and working with persons from diverse backgrounds. Chapter 11 covers assessment issues unique to forensic work.

COMPETENCE

Many psychologists in their day-to-day practices assess and diagnose patients without relying on formal psychological tests. Of course, psychologists performing these tasks need to have basic interviewing skills and knowledge about diagnostic categories. Although a diagnosis is often thought of in terms of an assigned label from the current edition of the World Health Organization's (WHO's; 2019) *International Classification of Diseases* (*ICD-11*) or the latest edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), the most helpful assessments consider the totality of the patient's history, strengths, and life circumstances. This is especially important when treating patients from historically marginalized groups because it is possible that psychologists may not have sufficient awareness of the impact of culture on their symptom presentation (see discussion in Chapter 5). Often, the most accurate assessments are made through multi-informant approaches, which have a greater chance of explaining discrepancies in behavior across situations (APA Task Force on Psychological Assessment and Evaluations Guidelines, 2020).

In addition, psychologists may need to have specialized knowledge about the population being tested or assessed. APA's guidelines are a good place to start to learn or review basic competencies required for certain areas of practice, such as work with persons with disabilities (APA Task Force on Guidelines for Assessment and Intervention With Persons With Disabilities, 2022), dementia and age-related cognitive change (APA Task Force for the Evaluation of Dementia and Age-Related Cognitive Decline, 2021), occupationally mandated psychological evaluations (APA, 2018b), child protection matters (APA, 2013b), and child custody evaluations (APA, 2022a). Psychologists using tests for forensic purposes should be aware of the APA guidelines regarding forensic work (APA, 2014).

Furthermore, psychologists should also be able to address the goals of the assessment. When assessing a client for bariatric surgery,[1] for example, psychologists should be less interested in whether the client has a *DSM* or *ICD* disorder and more focused on the reasons why the surgeons requested the evaluation (i.e., whether the client understands the nature of bariatric surgery and has the ability to comply with postoperative recommendations). Or, when asked to document the need for an emotional support animal, psychologists should know the difference between a service animal, an emotional support animal, and a therapy animal. They should know how to assess animal–human bonds, and the well-being of the animal (Ferrell & Crowley, 2021; Younggren et al., 2020). They should also understand the purpose of the assessment. For example, is it for housing, transportation, or some other need? The requirements for these assessments may vary.

When conducting assessments, psychologists will work at a higher level of care if they keep in mind the potential for some thinking errors that may influence their decisions. For example, in writing about the diagnostic processes of physicians, Groopman (2007) noted that some diagnostic errors are "below the level of conscious thinking" (p. 263), such as the availability heuristic (i.e., "the tendency to judge the likelihood of an event by the ease with which relevant examples come to mind"; p. 64), anchoring (i.e., being unduly influenced by an arbitrary starting point), or the confirmation bias (i.e., "confirming what you expect to find by selectively accepting or ignoring information"; p. 65). In her review of mistakes made by physicians, Sanders (2009) noted that confirmation bias was the single most common source of physician misdiagnosis.

The course of treatment does not always move in a linear path from diagnosis to intervention. Instead, a more accurate diagnosis may only emerge after trial and error. When learning to diagnose patients, medical students are often taught the adage "When you hear hoofbeats, think horses, not zebras" (i.e., look for the most common sources of a symptom instead of pursuing esoteric or rare disorders). However, sometimes hoofbeats do mean zebras (i.e., the rare diagnosis can be the correct one; Groopman, 2007).[2] Although a *DSM* or an *ICD* diagnosis may communicate information to a third-party payer or generate ideas about treatment, the specific *DSM* or *ICD* label is less important than the congruence of goals between the patient and the psychologist. One treating psychologist noted that he used to be an excellent diagnostician, except the patients did not always like to hear his results and were slow in meeting the goals he set for them. When he modified his approach to give greater weight to the opinions of his patients, he was surprised at how much more quickly

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[1]*Clients* are persons who are receiving psychological services, such as an assessment, whereas *patients* are persons receiving treatments. In actual practice a client may not be the person receiving the assessment, but a third party, such as a court or a potential employer.

[2]This section is an adaptation of "Moving Toward a Reflective Practice: A Review of *How Doctors Think* by Jerome Groopman," by S. Knapp, 2011, *The Pennsylvania Psychologist, 71*, p. 7. Copyright 2011 by the Pennsylvania Psychological Association. Adapted with permission.

they reached their treatment goals. Ideally, psychologists and patients will work collaboratively to gather information from a variety of sources to reach agreed-upon goals. The process requires psychologists to balance beneficence (i.e., getting the optimal diagnosis) with respect for the patient's autonomy in identifying their problem areas and goals.

Assessments often require psychological testing. The practice of psychological testing can appear deceptively simple. However, testing is a professional activity and not simply the application of technical skills. *APA Guidelines for Psychological Practice and Evaluation Guidelines* (APA Task Force on Psychological Assessment and Evaluation Guidelines, 2020) identify the general areas of competence that psychologists need to master to become proficient in psychological assessments and evaluations. These competencies cannot be reduced to simple phrases or a simple algorithm that untrained persons can follow, although psychologists do need to pay careful attention to the basics of test administration. However, psychologists also need to use their informed judgment in how they choose the tests designed to address the referral question, and whether or how to adapt the tests based on the patient's culture, reading level, and other factors. Psychologists need to use their judgment in interpreting the test data, integrating the test data into an understandable narrative based on the unique history and characteristics of the patient, and presenting the conclusions, methodology, and caveats to the target audience.

Although psychological tests can assist clinicians with case formulation and treatment recommendations, tests are only tools. Tests do not think for themselves, nor do they directly communicate with patients. Like a stethoscope, a blood pressure gauge, or an MRI scan, a psychological test is a tool, and the worth of the tool cannot be separated from the sophistication of the clinician who draws inferences from it (Meyer et al., 2001, p. 153).

Although all professional psychologists receive some training in psychological assessment, those psychologists who use psychological assessment regularly need to ensure their continued competence, especially since the knowledge base of neuropsychology is changing rapidly (Neimeyer et al., 2014).

PROFESSIONAL JUDGMENT IN SELECTING, USING, AND INTERPRETING TESTS

Psychologists should have a rationale for selecting the tests that they use. They should select the appropriate tests or adjust their interpretation to meet the unique needs of the individuals being assessed and the purpose of the testing. Test manuals can assist psychologists in making these determinations. Ideally, the test manuals describe the purpose of the test and the qualifications of those who use it, offer instructions on test administration, and include psychometric and other useful data. Psychologists are obligated to use testing instruments as they were originally designed but may adapt them based on research or evidence indicating the usefulness of the adaptation.

The interpretation of the test results must be based on a reasonable degree of competence. Test scores should not be used in isolation but should be integrated with other information about the patient. Psychologists need to recognize limits to the certainty with which diagnoses, judgments, or predictions can be made about individuals, and indicate significant reservations or limitations about test interpretations.

In some evaluations, psychologists can involve patients in the selection of some of the goals of the assessment. For example, patients may have been referred for a neuropsychological evaluation but want to know specific questions relevant to their lives, such as why they procrastinate or why they get distracted so much (Engelman et al., 2016). Even in evaluations mandated by third parties, such as evaluations for religious professionals, some evaluators have the latitude to ask clients what questions they have about themselves and what specifically they would like to know more about.

The use of assessment instruments with diverse patients requires special considerations. Cultural, racial, and other factors may affect the interpretation of many standardized psychological tests. Misinterpretations can occur if a test is used for a group for which no normative data have been obtained, and the psychologist fails to account for these limitations in the test interpretations. For example, the ability of a test to measure a particular psychological construct in one population may not necessarily mean that the same test has the same ability to measure the same psychological construct in another population (Wright et al., 2022). Also, the assessors themselves may have unfounded or unfair biases, which could skew the way that they interpret a test. One such example of insensitivity has occurred with the continued use of the "noose" item in the Boston Naming Test (Byrd et al., 2021), which is not essential from a psychometric standpoint and which needlessly offended many test takers and possibly impacted their performance on other items of the test.

However, psychologists may be asked to assess clients or patients who are from cultures for which no information is available on how to provide culturally meaningful assessments. The APA Ethics Code does not prohibit psychologists from assessing these individuals but does require psychologists to use appropriate caution and discretion in interpreting the test results.

Psychologists should be sensitive to the many ways that individual or cultural identity may influence test results. Psychologists should consider, for example, whether they have a good rapport with the test taker because a poor rapport may stress the test taker, cause them to put forth less effort or otherwise distort the findings of the assessment (APA Task Force on Psychological Assessment and Evaluation, 2020).

Generally, psychologists administer a test in the language that the patient prefers or in which the patient is most competent unless the purpose of the assessment is to determine the patient's abilities in using a particular language. Assessment reports should always indicate when tests have been administered in a language other than the patient's preferred language.

Certainly, it is desirable to use tests that have been translated into or have been constructed in the patient's primary language. However, caution needs

to be exercised when using translated tests because at times no word, concept, or idiom in the second language corresponds precisely to the English word, concept, or idiom. Some, but not all, psychological tests have been translated with sufficient safeguards to ensure their equivalence in the second language (APA Task Force on Psychological Assessment and Evaluation, 2020).

The quality of the data collected may be improved if psychologists speak to patients in advance concerning the nature of the tests, the type of questions that will be asked (including questions on sensitive topics), and the reasons why it is necessary to ask them. This is especially true for persons who because of their culture or background are not generally familiar with the nature or purpose of psychological tests. Finally, assessors need to remember that the impact of culture may vary according to the intersectionality of the patient's gender, race, income level, sexual orientation, or other factors (Hays, 2009).

Obsolete Tests

Standard 9.08b, Obsolete Tests and Outdated Test Results, of the APA Ethics Code states, "Psychologists do not base such decisions or recommendations on tests and measures that are obsolete and not useful for the current purpose." Although psychologists may generally prefer to use the most current version of the test that is available, they may have professional justifications for using an earlier version. Much of this decision depends on the purpose of the testing. Using an older version of a test in a longitudinal study may be more useful than using a more current version because of the desirability of keeping the posttest and pretest measures the same. Also, an earlier version of a test may have been subjected to more research relevant to its current use, justifying its greater usefulness with certain populations than a newer version. Also, after a careful review of the psychometric data, psychologists may temporarily use an earlier version of a test if it has been subjected to more research relevant to its current use with certain populations than the newer version. However, psychologists should adopt the newer version of the test when new norms suggest it is more appropriate for the populations being tested or when the test's discriminating ability has been refined (Campbell et al., 2010).

Online Assessments

Online assessments have advantages and disadvantages. On the one hand, they are easy to administer and may provide useful information to some persons who are considering psychotherapy. On the other hand, there are obvious problems with confidentiality and test security. Also, the results obtained from an online assessment may not be valid. The psychologist cannot standardize the testing environment, adjust for the patient's cultural or linguistic background, or ensure that the norms obtained from standardized testing conditions would

necessarily be the same for testing done via the Internet (Buchanan, 2002). For these reasons, psychologists need to use or interpret online assessments cautiously.

Collecting Adequate Data to Substantiate Findings

Standard 9.01a, Bases for Assessments, states, "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." Among other things, this standard requires psychologists to be careful about their biases and unchecked assumptions. They need to ask if their conclusions are based on the data provided or are influenced by previous diagnoses or reports. The diagnostic label *borderline personality disorder,* for example, evokes apprehension and caution among many psychologists. However, psychologists need to be certain that the use of that label by a previous diagnostician does not unduly influence their interpretation of current test data.

Standard 9.01b, Bases for Assessments, permits psychologists to develop opinions based on secondhand information if a direct evaluation of the individual is not practical. In these instances, the psychologists must document their efforts to conduct a direct evaluation and the results of these efforts, clarify the probable impact of the lack of a direct examination on the reliability and validity of the opinions, and limit the nature and extent of opinions accordingly.

In addition, Standard 9.01c, Bases for Assessments, permits psychologists to develop opinions based on a record review. This exception could occur, for example, when a psychologist conducts a psychological autopsy, responds to a hypothetical question on a forensic examination, or conducts a record review for another legitimate purpose. If a direct examination is not warranted or necessary, they can explain this limitation in the report. Additionally, the report should clearly identify the source of information on which the psychologists based their conclusions.

Automated Tests

Standard 9.09b, Test Scoring and Interpretation Services, requires psychologists to "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." In addition, Standard 9.09c, states, "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."

Psychologists retain responsibility for the selection of the particular test and testing service and the wording of the final report. They may use computerized assessments, but they still assume full responsibility for the wording of the

final report (Bersoff et al., 2012). The interpretations derived from computerized services are based on group norms and are not adjusted to consider the life circumstances of the patient. Psychologists must develop personalized interpretations based on the entire clinical picture of the patient and should note the limitations of their interpretations (see Standard 9.06, Interpreting Assessment Results). Automated tests do not replace the clinical judgment of psychologists.

Use of Tests by Unqualified Persons

APA Ethics Code Standard 9.07, Assessment by Unqualified Persons, states that psychologists do not promote the use of psychological assessment techniques by individuals who are unqualified unless "such use is conducted for training purposes with appropriate supervision." To an untrained person, it may appear that all psychologists do is add together a few scores, look up the results in a textbook, or cut and paste excerpts from a computerized printout. In reality, the appropriate use of psychological tests is far more complicated. Much harm can be done by the inappropriate use of psychological tests. Consequently, psychologists have a responsibility to restrict the use of these tests to those who know how to select, administer, and interpret them appropriately.

These standards, of course, do not preclude the use of assistants, employees, or supervisees who administer or score psychological tests under supervision. The responsibilities given to these individuals vary according to their qualifications and the demands of the testing situation. Nonprofessional employees could, for example, have their roles limited to submitting computerized forms to an assessment company, whereas an advanced psychologist-in-training who has had substantial supervised experience could perform much of the test administration and interpretation.

Test Construction

According to Standard 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." The development of tests can take years before psychometric data are sufficient to ensure their professional usefulness. Psychologists who develop these tests need to develop a test manual or equivalent documentation that describes the purposes of the test, its psychometric information, methods of administration, scoring procedures, and other relevant information. Tests and manuals need to be updated and revised as needed. *The Standards for Educational and Psychological Testing* (AERA et al., 2014) describe the types of information that psychologists should include in test manuals.

Unfortunately, some individuals have developed and used short checklists purporting to measure certain traits but have failed to use a normative sample to establish reliability and validity (other than face validity) of the checklist, and to gather information on the psychometric qualities of the test.

CASE EXAMPLE: AN INADEQUATE SERVICE

A psychologist developed a "relationship checklist" based on several common issues that he had found through his work with couples. The ostensible goal was to help couples identify whether their relationship was in trouble. He intended to place the test on his website along with a scoring system in which he arbitrarily assigned the ranges for troubled, potentially problematic, and secure relationships.

Fortunately, this psychologist sought consultation before placing the "test" on his website. The consultant noted the limits of online assessments (see the previous section Online Assessments) and urged the psychologist to abandon the test format. Instead, the consultant suggested that the psychologist write a brief article in which several test questions were reframed as thought questions for couples to consider about their relationship. In addition to the psychometric limitations, the consultant correctly noted that the results of web-based tests precluded the necessity of direct counseling if the results became upsetting to the test taker. It also raised questions concerning the adequacy with which the test taker was informed of the nature, purpose, and limitations of the test (Kier & Molinari, 2004).

Testing Remotely

During the height of the COVID-19 pandemic, when many school classes were conducted remotely and medical offices started using remote interviews with patients, many psychologists started to assess their patients remotely. Some evidence suggested that clients had consistent performance across remote and on-site testing conditions (e.g., Brearly et al., 2017). However, psychologists still need to use caution when using or interpreting tests remotely. None of the commonly used psychological tests were developed or originally normed using remote administration, and some patients may have had their responses influenced by the mode of test presentation. For example, the results of individual tests may be skewed if the internet connection is weak, if the client is unfamiliar with communicating remotely, or if the client is at a home with many distractions. Clients who have limited incomes are more likely to have poor internet connections or to have smaller homes where it is harder to get a room free from distractions (Farmer et al., 2020).

Novel Assessment Procedures

Recent years have seen the development of a number of technologically assisted methods for assessment including ecological momentary assessment (which collects patient data in real time, often through the use of smartphones; Rogers, 2021), wearable devices to collect physiological data, and virtual reality environments, among others. New technologies are continually being developed, and

what is novel and innovative today may be routine or even obsolete tomorrow. These methods hold great promise in helping to increase the reliability and usefulness of assessments. Psychologists need to keep several things in mind as they use these new technologies. First, many of them rely on digital technology, making data security an important issue. Second, psychologists need to consider the ability of their clients or patients to use the technology. Finally, all the psychometric issues concerning traditional tests apply equally to novel assessments, including construct validity, reliability, considering cultural bias, and so on.

Explaining Assessment Results

Psychologists typically are required to give feedback to participants on the results of testing (Standard 9.10, Explaining Assessment Results). According to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (U.S. Department of Health and Human Services [USDHHS], 2002), patients generally have access to test reports. Consequently, psychologists need to select their words carefully to ensure both accuracy and tactfulness in the event that patients read the report. The best solution is preventive. That is, psychologists should be meticulous about the wording of their reports.

Under some circumstances, psychologists may not have to share test results with patients. Such a restriction might occur, for example, in an assessment done in reasonable anticipation of a civil, criminal, or administrative hearing. Some other possible exceptions are unclear in the HIPAA Privacy Rule and still await clarification by the U.S. Department of Health and Human Services (the federal agency charged with oversight of HIPAA) or the courts.

In his description of the processes for evaluating religious professionals, Malony (2000) noted that the APA Ethics Code permits psychologists to evaluate applicants for occupations without sharing the results of that evaluation, as long as the process has been explained to them ahead of time. Nonetheless, Malony argued that evaluators owed some responsibility to the candidates as well as to the hiring institutions. Therefore, he urged evaluators to arrange with the referring institution to share the results with the applicants.

CASE EXAMPLE: A TROUBLED CANDIDATE

At the request of a religious denomination, a psychologist tested a lay missionary who was interested in ordination as a minister. However, the candidate had extreme posttraumatic stress disorder (PTSD) as a result of witnessing atrocities in the country where she had served as a lay missionary.

In the psychologist's opinion, the extreme PTSD was likely to impede her ability to perform as a minister. The psychologist helped the denominational committee and the candidate consider options, such as psychological treatment, before deciding on the optimal vocational path.

Sometimes psychologists are asked to evaluate the tests and reports of other psychologists, such as in the case of a child custody evaluation. In reviewing these tests and reports, psychologists should be aware of the limits on what they can say about persons whom they have not directly evaluated. They may, however, comment on the relationship of the test data to the test interpretation. They could point out, for example, that the original psychologist made a computational or interpretative error, failed to address important questions in the reports, or failed to identify the bases for interpretations.

INFORMED CONSENT (PATIENT PARTICIPATION) IN ASSESSMENTS

Psychologists conducting psychological assessments need to obtain the informed consent of participants. As we described in Chapter 6, it may be desirable to reframe the issue as one of ensuring maximum patient participation in the assessment decisions. However, Standard 9.03a, Informed Consent in Assessments, provides for three exceptions to the general informed consent requirement in assessments. Informed consent for assessments may be waived when (a) testing is mandated by law (e.g., in response to a court order) or government regulation; (b) consent is implied because it is conducted as part of a routine educational, institutional, or organizational activity; or (c) the purpose of testing is to determine whether an individual is competent to make decisions.

Many difficulties can be addressed if psychologists clarify expectations and roles ahead of time. Often employers or third parties requesting testing have not considered the advantages, limitations, or implications of psychological testing. Psychologists can help them clarify their goals and expectations.

Sometimes psychologists assess individuals to gather information or to create reports with a diagnosis (or statement of the problem) and to make treatment recommendations. The individual who requested the testing may also expect to receive treatment from the psychologist who did the assessment. At other times a third party requests the testing. In either situation, the psychologist generally identifies the purpose of the testing and then proceeds to select and administer the tests. Once they complete the testing, psychologists can share the product, report, or information with the patients and, if appropriate, get their consent to begin treatment. Psychologists who are conscientious about involving patients in the treatment process can be equally conscientious about involving patients in the assessment process. At a minimum this includes describing the general nature of the assessment and its desired goals.

Therapeutic assessment is a process that involves patients or clients in defining the goals of assessment and the means of achieving those goals (Aschieri et al., 2018). This approach does not involve a list of fixed steps in assessment, but rather it endorses a humane and respectful perspective that attempts to maximize patient participation in the assessment as much as possible. It may mean, for example, the development of a good assessor–client relationship whereby the patient or client feels comfortable expressing concerns or goals; individualizing

tests to best address the patient's concerns even if it means eschewing standardized test batteries; and involving patients in the wording of the final report. Therapeutic or collaborative approaches have been applied in many assessment situations, including those in which patients are at risk to die from suicide. Collaborative assessment processes for suicidal patients help them feel understood and minimize the risk that the psychologists will come across as judgmental or controlling (Jobes 2016; Knapp, 2022). The recommendations derived from collaborative assessments of suicidal patients have been shown effective in reducing the risk of suicide attempts (Jobes, 2016).

Although consumer-focused or therapeutic assessments have much merit, they may not be a practical strategy when conducting forensic or employment assessments in which the court or an employer (not the person being evaluated) is the client and relying on the results of the assessment. Nonetheless, Fischer (2004) successfully used elements of a collaborative approach in some child custody assessments. This suggests that even in forensic testing, psychologists sometimes can increase the degree of collaboration with the person being tested when they can find some congruence between the needs of the person being evaluated and the referral source.

TEST SECURITY

The challenges to test security have increased with the passage of the HIPAA Privacy Rule and the increased use of tests in litigation. Requests for the release of test data (e.g., test reports, summaries, client responses, or products from the test and psychologists' notes and observations during the test) and test materials (e.g., manuals, instruments, protocols, test questions, or test stimuli) are likely to occur in two situations. First, patients may request access to or possession of their records, including test data or test materials. Second, patients may request test data or test materials in the context of a court proceeding. The use of psychological data in courts has been increasing in recent years. These instances include cases that involve recommendations regarding child custody, civil suits in which emotional harm is alleged, or criminal suits in which the mental state of one of the parties is an issue. The 2017 APA Ethics Code needs to be read in light of the HIPAA Privacy Rule and copyright laws.

The Privacy Rule established minimal rules on patient privacy and patient control over health care information. As noted in Chapter 8, the restriction of patient access to psychotherapy notes under the Privacy Rule does not apply to assessments (Chapter 11 covers forensic tests in more detail). Consequently, patients in covered entities have access to their assessment results. The Privacy Rule created an exception whereby psychologists may deny patients access to their protected health information if providing access would be reasonably likely to cause substantial harm or endanger the life or physical safety of

the individual or a third person.[3] Even in those situations, patients have a right to have the denial reviewed by another health care professional. Next, we explain the meanings and implications of the terms test data and test materials in more detail.

Test Data and Test Materials

According to Standard 9.04, Release of Test Data, test data include

> 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.*

As previously noted, the APA Ethics Code distinguishes between test materials (Standard 9.11, Maintaining Test Security) and test data (Standard 9.04, Release of Test Data). Campbell et al. (2010) expanded on this distinction by noting that any data from a test that derives from, indicates, or reveals something about a specific patient falls under the definition of test data. "Once individualized information is entered onto a data sheet, the materials become test data because they contain information that is descriptive of the examinee" (p. 321).

For purposes of defining test data, the term *notes* refers only to notes taken during an assessment involving testing and does not include notes taken in a private counseling or psychotherapy session (Fisher, 2012). It could be argued that notes taken by psychologists during an initial interview for therapy fall under the definition of psychotherapy notes under HIPAA and are outside of the purview of what was intended in the definition of test data in Standard 9.04.

Release of Test Data

How should psychologists respond when a patient requests test data? Looking at the APA Ethics Code and the HIPAA Privacy Rule together, we conclude that psychologists must have a client or patient release or court order before they

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[3] "A covered entity may deny an individual access, provided that the individual is given a right to have such denials reviewed . . . in the following circumstances:

(i) A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person;

(ii) The protected health information makes references to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person; or the request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgement, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person." (USDDH, Office for Civil Rights, 2002, 45 CFR §164.524 (a) (3))

can release any information, including test data or test materials. In addition, psychologists have the discretion to refuse to release test data or test materials under certain circumstances described later. Also, the APA Ethics Code could be interpreted as having an implicit predisposition to permit the release of information to clients or patients, or their representatives (Behnke, 2003).

Potential to Harm Clients or Patients

According to the APA Ethics Code (which is often put into the binding regulations of state licensing boards) and the Privacy Rule, psychologists have the option of withholding test data. The APA Ethics Code permits withholding test data if it would cause substantial harm to the patient or misuse or misinterpretation of the test. However, the Privacy Rule establishes a higher threshold for withholding test data from patients. Under the Privacy Rule, psychologists have an obligation to release protected health information to patients (except psychotherapy notes) unless they can demonstrate a threat to the life or physical safety of the patient or a third party or another highly unusual circumstance specified in the regulations (USDHHS, 2002, 45 C.F.R.164.524 (a) (3)). When state regulations of the licensing board conflict with the Privacy Rule, the standard that is most protective of patient privacy, from the standpoint of the patient, must be followed. Consequently, psychologists covered by the Privacy Rule must adopt the higher Privacy Rule standard before withholding test data from patients.

This standard suggests that psychologists need to show discretion in what they place in psychological reports, knowing that patients are more likely to see them sometime in the future. Other than withholding test results and test data from a third party if the restriction was explained in advance and done in reasonable anticipation of a criminal, civil, or administrative hearing, psychologists need to use discretion in deciding how to respond to patient requests for test data.

Potential to Harm the Public Through Compromise to Test Security

How should psychologists respond when they receive requests for test data or test materials for use in court proceedings? The general rule is that one can send test data in response to patient authorizations (i.e., release of information forms) or a court order. In part, this standard represents greater respect for patient autonomy in determining the use of their records. However, it also reflects practical realities. According to HIPAA, patients have great access to their testing records. If patients can get the records themselves, then they can easily send those records to their attorneys or anyone else. Thus, any prohibition against sending the testing records to third parties based on a patient release would become moot.

How should psychologists respond when they receive requests for test materials for use in a court or by an attorney? The general priority is to protect the security of the copyrighted test materials. However, psychologists are not

permitted to turn over copyrighted test materials to clients or other persons who are not qualified to use or interpret them. This standard has legal precedent. For example, in *Detroit Edison v. NLRB* (1979), the U.S. Supreme Court ruled that the National Labor Relations Board had abused its discretion in ordering Detroit Edison to turn over the test batteries and answer sheets that it used in making hiring decisions.

If tests gradually get into the public domain, their usefulness is eventually degraded. For example, individuals can alter their responses and manipulate test outcomes, resulting in substantial public harm. A coached student may be misplaced in a class for gifted students, an impaired airplane pilot may be able to fly, or a court decision may be based on inaccurate information.

CASE EXAMPLE: AN INACCURATE PLACEMENT

A highly motivated parent insisted that her child be placed in a class for gifted students. She surreptitiously obtained a copy of the Wechsler Intelligence Scale for Children (3rd ed.) and coached her child on the answers. The child was misplaced into a gifted program, where she became unhappy and struggled with the classwork.

Despite copyright protections, information about test materials sometimes leak into the public domain. It is often possible for motivated persons to find copyrighted test materials in libraries, bookstores, or other sources. In addition, some secure information has been posted on the internet, thus increasing the likelihood that copyrighted information is being disseminated. One website contains accurate facsimiles of the Rorschach inkblot cards along with popular responses and scoring systems (e.g., Wikipedia at https://en.wikipedia.org/wiki/Rorschach_test).

As the usefulness of tests degrades, it will become necessary to invest in substantial research programs to replace these tests, and there will be substantial costs to individual psychologists, who will need to purchase the new tests and become trained in them. In addition, it appears unfair to the developers of tests, who will lose a substantial amount of income and thus the incentives to stay in the business of developing new tests. Much of the increased cost could eventually get passed on to the consumers.

Options for Psychologists

At this time, we cannot offer answers for all the scenarios that might occur with test reports, test data, and test materials. Case law may eventually clarify the obligations of psychologists. However, the following section summarizes how psychologists could respond to some likely scenarios and responses, given the complicated interplay of HIPAA and the APA Ethics Code.

Patients may request to see test materials. If it appears that viewing test materials would be helpful for patients to understand the test data, it may be appropriate for psychologists to show them limited amounts of test materials in their office to educate them as to the general methodology of the test.

However, giving patients possession of the actual test materials or allowing them to take extensive notes on the content of the testing stimuli may conflict with copyright laws. As of the writing of this volume, we do not know how courts will reconcile the apparent conflict between the HIPAA Privacy Rule and copyright laws. As stated in Knapp et al. (2013), psychologists should err on the side of test security, although there can be no guarantee that sometime in the future a court may rule otherwise.

Another scenario is that an attorney (other than the one who has hired the psychologist) may request to see or possess test data or test materials. It is generally appropriate to send out test data in response to a patient request or court order. However, questions arise concerning the appropriate response when an attorney requests copyrighted test materials. The most prudent response would be to ask the attorney to designate a mental health professional who is qualified to review the test materials. Other psychologists may elect to err on the side of withholding the test materials and wait for a court order for those materials or ask for a protective order pursuant to the release.

A third scenario is that a court may request to see or possess test data or test materials pursuant to a court-ordered evaluation. A proactive stance may be to request that the original court order for testing specify that the copyrighted test materials be released only to qualified persons. Ideally, the court will be advised as to the qualifications of those who can see the data. For example, for many personality or intelligence tests, the qualified person may be a psychologist or certain appropriately trained psychiatrists. For vocational or other tests, the qualified persons may include rehabilitation counselors or other professionals.

Psychologists who withhold copyrighted test materials should convey their concerns tactfully to the court and emphasize the public interest issues in their requests. Psychologists may ask the court for a protective order to prevent the attorneys or others who receive this information from disclosing or using it for any other purpose. Or, the court order may stipulate that the test materials must be sent to a professional qualified to interpret them. A psychologist who sends out test materials in response to a court order is not in violation of the APA Ethics Code.

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Forensic Psychology

Forensic psychology refers to psychological work applied to legal issues. Psychologists may be hired as forensic experts by an attorney, appointed by a judge to treat an individual and report periodically back to the court, or be hired by a litigant or witness involved in the judicial system. Forensic psychologists provide a valuable service by helping courts make accurate and fair decisions. Also, many psychologists who do not have forensic practices may sometimes find themselves unintentionally working in the forensic area. Forensic psychology services often rest on the overarching ethical principles of public beneficence and justice, insofar as everyone in society benefits when the court system has access to relevant information that helps it function more fairly.

Psychologists working in forensic areas (especially in the area of family law) have an increased exposure to legal risks. For example, almost two thirds of psychologists who conducted child custody evaluations had a licensing board complaint filed against them sometime in their careers (Ackerman et al., 2021). The reasons for this are not hard to understand. The good feelings and positive relationships common in the psychotherapeutic relationship do not tend to exist in the forensic setting. The report of the forensic psychologist, if not favorable to the client[1] or opposing counsel may engender ill feelings or a desire for revenge.

[1]We are using the term *client* instead of patient because the recipient of forensic services might not be receiving health care services from the psychologist. Also, sometimes the clients of psychologists are not the individuals being evaluated but attorneys or the court.

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Clients or other affected parties may file a complaint or lawsuit to "neutralize" the report of the psychologist. In addition, because of the close scrutiny given to the work of forensic psychologists, their mistakes are rarely invisible.

Forensic psychologists can find guidance in the American Psychological Association's (APA's; 2017a) *Ethical Principles of Psychologists and Code of Conduct* (APA Ethics Code), the *Specialty Guidelines for Forensic Psychology* (APA, 2013c), the *Professional Practice Guidelines for Occupationally Mandated Psychological Evaluations* (APA, 2018b), the *Guidelines for Child Custody Evaluations in Family Law Proceedings* (APA, 2022a), the *Guidelines for the Practice of Parenting Coordination* (APA, 2022c), and the *Guidelines for Psychological Evaluations in Child Protection Matters* (APA, 2013a). Psychologists can also find guidance from sources outside of APA, such as the Association of Family and Conciliation Courts' child custody (AFCC Task Force for the Revision of Model Standards for the Practice of Child Custody Evaluation, 2022) or parenting coordination guidelines (AFCC Task Force on Parenting Coordination, 2017–2019).

This chapter covers the topics of competence, boundaries, confidentiality, informed consent, and fees in forensic activities. In addition, we consider ways that psychologists can strive to maintain integrity while working within the judicial system.

THE NATURE OF THE JUDICIAL PROCESS

The adversarial process found in the Anglo American legal tradition requires two sides to confront each other with facts, questions, and evidence. The court then decides which side is found guilty or not guilty, or negligent or not negligent, depending on the nature of the case. The adversarial role of the forensic psychologist differs considerably from the psychotherapeutic role, in which agreement and cooperation are the norm. Psychologists perform best within the legal system when they understand their roles (Knapp et al., 2013).

Psychologists often participate in the legal system as expert witnesses. Experts can testify on a wide range of situations, such as the effects of brain damage an individual experienced after an industrial accident, whether the testimony of an eyewitness was reliable, or whether an individual meets the legal definition of insanity (Cutler & Kovera, 2011). Although the standards vary from jurisdiction to jurisdiction, the general rule is that expert witnesses give information to the courts that is outside the expertise of the average layperson. Judges admit psychologists as experts if their education, training, and experience qualify them to render expert opinions related to the questions before the court. Although the opposing counsel may object to the admission of the expert witness, the judge has the final decision on whom to admit as an expert. According to *Daubert v. Merrell Dow Pharmaceuticals, Inc.* (1993), federal judges will admit testimony if it is scientifically reliable. Therefore, opinions that are not well accepted in the scientific community can be challenged. Some state courts have adopted rules similar to *Daubert* (Cutler & Kovera, 2011).

The general rule is that expert witnesses cannot be sued for malpractice for the content of their testimony, although some jurisdictions make exceptions.

Nevertheless, the content of the testimony could be the basis for a complaint before a licensing board or ethics committee if, for example, the client complained that the methodology for gathering or interpreting the data fell below minimal standards of conduct. Other judicial rules vary from state to state, and state rules vary from the rules in federal courts. Furthermore, within each state, some rules are made by the local court, and every court has its own cultural milieu.

COMPETENCE

According to Standard 2.01f, Boundaries of Competence, of the APA Ethics Code, "When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles." Psychologists involved in forensic work need to ensure that they can perform the roles expected of them. If a psychologist is competent as a health care provider, that does not necessarily mean they are also competent as a forensic psychologist. For example, psychologists who are competent in evaluating children should not assume that they are competent as custody evaluators. In addition to the ability to write a good report, competency as a custody evaluator requires the ability to present one's findings in court and to justify them under cross-examination. Furthermore, even psychologists who are generally competent in child custody evaluations may decline a specific case that requires expertise beyond their own. Even when they do take a case, prudent psychologists reserve the option of seeking expert advice on issues outside of their competence. In addition, work as a forensic psychologist typically requires a higher degree of accuracy and thoroughness than work done in general clinical practice.

Like all psychologists, forensic psychologists need to be objective in their work. Forensic psychologists should also be aware of the role that heuristics or biases, such as the availability and representativeness heuristics, confirmation bias, or the fundamental attribution error, could influence their work (Neal et al., 2022). Also, competent forensic psychologists guard against implicit prejudices or biases that could distort the nature of their work. For example, in the criminal justice and child welfare systems, the professionals are usually White, while people of color and lower-income persons are overrepresented among the service recipients. Therefore, psychologists need to be especially sensitive to the role that implicit biases or a lack of cultural awareness could have on their work (Lens, 2019).

Psychologists should also guard against gender-related biases. For example, a lower threshold of culpability might apply to a mother who is accused of neglect compared to a father. Or a woman who has been the victim of domestic abuse might be accused of "alienating" her children from the father, when her behaviors are a natural reaction of an abuse survivor.

Finally, like all psychologists, forensic psychologists should be alert to the signs of burnout, vicarious trauma, or compassion fatigue in their work (Neal et al., 2022). The nature of their work may mean that they are exposed to more

trauma and high conflict cases than psychologists who only deliver health care services.

How do psychologists know whether they have competence in forensic work? In some specialty areas of practice, psychologists can obtain a proficiency credential such as those awarded by the American Board of Forensic Psychology. Instead of earning credentials, psychologists can submit their work to an expert forensic psychologist for periodic review. Forensic supervisors or consultants can review tapes, copies of reports, or other work products of the psychologist to determine if they have reached the desired level of competence.

According to Standard 9.01a, Bases for Assessments, "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." Expert witnesses should present accurate and precise information to the court. For example, when testifying as experts, clinical psychologists should know the psychometric properties of the tests they used, why they used them, the degree of confidence they have in their interpretations, and their limitations (Rotgers & Barrett, 1996). Courts often have to consider many complex issues that have no simple answer. Psychologists should expect that a professional working for another party in the case will review their notes, tests, and reports.

Although psychologists must base their conclusions on information sufficient to substantiate their findings, the APA Ethics Code permits psychologists to express opinions based on secondary sources under limited circumstances. First, if psychologists are unable to conduct a direct examination, they may give an opinion of the individual not directly evaluated if they "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" (Standard 9.01b, Bases for Assessment). Second, when psychologists conduct a record review, consult, or supervise, they may develop opinions if a direct examination is not warranted or necessary and they "explain this [limitation] and the sources of information on which they based their conclusions and recommendations" (Standard 9.01c, Bases for Assessment). For example, they may be asked to review the records that led to an educational placement or a court decision (Fisher, 2012).

A general rule in conducting forensic work is to accept information from secondary or collateral sources. At times, these sources may come from police reports or other government documents with a presumed degree of reliability. At other times, neighbors or relatives may provide information whose reliability might vary. In addition, many forensic psychologists will conduct Internet searches for additional information on the persons they are evaluating. Nothing in the APA Ethics Code nor the guidelines for forensic psychologists (APA, 2013c) prohibits using this information. However, Pirelli et al. (2016) cautioned that evaluators should consider using this information on a case-by-case basis, recognizing that sources on the Internet vary in their reliability. Psychologists

should inform examinees that they may use internet-based information in their reports, allow examinees to respond to information gathered on the Internet, and document the source of any data obtained from the internet.

Over the years, both the demand for and the standards expected of forensic work have increased. Psychologists conduct evaluations of families to assist courts in determining child custody arrangements and termination of parental rights. They assess for mitigating circumstances when sentencing offenders, the degree of risk for sexual offenders, and the optimal services for a child adjudicated as delinquent. Furthermore, forensic psychologists evaluate the competence of older adults to manage their own affairs, if a refugee qualifies for asylum in the United States, and so on. Over the years, the number of tests used and the amount of time spent in making custody recommendations have increased (Ackerman et al., 2021). This may reflect greater concern over liability issues on the part of psychologists. Psychologists may face demands to abandon a completely objective standard when issuing reports or opinions. Sometimes the demands may be overt; sometimes they may be subtle. The difficulty of being objective is compounded by the fact that psychologists are often asked to testify on matters in which the state of the art does not ensure precision or a high degree of certainty. For example, although the predictions of violence have improved substantially in recent years, they are based on probabilities and can produce false positives. Similarly, many skilled practitioners have provided useful information to courts on child custody matters, although it is sometimes difficult to justify those decisions purely based on scientific data.

Sometimes attorneys suggest reasonable changes in the content or format of a report. They may have relevant background information on the client and ideas about how to better address the legal issues involved, or they may otherwise help psychologists to improve the clarity of their reports. Psychologists can make these changes, improve the quality of the report, and still protect their integrity.

At other times attorneys may recommend unreasonable changes in the content of a report. The recommendations of the attorney may compromise the accuracy of the information so that it is more consistent with the desired position of the attorney. Psychologists need to be aware of these efforts to shade their work. Although psychologists should listen carefully to the input from attorneys, they should not let these opinions override their professional opinions. The primary concerns of the psychologist should be accuracy and thoroughness. Forensic psychologists sometimes withdraw from cases because the retaining attorneys were attempting to unfairly influence their opinion.

Shuman and Greenberg (2003) noted that some psychologists believe that they must choose between being an advocate for a particular position and being accurate. However, they argued that "pitting integrity against advocacy is a false choice" (p. 219). Instead, psychologists are the most effective advocates when they discuss the limitations of their data and balance all perspectives fairly. "The role of the expert is not to deliver favorable testimony as a matter of contract. The obligation is to render services at the relevant professional standard of

care" (p. 223). Shuman and Greenberg argued that such candor and balance will, in the long run, protect the integrity of psychologists and the credibility of their testimony. Of course, some attorneys prefer not to work with psychologists who fail to engage in blind and unrestrained advocacy for their position.

Even after a report has been written, psychologists can take steps to ensure their integrity. L. S. Brown (2000) concluded that expert witnesses can help jurors by "revealing her or his information in a respectful form that educates and empowers jurors and makes them a part of a collaborative thought process with the psychologist" (p. 81).

At times psychologists may have to report that they do not know the answer to a question.

Expert witnesses attempt to educate or empower judges or juries, which may mean providing new information or debunking myths that they may have. For example, many jurors (and judges) may hold false beliefs about rape (e.g., men can never be raped; women secretly wish to be raped; if the victim did not resist physically, it is not rape), which may influence their perceptions of culpability or the severity of the sentence given (Gemberling & Cramer, 2014).

Psychologists who have worked with divorcing couples have seen how the processes of divorce and custody cases can harm the parties involved. Many psychologists, attorneys, and judges believe that the very nature of the adversarial process impedes the ability of parents to reach agreements concerning child custody, exacerbates family tensions, and harms the children. The adversarial system often requires parents to emphasize the faults and shortcomings of the other parent. It is difficult for divorcing parents to testify concerning the many weaknesses of a spouse on one day and then try to work out transportation to baseball practice on the next.

Some courts and attorneys offer alternative dispute resolution mechanisms to solve disagreements concerning child custody. For example, many courts prefer mediation. Although mediation has many positive qualities, it may not be appropriate for all couples, especially if the relationship is marred by domestic violence or intimidation. Other courts require parental counseling, parent education, reunification therapy, or other interventions designed to improve the ability of the parents to raise their children or to cooperate with each other. The exact nature of these interventions may vary considerably. The name is less important than the actual functions that are required. For example, courts sometimes order couples to participate in *family education.* This term could mean the actual education of the family in some cases. In other courts, family education is more akin to family counseling. Psychologists, therefore, need to clarify the expectations of different parties.

Finally, some attorneys have developed *collaborative law* projects. According to collaborative law, attorneys and their clients work toward settlements (Tesler, 1999). Often collaborative law projects involve a team approach. They may, for example, draw on the expertise of a child specialist to consult with the parents and assist them in raising their children. Advocates of collaborative law claim that their process results in less hostility, lower costs, and quicker settlements

than adjudicated cases. The claims for this approach need to be considered judiciously, as it is possible that the more cooperative families benefit the most from this intervention. Nonetheless, the collaborative approach attempts to avoid or minimize the iatrogenic qualities of the adversarial process.

MULTIPLE RELATIONSHIPS AND PROFESSIONAL BOUNDARIES

According to Standard 3.05c, Multiple Relationships:

> 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.

Psychologists should avoid mixing treatment and forensic relationships. However, accommodations may be made in limited situations. For example, some psychologists treat patients who have been court-ordered for treatment, and the court requires some accountability for their services. Psychologists may treat patients who, in the course of psychotherapy, become involved in litigation, and have information that is relevant to the court proceeding (see S. A. Greenberg & Shuman, 2007; Heltzel, 2007, for good examples of the debate about mixing psychotherapeutic and forensic roles).

The forensic role differs considerably from the treatment role. Whereas psychotherapists focus on the welfare of their patients, forensic psychologists focus on their obligations to the attorneys or courts that hired them. Their relationships with the clients are courteous but not necessarily intended to promote their welfare. In fact, there are times in which a forensic psychologist's

CASE EXAMPLE: WHAT IS MY ROLE?

A psychologist was asked by his client involved in a custody dispute to "just write a short letter" describing his progress in treatment and parenting skills. The client was generally pleased with the letter but asked the psychologist to include information about how the well-being of his children would improve if they could have regular visits with him. The psychologist rewrote the letter according to the wishes of his client.

Without intending to do so, the psychologist let himself get maneuvered into making a custody recommendation. Any time psychologists write letters recommending custody or visitation arrangements, they are making a custody recommendation. This letter shifted the psychologist from a treating role into a forensic role. Psychologists should only make such recommendations after evaluating all the parties in the family, not based on a psychotherapeutic relationship with one parent. Furthermore, as the father's psychotherapist, this psychologist lacked the objectivity needed to make a custody recommendation.

conclusions may directly conflict with the interests of a patient whom they are evaluating. Furthermore, the alliances in forensic versus treatment settings differ. The development of trust with patients is an essential component of therapy. In contrast, a certain level of guardedness may be necessary in forensic settings, particularly when working with litigants who may not be participating voluntarily or who may not be invested in being truthful. Differences in the informed consent process, nature of record keeping, and fees are discussed in the sections that follow.

Multiple Roles and Forensic Relationships

Psychologists can have several different roles in forensic settings. Sometimes they treat patients who have been ordered by the court to receive treatment and the court requires some accountability for their services. This creates a dual role in that the psychologist is responsible for treating the patient and for providing information to the courts. Other psychologists may be treating patients who, in the course of psychotherapy, become involved in litigation, and the information from psychotherapy is relevant to the outcome of the court case.

Still other psychologists may work in small towns where no one else is available to evaluate patients for the courts, even though the psychologist may have previously had a treatment relationship with the individual who is to be evaluated. Issues related to forensic multiple relationships are covered in Chapter 9.

Court-Ordered Treatment

Sometimes courts order patients into treatment and demand access to treatment information. The disposition of a case against a patient may depend, largely or in part, on the nature of the patient's participation in psychotherapy. For example, a court may order parents into treatment before they permit them to visit with their children. The court may expect the psychologist to provide both information relevant to the disposition of the children and meaningful treatment to the parent or child. This places the psychologist in a hybrid role of having loyalties to both the patient and the court.

The demands of the court for all relevant information may conflict with traditional standards of confidentiality. On the one hand, the court needs assurance that the treatment has fulfilled its goals. On the other hand, the psychologists' ability to help their patients is limited if they do not have trusting relationships with their patients.

The best solution is to establish a balanced policy of confidentiality that all parties understand ahead of time. The psychologist should try to protect patient privacy as much as possible while meeting the demands of the court. For example, the psychologist can communicate general information to the court but withhold more specific information not directly relevant to the issues before the court. However, psychologists cannot guarantee full confidentiality because

the release signed by the patient ordinarily allows the court to have complete access to information about the patient.

The hybrid role of the forensic psychotherapist contains the potential for misunderstandings and ill feelings (L. Greenberg & Gould, 2001). Often these roles occur in high-conflict divorce or custody cases in which clients actively seek the opportunity to file a complaint. The failure to provide clear delineation of roles may give those clients just that opportunity.

L. Greenberg et al. (2003) noted that psychologists treating children involved in custody disputes can be most effective if they are *forensically informed* or understand the competing factors that influence the course of treatment. Among other things, forensically informed psychologists scrupulously maintain their neutrality and appreciate that they may receive distorted information. Parents may present information only supportive of their perspective, omit relevant information unfavorable to them, and otherwise intentionally or unintentionally misrepresent information. Parents may seek to undercut or remove psychotherapists who do not support their agendas. Courts, attorneys, and psychologists can reduce these problems if they specify the structure (costs and expectations) of the psychotherapy, how they will use information, and the relationship that the psychotherapist will have with third parties ahead of time.

Other Hybrid Roles

In smaller communities and rural areas, psychologists may be called on by a court to both evaluate and treat an individual. When this situation arises, the *Specialty Guidelines for Forensic Psychology* states, "When providing both forensic and therapeutic services, forensic practitioners seek to minimize the potential negative effects of this circumstance" (APA, 2013c, Section 4.02.01). That is, the specialty guidelines recognize that the hybrid role may create problems and urge psychologists to minimize the negative effects of the multiple relationships.

Also, psychologists may initiate a forensic evaluation only to learn that the client needs immediate mental health services and that a delay in obtaining those services is not feasible. In such cases, forensic psychologists "consider whether they can continue in a forensic role with that individual so that potential harm to the recipient of services is avoided" (APA, 2013c, Section 4.03).

CASE EXAMPLE: A CHILD IN NEED

A psychologist conducting a termination of parental rights evaluation immediately learned that one of the children was seriously suicidal. One parent appreciated the depth of the child's depression; the other did not. The evaluator arranged for the emergency hospitalization of the child and then submitted his resignation from the case, noting that the extent of his involvement in arranging treatment compromised any perception of neutrality.

Therapy With Patients Involved in Litigation

Some patients are involved in litigation when they enter therapy. They may have initiated a lawsuit involving an automobile accident, a child custody dispute, or some other issue. They may have started psychotherapy with the assumption that they could count on the help of their treating psychologist in their court case. These expectations may be reinforced by friends or attorneys who assume that the treating psychologist is necessarily a legal ally.

Psychologists can take steps to identify these patients early, such as by asking all patients at the start of treatment if they are currently involved in litigation. Also, they can ask all patients who have sustained recent physical injuries or who request help for their children to give more details about their life circumstances and the possibility of litigation.

Nothing is inherently wrong, of course, with treating patients involved in litigation. However, psychologists need to decide whether they are competent and willing to provide psychotherapy to patients under these circumstances. Psychologists who decide to treat these patients should give increased attention to the informed consent process. These patients need to know that they may compromise the confidentiality of their sessions if they enter their mental health in litigation. In addition, the process of litigation may exacerbate whatever illness the patient has, place subtle pressures to maintain a sick role, and slow recovery. Because of the stress of litigation or other factors, patients may have difficulty hearing a psychologist discuss the distinction between treatment and forensic services. Psychologists should take care to ensure that their patients understand the implications of treatment under these circumstances.

CASE EXAMPLE: AN UNPREPARED PSYCHOLOGIST

A patient asked a psychologist to testify on his behalf in a civil suit arising out of a car accident. After agreeing to testify for this patient, the psychologist was insulted that opposing counsel had access to his psychotherapy record and was offended by the aggressive nature of the cross-examination on the witness stand. The patient was offended by some of the remarks made by the psychologist.

The psychologist failed to specify the payment arrangements with the patient ahead of time but ended up spending several dozen hours preparing reports, talking to attorneys, traveling, and testifying. Although the patient won the case, he failed to pay the psychologist and never returned to treatment after the case ended. This psychologist had not prepared for a forensic role. He did not appreciate the degree of scrutiny that would be given to his work, the amount of time that would be involved, the need to discuss the general nature of his testimony with the patient ahead of time, and the need to clarify payment.

Other patients present themselves for psychotherapy with apparently nonlitigious problems, but soon after treatment begins, they solicit the involvement of the psychologist in a court case. Psychologists need to anticipate the complications that may occur in these situations and, as soon as possible, communicate clearly to the patient the potential nature of their involvement. If possible, it is preferable for the treating psychologist to maintain only that treatment role and to insist that another psychologist be hired to conduct the forensic evaluation.

INFORMED CONSENT

Psychologists should ordinarily obtain the informed consent of forensic clients. However, psychologists do not have to get informed consent for testing patients when a court orders the evaluation. Nonetheless, Standard 9.03b, Informed Consent in Assessment, states,

> 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.

Even when a court orders the evaluation of a client, psychologists should still attempt to get the client's assent even though they do not have the legal ability or status to give consent. Psychologists should inform clients of the nature and purpose of forensic work, including limits on confidentiality and probable use of the data. In a forensic environment, psychologists should explain how an evaluator differs from a psychotherapist. Just the fact that a psychologist treats a client with some basic civility may incidentally reinforce a mistaken preconception that an evaluating psychologist is there as a psychotherapist.

Informed consent also applies to the relationship between retaining parties and the forensic psychologist. A lack of clarity lends itself to misunderstandings and ethical conflicts. Psychologists need to discuss fees, who will pay them, the legal issues that the attorney wants addressed, and the type of services that are being requested. That is, psychologists should determine if they are being asked to interview a client, write a report, appear in court, or do all of these. Also, psychologists should insist ahead of time that the data to which they have access (or the time available with the client) will be adequate for them to complete the tasks requested of them. In addition, psychologists should discuss any prior or current personal or professional activities that might produce a conflict of interest, psychologists' areas of competence and limits to their areas of competence, and (if relevant) the scientific bases and limitations of the methods that they will use (APA, 2013c). Psychologists should also inform the attorney or client of the possibility that they may need to seek additional consultation from other mental health professionals. Hess (1998) stated that problems that arise between psychologists and attorneys can often

be traced to "the first telephone call between the consulting psychologist and the attorney or client. A seemingly inconsequential issue that could be handled easily and early in the relationship may grow into a major problem if left unattended" (p. 109).

CONFIDENTIALITY AND RECORD KEEPING IN FORENSIC SETTINGS

The extent to which forensic services are covered by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (U.S. Department of Health and Human Services, 2002) is unclear. The HIPAA Privacy Rule probably exempts forensic services completed for an attorney (Knapp et al., 2013), while court-ordered treatment conducted by a covered entity probably falls under HIPAA. However, hybrid roles, such as a court-appointed parent educator, parent mediator, or case manager, might be interpreted as health care, depending on the nature of the service being provided, or might not be, depending on whether the psychologist is otherwise covered by HIPAA or other circumstances.

Whether the Privacy Rule covers forensic services could have practical implications for psychologists. If the Privacy Rule covers the services, then clients would have various rights including the right to a privacy notice, the right to access their health records (excluding psychotherapy notes, unless permitted by state law), and the right to request an amendment to their records.

In any event, forensic psychologists need to attend carefully to record keeping, which should be sufficient "to allow for reasonable judicial scrutiny and adequate discovery by all parties" (APA, 2013c, Section 10.06). Psychologists should justify every important decision in the record. Salient information that appears to support conclusions contrary to that of the psychologist should be presented. Psychologists should document why that information did not change the conclusions found in the report. The documentation should start with the first phone call the psychologist receives and include information on every meeting, phone call, contact, or cancellation received during the course of the case, no matter how seemingly trivial.

Forensic psychologists should expect the court or another professional to review their documentation, including all records, original notes, test data, and test materials. Chapter 10 covers when or whether to send raw test data or test materials. However, whether the information goes to an expert directly or through an attorney, another health care professional will likely scrutinize the rationale and selection of tests, the scoring, and the interpretation (including errors in computation and interpretation).

Psychologists may use computer-generated test reports. However, these reports cannot replace the clinical judgment of the psychologist. It would be unacceptable for a psychologist to repeat the conclusions of the report without having a professional rationale for doing so.

Privileged-communication laws permit patients to withhold information from the courts in limited circumstances, but they do not typically apply to court-ordered examinations or court orders that are explicit about who gets information. Nonetheless, psychologists should scrupulously obtain signed release-of-information forms or be certain that the court orders explicitly permit them to release information (Committee on Legal Issues, APA, 2016). Clients need to be informed at the start of the evaluation of the use of the information generated by the evaluation that will go to their attorneys or the courts.

CASE EXAMPLE: AN UNCLEAR COURT ORDER

A psychologist was hired as an expert witness in an employment discrimination case and had a court order that permitted him to release information to the courts and the attorneys and to testify in a hearing concerning the case. However, one of the attorneys asked the psychologist to testify in a contempt hearing against one of the parties, who was not complying with an interim court order. The psychologist refused unless the court also amended its order to permit him to testify in this hearing.

At times attorneys ask psychologists to examine patients and then may or may not use the information in court. In those situations, the judges, following the precedents in their jurisdictions, ultimately decide whether the work product of the psychologists gets admitted into court.

FEES

Standard 6.04a, Fees and Financial Arrangements, states, "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." Judicious psychologists inform clients and/or their attorneys of the cost of the services and other payment policies, including acceptance of payment with credit cards, the policy on billing for missed appointments, and the range of services covered (e.g., report writing, testing, phone calls, court testimony). It is appropriate for psychologists to charge for their time expended in the case, including travel time, preparation time, and time spent in the courtroom. Prudent psychologists document the understanding of fees.

Psychologists working on forensic cases should avoid being paid on a contingency basis (i.e., getting paid only if the client wins in court; APA, 2013c). Such arrangements can give the appearance that psychologists might taint their testimony for their own financial gain. In addition, the client may lose the case, or the award may be much less than expected. It may be desirable to obtain a

promise-to-pay letter from the client's attorney, although this is not a guarantee of payment.

Prudent forensic psychologists insist on getting paid in advance for their work. Failure to do so may result in a situation in which the client or the client's attorney will stall or withhold payment for the services if the report from the psychologist does not contain the elements that they wanted. Such a fee dispute can tarnish the perceived objectivity of the expert witness or result in subtle bargaining for changes in the report.

Even psychologists who get involved in the court system because they treat litigants in a case need to be concerned about fees. Certainly it would be reasonable for psychologists to provide some services to patients, such as writing a brief letter or making collateral phone calls, without charge, just as part of doing business. However, special care needs to be taken with forensic cases, which can escalate into dozens or even hundreds of hours of work.

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Special Topics in Psychotherapy

Other chapters in this volume have discussed many of the ethical topics related to the practice of psychotherapy. In this chapter, we address special topics related to psychotherapy that other chapters have not covered. These include the obligations of psychologists when they are approached by patients who are already receiving services from others, coordinating treatment with other professionals, the duty to consult or refer, rules regarding the termination of patients, and treating patients who have moral beliefs that differ substantially from those of their psychotherapists. In addition, we cover the topics of determining the proper course of action when confronted with unethical institutional policies, the importance of organizational citizenship, and how to respond when learning about psychologists who violate ethical principles.

TREATING PATIENTS WHO ARE RECEIVING SERVICES FROM OTHERS

Sometimes psychologists are approached for services by patients who are currently receiving services from another professional. At times this decision may reflect impulsivity, poor judgment, deception, or pathology on the part of the patients. In these situations, it may be best for the potentially new psychotherapist to instruct these patients to go back to their current psychotherapist and try to resolve whatever issues appear to be present.

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At other times patients may have good reason to feel dissatisfied with their current psychotherapists and want information about other treatment options. Other patients may want specialized services that their current psychotherapist cannot provide, such as neuropsychological testing. In other situations, the patients' employers may have changed insurance companies, and they could no longer see their current psychotherapist as an in-panel provider, and the patients believe that they cannot afford the cost of treatment from an out-of-network provider. It is also possible that patients who are participating in one theoretical approach of psychotherapy may have heard about another approach and believe that they would prefer the new approach.

Standard 10.04, Providing Therapy to Those Served by Others, of the American Psychological Association's (APA's; 2017a) *Ethical Principles of Psychologists and Code of Conduct* (APA Ethics Code) does not establish an inflexible rule for these situations but instead encourages psychologists to proceed carefully "in order to minimize the risk of confusion and conflict and . . . with caution and sensitivity to the therapeutic issues." Psychologists who receive a request for services from a patient currently working with someone else should first explore the circumstances of the request. They should ask about the reasons for the inquiry and consider the best interest of the patient. Ethical principles can guide psychologists on how to behave. Psychologists can consider beneficence (what is in the best interests of the patient), nonmaleficence (what can be done to avoid harm to the patient), and respect for patient decision making. Also, psychologists need to consider the interests of other professionals involved.

Often it will be appropriate to consult with the first psychotherapist with the consent of the patient. If the patient wants to receive services from both providers simultaneously, then psychologists need to determine if their services would conflict with what the first psychotherapist is providing, to avoid confusing the patient. For example, it would not help the patient if one psychotherapist was teaching "thought stopping" to the patient while the other was encouraging acceptance of one's thoughts, consistent with acceptance and commitment therapy.

Often the providers and their patients can arrange for both providers to work with the patient sequentially or simultaneously, depending on the patient's needs. For example, one provider may conduct short-term therapy for a circumscribed problem, such as a specific phobia, while a second psychotherapist may see the patient and their spouse for couples therapy. In either case, the patient is best served when all parties communicate transparently and honestly about their expectations, methods, and goals.

COORDINATING JOINT TREATMENTS

To maximize effectiveness, psychologists should coordinate their treatment with other health professionals. Literature on patient safety may be instructive for psychologists in these situations.

Every year thousands of patients die because of medical errors. A *medical error* is any mistake that substantially harms or creates a realistic threat of harming a patient. Many medical errors involve prescribing or delivering the wrong medication or the wrong dose of medication. Other medical errors include laboratory mistakes (e.g., the wrong name is submitted with a blood vial), dietary errors (e.g., providing the wrong diet in the hospital), or practitioner errors (e.g., conducting surgery on the wrong body part, failing to adequately monitor a patient who is suicidal or homicidal).

Systematic communication failures cause most medical errors. For example, a nurse or pharmacist may have misinterpreted the medication abbreviation used by the physician, residents may have been afraid to express their doubts or concerns to the attending physician, or patients may not have been given the opportunity to describe their symptoms clearly to their health care providers.

These communication errors may involve psychologists who work in hospitals or other organized health care settings, but the principles are also relevant to outpatient psychologists. Whenever two or more healthcare professionals are providing treatment, it is essential that they communicate with each other and foster a *culture of safety* to protect patient welfare. This means striving to enhance communications with patients and with others involved in their care (e.g., other health care providers, family members) and office staff. It also means showing a willingness to listen to others as well as to give information. The cooperative and patient-focused attitude is especially important when working in integrated care settings where psychologists work with professionals from different disciplines who may have different perspectives on patient care.

Of course, it is essential to develop a trusting relationship with patients or when clinically indicated, patients' families, who may share valuable information essential for their treatment. However, patient welfare also requires that psychologists work closely and share information with psychopharmacologists and other health care professionals treating the patient. For example, medical errors can occur if psychopharmacologists do not receive accurate information from psychologists about their mutual patients. Psychopharmacologists need to know how the patient is responding to medications or if the patient is taking other medications, over-the-counter drugs, or alternative herbal remedies that could compromise the effectiveness of their prescription drug or otherwise jeopardize health and safety. Unfortunately, some patients do not tell their psychopharmacologist about their use of complementary or alternative medical remedies.

Conscientious psychopharmacologists want what is best for their patients and appreciate constructive feedback. A majority of psychotropic medications are prescribed by nonpsychiatrists, mostly pediatricians, family practitioners, and general practitioners. They may especially appreciate the input of psychologists.

Professional psychologists need to know enough about psychopharmacology to have a general sense about which medications will benefit their patients. Ideally, psychologists will know enough about evidence-based treatments to know when medical or non-medical treatments are indicated or how they

could be combined. Also, their level of knowledge of psychopharmacology should be appropriate for the populations they serve and the disorders they encounter (APA, 2021b). However, prescribing medications can be very complex and involve multiple factors about which a nonmedically trained psychologist might be unaware. Psychologists should be careful not to go beyond the scope of their competence or license to practice.

CASE EXAMPLE: A PHYSICIAN WAS TOO RECEPTIVE

A psychologist was treating a patient who was receiving medication that appeared inappropriate for their diagnosis. When the psychologist called the physician to talk about the diagnosis, the treatment plan, and the possibility of a different medication, the physician asked, "What medication should they be on?" "What dosage should I start them at?" and "When should I begin to increase the dosage?" Although we commend the physician for being receptive to the opinions of the psychologist, it would be helpful if the physician knew more about the psychopharmacological treatments available. In this case, the psychologist asserted that the decision of medication rested with the physician, but she did note that "many patients with this kind of disorder have responded well to. . . ." Because of her limited knowledge of psychopharmacology as it pertained to this medication, she declined to comment on the starting doses and titration procedures.

CASE EXAMPLE: AN UNRECEPTIVE PHYSICIAN

A psychologist was treating a patient who was receiving medication that appeared inappropriate for their diagnosis. When the psychologist called the physician to talk about the diagnosis, the treatment plan, and the possibility of a different medication, the physician said, "I think I know what I am doing, young lady. You just stick to your talking stuff and let me worry about the medication."

Here the psychologist found herself in a quandary. On the one hand, she acknowledged that the physician had greater knowledge and skills in psychopharmacology, recognized the possibility that her concerns might be unfounded, and did not want to undermine the physician–patient relationship. On the other hand, she knew that this medication was not commonly used for this patient's condition, and the patient was not benefiting from it. Here the psychologist had to balance two forms of nonmaleficence: the potential harm to the patient from the wrong medication with the need to protect the patient's relationship with her physician. If the psychologist believed that the harm from the medication was especially salient or if the patient began to deteriorate on the new medication, the psychologist might decide to educate the patient on the possible harm (or lack of benefit) of the medication and recommend that the patient seek a second opinion.

Although psychologists defer to psychopharmacologists on the coordination of medications, they do not have to be mute when it comes to discussing medications. When developing treatment plans for patients, psychologists can help patients understand the costs and benefits of the medication. They can also monitor the overall state of the patient and inform the psychopharmacologist of any changes in the patient's status. For example, one of the major reasons for medication failure is that patients do not take the medications as intended. Appropriately trained psychologists can help patients think through attitudes and habits that could increase their compliance with the medication. Medication adherence involves the complex interaction of many factors, but data from veterans diagnosed with posttraumatic stress disorder (PTSD) suggests that those engaged in psychotherapy were less likely to discontinue their medications prematurely (Duek et al., 2021).

In addition, psychologists should share information with other health care providers when their patients are using herbal remedies or nonprescription drugs that may interact with prescription medications. Also, psychologists can help monitor side effects or adverse reactions to psychotropic (or other) medications. Sometimes the adverse effects can be sudden and life-endangering. At other times the side effects may involve more long-term issues, such as a substantial weight gain or an unexplained deterioration in mood or behavior (Olfson, 2015). Furthermore, psychologists should inform the psychopharmacologist of any adverse events or suspected medication errors. Although this does not happen often, medication errors can be fatal.

DUTY TO CONSULT OR REFER

Psychologists have a duty to consult or refer when the patient is not benefiting from treatment or is unlikely to benefit from treatment (APA Ethics Code Standard 10.10a, Terminating Therapy). This duty may become apparent in the first interview with the patient, or it may not become apparent until after many sessions.

Sometimes psychologists treat patients with disorders for which psychopharmacology and behavioral interventions are both effective or more effective when used in combination. At other times medication or outpatient psychotherapy alone is indicated for therapeutic benefit. When patients have disorders that may respond either to nonmedical treatments or medication (e.g., depression, panic disorder), psychologists need to inform patients of their treatment options. At times the behavioral services need to be of greater intensity than weekly outpatient therapy, such as an intensive outpatient or partial hospital program. Patients need to know, in general layperson's terms, the nature of each treatment, approximate costs (i.e., money, time, and effort), and probable benefits.

Nonmedical psychotherapists sometimes work with patients with serious and chronic mental health conditions, such as schizophrenia or bipolar disorder.

CASE EXAMPLE: AN INFORMED PATIENT AND AN INFORMED PSYCHOLOGIST

A well-educated patient came to the first session with a psychologist with a detailed article about the benefits of a new medication for anxiety disorders. The psychologist was aware of the medication and the recent publicity about it. The psychologist appropriately described the benefits of the medication but noted that the outcome study had a high dropout rate, failed to include long-term outcome results, and was expensive. The psychologist also described non-medical treatments for anxiety. Nonetheless, the psychologist offered to make a referral to a competent psychopharmacologist if the patient wished.

Effective treatment of these patients usually requires psychologists to work with a psychopharmacologist. Depending on the circumstances, a nonprescribing psychologist may refer the entire treatment of the patient to a psychiatrist or psychopharmacologist or may continue to provide psychotherapy while the psychopharmacologist prescribes and monitors the medication.

The failure to refer patients with serious and persistent mental health conditions for medication treatment could be grounds for malpractice. For example, in *Osheroff v. Chestnut Lodge, Inc.* (1985), a patient was diagnosed as having a personality disorder and received 7 months of intensive psychodynamic psychotherapy in a hospital. His family complained about the lack of improvement and after the hospital refused to change the treatment plan, transferred him to another hospital, where he responded well to medications and was discharged within 3 months. A malpractice suit was later filed against the first hospital.

The court determined that the psychiatrists in the first hospital were negligent in their diagnosis and treatment of the patient. Expert witnesses opined that the treating psychiatrists should have modified the treatment plan when it became obvious that the intensive psychotherapy was not helping the patient. The lesson is that psychologists need to reconsider their treatment plans, seek consultations, or make referrals if patients are not benefiting.

However, the *Osheroff* case should not be construed to discourage psychologists from working with individuals with serious and pervasive mental health conditions. A variety of psychosocial treatments have been found effective in reducing symptoms and improving the lives of patients with serious and pervasive mental disorders, especially when working in conjunction with a psychopharmacologist.

According to Stewart and Chambless (2008), psychologists saw patients for a median of 12 sessions before reevaluating treatment or seeking a referral. Nonetheless, Lambert and Shimokawa (2011) found an algorithm that could predict patients at risk for failure by the fourth session. This suggests that psychologists should adopt a lower threshold for reevaluating patient progress, treatment goals, and the psychologist–patient fit. One rule of thumb might be

for psychologists to reevaluate patients who have not made progress or who have not developed a good working relationship by the fourth session, in the absence of an obvious reason, for example, a patient might have had a substantial interpersonal loss during the first four sessions, which worsened their mental state. In this situation, the psychologist has reason to believe that the lack of progress is due to the intervening life event and not necessarily the psychologist–patient relationship, an erroneous diagnosis, or the choice of an inappropriate treatment modality. Or a psychologist may be working with a reluctant adolescent and need several sessions to build a working rapport with the patient. However, in the absence of obvious reasons, psychologists should be quick to reevaluate their cases.

Having a mechanism in place to evaluate progress can be helpful. Some psychologists use a standardized outcome measure. However, even soliciting patient feedback at the end of each session provides some measure, albeit rough, of the patient's perception of progress. It is often an asset for psychologists to maintain an optimistic outlook for patient recovery in difficult cases. However, psychologists need to balance their optimism with the recognition that they may fall prey to the Dunning-Kruger effect (see Chapter 5, this volume; Epley & Dunning, 2006) and overestimate the quality of their judgments. They should

CASE EXAMPLE: SHOULD THIS PATIENT BE REFERRED?

A patient with chronic depression received both psychotherapy from a psychologist and medication from a psychiatrist. The treatment substantially reduced suicidal ideation and brought some stability to the life of the patient. Nonetheless, moderate depressive symptoms remained, and the psychologist believed that he had reached his limit in terms of helping the patient and felt that the patient would be better served by seeing another psychotherapist. However, they had a good working relationship and the psychologist feared that the patient would interpret the referral as a personal rejection.

Here, the overarching issues of beneficence (ability to help the patient) or nonmaleficence (continuing to treat the patient with minimal likelihood of improvement) appear to conflict with the goal of respecting patient autonomy and keeping the relationship going. The use of specific questions may provide some information to help resolve this issue. The psychologist could ask the patient whether they believe psychotherapy is of benefit. Even if the patient is not improving, the fact that the patient is stable may indicate that they are getting some benefit from the treatment. Can the psychologist identify other sources of information to help elucidate the extent to which the patient is progressing or benefiting? Do consultants believe that another modality would have a reasonable likelihood of producing meaningful change, and if so, would this necessitate a referral? Ultimately, decisions about when to refer and when or how to coordinate treatments should focus on the well-being of the patients and involve them in as much of the decision making as is clinically reasonable.

also keep in mind that implicit situational demands may cause some patients to underreport their level of distress or lack of comfort in the psychotherapeutic relationship.

Consequently, if patients have not developed a good working relationship with their psychologists or have not started to improve by the fourth session in the absence of an obvious reason, it would be prudent to reconceptualize the case. Most often this would occur by looking to the quality enhancement strategies (i.e., empowered collaboration, consultation, redundant protections, and documentation). Candid reflections with the patient may result in useful information that could invigorate treatment. Routine collection of feedback through standardized feedback forms at selected points in psychotherapy might also be used to supplement the direct interviewing of patients (Lambert & Shimokawa, 2011). However, at times, prudent psychologists may decide to refer the patient to another provider for medication, to seek consultation, to refer the patient to a new psychotherapist, or to do a combination of these actions. Consider the situation in the following example.

TERMINATION

Except when institutional policies state otherwise, psychologists may refuse to treat potential patients for any reason, including their ability to pay for services. Once treatment has started, however, psychologists do not have an unqualified right to terminate unless the treatment is completed, the patient ends the relationship, the psychologist recommends alternative services and provides termination counseling, or unless precluded by the actions of the patient or third-party payer (APA Ethics Code Standard 10.10, Terminating Therapy).

There are limited exceptions to this general rule, however. According to Standard 10.10, Terminating Therapy, psychologists may terminate treatment, even without the consent of the patients, if patients no longer need treatment, are not likely to benefit from treatment, or may be harmed by the treatment, or if the patient or someone close to the patient has threatened the psychologist. Psychologists are required to provide termination counseling to patients in these circumstances except when precluded by the actions of third-party payers or patients.

Typically, the moral principles of beneficence and respect for patient autonomy do not conflict. Usually, psychologists who initiate a treatment relationship with patients continue to provide that treatment until the patient no longer needs the treatment or has decided to discontinue services.

Sometimes, however, the moral principles of beneficence and nonmaleficence conflict with respect for patient autonomy. That is, the psychologist may have concluded that psychotherapy no longer benefits the patient or may even harm the patient despite the desires of the patient to continue in treatment. For example, the patient may have problems outside of the psychologist's areas of expertise. Or the psychologist may be unable to handle the transference or

countertransference productively. Or the patient (or someone associated with the patient) may have threatened the psychologist.

Abandonment

Abandonment means termination of and failure to refer a patient when the psychologist knew or should have known that the patient needed more treatment. Abandonment can result in an ethics or licensing board complaint or a malpractice suit. An essential question becomes whether the psychologist acted consistently with professional standards of conduct when they terminated the patient.

Abandonment can be intentional or unintentional. *Intentional abandonment* occurs when psychologists know that further treatment is needed but nonetheless terminate or withhold services or a referral. A lower standard of proof is required when a verdict of intentional abandonment is sought. A termination itself when a patient clearly needs continuing care might be sufficient to establish liability. Alternatively, *unintentional abandonment* occurs when psychologists terminate treatment when they did not know that further treatment was needed, and a patient is harmed or harms another as a consequence of the termination. Expert witnesses would be needed to help the court determine whether the termination fell below the standard of reasonable care and whether the psychotherapist is liable for the harm to the patient or others (Knapp et al., 2013).

De Facto Abandonment

Patients may feel abandoned any time they lose reasonable access to their psychologists. This may occur when the psychologist takes an extended vacation and provides inadequate backup or if a treatment relationship ends abruptly, such as when a psychologist suddenly moves to another city or leaves an internship setting and makes no efforts to prepare the patient for the change.

CASE EXAMPLE: LIMITED BACKUP

A psychologist with a part-time practice provided no backup services. She had no answering service and did not check phone messages between sessions. She informed all prospective patients of these facts when they started treatment and screened out patients who appeared to have severe problems that might require emergency or after-hours interventions.

Is this psychologist acting ethically or showing good risk management practices? To a large extent, the answer depends on the skill with which the psychologist screens out the more severe patients. Nonetheless, her practice involves some risks. Some patients may develop symptoms that are more severe than their initial presentation and may need crisis services.

Difficulties may also occur if psychologists abruptly change their schedules and can only offer times to their patients that conflict with their patients' work or parenting obligations.

Psychologists should also consider their responsibilities for coverage when they go on vacation or if they become ill and must take an extended leave from work. At such times, psychologists should inform their patients of the coverage arrangements. For example, it is acceptable for psychologists in solo practice to cover for each other, and it is also acceptable for those psychologists to give each other background information on patients who may be likely to need crisis services. However, it is desirable in these circumstances to inform patients of the coverage arrangements ahead of time (such as in the privacy notice) to eliminate any perception that the psychologist disclosed confidential information unnecessarily without their consent.

When Treatment Will Not Benefit or May Harm the Patient

Some patients with severe disorders may benefit from treatment if it stabilizes their condition or keeps them from deteriorating. Consequently, psychologists may continue to treat some patients who fail to improve in psychotherapy, as long as they are receiving some benefit from the service.

Under rare circumstances, some patients may want to continue treatment when they derive no benefit from it or it might even hurt them. Some patients with pervasive personality disorders may insist on more treatment and threaten to sue or file a disciplinary complaint if the psychologist terminates treatment against their will. Psychologists can minimize these problems by proactively suggesting options to facilitate progress when there is an impasse in treatment. If no progress is made even after these modifications, and a termination seems like the optimal option, psychologists can explain the reasons for considering termination, identify and document objective benchmarks for progress, give patients some time to process the issue, and allow a reasonable amount of time to coordinate referrals if indicated. Psychologists would not be acting competently if they continued a treatment that had no reasonable likelihood of benefitting the patient. Consequently, they may restrict or refuse appointments with patients if it is clinically indicated to do so (Gutheil, 1985). Psychologists should document these decisions carefully.

Situations such as the one in the preceding case example may reflect a conflict between the principles of respect for patient autonomy and beneficence and nonmaleficence. That is, ordinarily, psychologists respect the wishes of the patient to continue to provide treatment. However, psychologists should not continue to treat if they believe that continued treatment would not benefit or would harm the patient.

Before making these decisions, psychologists need to ask themselves several questions based on the quality enhancement strategies presented in Chapter 9: "If it appears necessary to terminate the patient, have I sought consultation

CASE EXAMPLE: A DIFFICULT PATIENT

A patient with a serious and pervasive personality disorder was not benefiting from treatment or cooperating with the treatment program. She refused to seek consultation with a psychopharmacologist for medication, and she often missed appointments, only to call during the week for consultations under the false pretext that it was an emergency. When she did attend appointments, she idled away most of the hour resisting efforts on the part of the psychologist to focus on clinical issues, only to raise serious issues minutes before the sessions were to end.

The psychologist told her she could only remain in treatment if she (a) sought consultation for medication and took medication if clinically indicated, (b) used psychotherapy productively, and (c) discontinued calling between sessions unless it was an emergency.

The patient responded by making vague threats about filing a licensing board complaint and refused to leave the office unless she got a promise that the psychologist would always be there to treat her. She cajoled another health professional to call the psychologist and urged her to "quit being so mean" to her. The psychologist acted appropriately in insisting that treatment could only proceed if the patient engaged in behaviors likely to permit a favorable outcome. Fortunately, psychologists can rely on a body of literature concerning therapy-interfering behaviors to guide their responses (e.g., Koerner, 2012).

on this issue?" "Have I gathered all the information I need to make the best decision?" "Have I involved the patient in discussing the options as much as feasible?" and "Have I attempted to reach a consensus with the patient on treatment goals and procedures?" Prudent psychologists document the answers to these questions in detail.

If, after doing all of these things, the psychologist is still unable to help their patients, then they should consider discussing the prognosis candidly with their patients. This situation requires great clinical acumen. Of course, it is possible that the treatment may be preventing the patient from deteriorating further or that the patient otherwise places great value on the treatment. When patients show life-endangering features, psychologists need to balance long-term benefits (the patient may eventually become cooperative with treatment—even if it is with another provider—and make progress) with short-term risks (the patient may actually attempt suicide). All factors being equal, psychologists should err on the side of continued treatment if the possibility of harm is realistic. Sometimes not all of the factors are equal, and patients are better off with a psychologist who terminates an iatrogenic treatment.

WORKING WITH PATIENTS WITH DIFFERENT MORAL PERSPECTIVES

May psychologists refuse to treat patients who engage in acts that they believe are immoral? Or do psychologists have an obligation to support their patient's goals in treatment, even if doing so would violate the psychologists' deeply held beliefs?[1]

Sometimes patients do things that psychologists and society in general agree are morally offensive, such as sexually assaulting children, or attacking an innocent third party. In these situations, psychologists will act to protect the public because general beneficence (i.e., the well-being of members of the public) supersedes the decision-making autonomy of their patients.

However, other patients do things that only some psychologists or some (but not all) members of the general public find morally offensive. For example, a psychologist may believe that all children should be born to parents who are married to each other. Or psychologists may believe that all women should strive for egalitarian marriages and oppose any vestige of marital inequality, or that a patient who wants to remain a virgin until marriage is holding on to an outdated vestige of Victorian morality. Other psychologists raised or acculturated within the United States may find the life choices of non-Western patients to be offensive. For example, a patient may wish to agree to an arranged marriage, wear a veil, or otherwise adopt customs that are contrary to the social conventions of the West.

Psychotherapists who attempt to screen out patients whose moral values differ from their own may not be considering all the relevant ethical principles guiding psychologists. On the one hand, patients have a right to make life choices on their own, and, as long as they are not harming themselves or others, it could be argued that psychologists should respect those beliefs. In addition, the overarching ethical principle of justice assumes that society will be better off when people can access health care without worrying whether a practitioner will discontinue treatment abruptly because of their beliefs or lifestyle or will use the treatment to attempt to persuade them to adopt different lifestyle choices. On the other hand, some could argue that it is unfair to psychologists to expect them to promote life choices at variance with their own beliefs.

We can look to principle-based ethics for some guidance in these situations. As discussed in Chapter 4, according to principle-based ethics, psychologists can evaluate the morality of their behavior according to the extent to which it conforms to several overarching moral principles. When moral principles collide, moral agents can allow one moral principle to override another, as long as they try to mitigate harm to the offended moral principle.

Although we did not identify the moral beliefs of the psychologist as an overarching ethical principle, we may consider it as such for the purposes of decision making in this situation. When treating patients whose moral values

[1]The authors thank Drs. Michael Gottlieb and Mitchell Handelsman for their assistance in this section. The ideas are further explored in Knapp et al. (2015).

differ from the psychologist's own, it's important to balance respect for one's own beliefs and respect for the autonomy of the patients to live their lives as they wish with the principles of general beneficence and justice (i.e., the social benefits of having all persons able to access treatment without fear of being rejected because of their beliefs or lifestyle). If the patient is already in treatment, psychologists must also consider the moral principle of nonmaleficence (i.e., avoiding harm to the patient).

How then should psychologists respond when the behavior of a patient offends their deeply held moral values? We do not believe that we can give a definitive answer to all psychologists on how to balance these concerns in all situations. However, we recommend three factors for psychologists to consider as they weigh these decisions. First, a willingness to work with patients with moral values different from one's own and to respect their worldviews does not mean that psychologists cannot examine or explore those views. Second, psychologists should inform patients of reasonably anticipated ideologically based treatment limitations ahead of time. Finally, despite their best efforts, psychologists will necessarily encounter individuals with morally diverse perspectives and should be capable of dealing with them at some level, even if it is only to conduct crisis intervention, until they can refer them to another treatment professional. We discuss each of these in more detail next.

Exploring Beliefs

Ordinarily, psychologists should work within the worldview of their patients without trying to impose their own beliefs on them. As it applies to religious patients, psychologists should generally work within the worldviews of their patients and avoid spiritual intolerance (Pargament, 2007).

However, psychologists need not passively accept whatever their patients say. As Plante (2007) stated, psychologists need not be "complacent or condone destructive thoughts, feelings, and behaviors, most especially when they result in significant physical or mental harm, abuse, or neglect as defined by both legal and ethical definitions" (p. 899). For example, a patient may intend to acquiesce to an arranged marriage, even though the match appears particularly disadvantageous to her. If the marriage does appear to be particularly harmful to the patient, then the psychologist can certainly discuss the advantages and disadvantages of agreeing to it. The actual process of exploring beliefs can be nuanced, however, and should convey caring for the patient and respect for their worldview (except those narrow portions related to self-harm; e.g., Knapp et al., 2010; Pargament, 2007).

Although psychologists should adopt a high threshold for attempting to change the beliefs of their patients, they can adopt a low threshold for exploring those beliefs. It is legitimate to ask patients to question and reconsider major life choices. If a patient stated that she wants to terminate a pregnancy, it is entirely legitimate (and indeed desirable) to discuss her priorities, goals, alternatives, and moral values. It is also appropriate to discuss these same factors if a patient with a problem pregnancy says that she wants to keep the child.

The decisions on when to support or probe can become challenging. For example, psychologists who ask patients to explore the possibility of ending a pregnancy need to be aware of their own motivations. They may allow their moral judgments to influence the extent to which they identify patient behaviors as harmful. They should ask themselves if they would have spent as much time helping a patient with her decision to not abort a child (in or out of marriage). The goal of these questions and discussions is to help patients evaluate the situation and determine what they want to do, as one would with any major life decision.

Similarly, psychologists may encounter individuals who feel conflicted about their same-sex attraction because these feelings run counter to their religious beliefs. It is quite appropriate for the psychologist to ask patients to establish a methodology for reconsidering these religious beliefs by respectfully asking in-depth questions. It may also mean educating the patient about the pernicious impact of internalized homophobia and informing the patient about the research on the biological bases of same-sex attraction or connecting them with religious sources or leaders who do not see a conflict between faith and homosexuality (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). Here, and in other places, science overrides ideology. A psychologist should accurately represent the research, even if it would appear to weigh decisions in a manner contrary to the belief system of the psychologist. For example, a psychologist may believe that same-sex attraction is morally wrong, but that psychologist nonetheless has an obligation to accurately report the failure of reorientation psychotherapies to change a person's sexual orientation.

Psychologists need to adopt a neutral position even with patients who appear to share their beliefs. The apparent similarity in beliefs may mask actual differences in beliefs that are relevant to the presenting problem, hinder the discussion of their ambivalence, or hide conflicts that the patient may have with ecclesiastical authorities. As a result, psychologists may inadvertently be imposing their own values on the patient.

Information Concerning Limitations on Treatment

Psychologists who cannot work with certain patients should clarify their positions before treatment begins. It would be harmful for patients to encounter a psychotherapist who, after the patient discloses a sensitive issue, subsequently expresses unfriendly or condemning attitudes toward them. Psychotherapist rejection can be painful and harmful. Of course, it is not feasible to delineate every potential moral conflict that could occur, but psychologists should identify the more common moral conflicts ahead of time to prospective patients.

Expect Patients With Different Moral Perspectives

Even if psychologists wanted to screen out patients with diverse moral perspectives, they would never be able to do so completely. Even those psychologists

who choose to adopt and advertise a moral perspective in their practices, may encounter patients whose moral choices differ from those of the psychologist. A Christian counseling service may, for example, have a clientele that is less likely to reveal conflicts over same-sex attraction or an unwanted pregnancy. However, no practice can ever be free from all moral controversies. All psychologists may encounter patients who unexpectedly present with behaviors or attitudes that the psychologist finds morally offensive. Even in religious counseling centers, psychologists will encounter patients who feel attracted to members of the same sex or who have unwanted pregnancies; a patient presenting for depression may suddenly, in the course of treatment, reveal a same-sex attraction; or a patient being treated for anxiety may, in the course of treatment, become pregnant and express a desire to get an abortion. Even evangelical teenagers may become sexually active, fail to use contraceptives, and end up with unwanted pregnancies.

Some psychologists may balance the overarching ethical principles in such a way that they feel compelled to refer patients to psychotherapists who have different moral beliefs. This involves issues of competence in that psychologists may encounter some patients where the divergence of values is so strong that the psychologists have lost the ability to assist their patients. That is to say, they may let the strength of their own moral beliefs override general beneficence or justice (i.e., the benefits of everyone being able to receive respectful treatment regardless of their beliefs or lifestyle). However, if those patients are in crisis or great distress, the overarching ethical principle of nonmaleficence becomes relevant and the balance gets shifted in favor of continuing effective treatment, at least until the crisis has passed and the psychologist can make a referral. In addition, the referral needs to be done in a sensitive and caring manner with an effort to reduce the distress on the part of the patient and avoid a judgmental attitude.

WORKING IN INSTITUTIONS: ORGANIZATIONAL CITIZENSHIP

Working in institutions can offer many advantages, such as the availability of colleagues for consultation, administrative support services, and freedom from the administrative and business burdens of dealing with insurance companies. When it comes to delivering health care services, institutions may offer a wider range of specialized services than an individual could. Of course, working in institutions can have disadvantages as well, such as the lack of control over work conditions and sometimes having to deal with difficult coworkers or institutional policies that do not appear to be in the best interests of patients or that squander resources.

Organizational citizenship refers to the extent to which moral agents promote the well-being of the organization or institution for which they work. Some employees contribute to the well-being of their organization by fulfilling their job responsibilities conscientiously and may pitch in and go beyond their job descriptions when they see an opportunity to help the organization meet

its goals. They may, for example, assist a colleague who is struggling with their workload.

Good organizational citizenship also means refraining from harmful actions. Good organizational citizens avoid harmful gossip, do not magnify problems beyond their actual significance, and address issues with administrators respectfully. These behaviors help create an atmosphere of trust and support whereby colleagues can feel good about going to work, less defensive when mistakes are made, and free from the burden of working in an overly punitive atmosphere.

Good organizational citizenship is an element of public beneficence. That is, psychologists can impact the extent to which their organization meets its goals to the public through their behavior toward their administrators and fellow staff members. Consider the following example.

CASE EXAMPLE: A PSYCHOLOGIST WORKING IN A PRISON

A correctional psychologist understood that the quality of the lives of prisoners depended, to a large extent, on the nature of their contacts with the correctional officers who could either be harsh and dehumanizing or could balance the need for order with respect and compassion. Therefore, he went out of his way to develop good relationships with the correctional officers, who then spontaneously asked him for advice on how to handle difficult prisoners and alerted him to prisoners whose behavior warranted concern.

CONFRONTING UNETHICAL POLICIES

Psychologists working in institutions such as hospitals, schools, prisons, or public agencies may be asked to do things that are contrary to professional standards (e.g., W. B. Johnson, 2016; W. B. Johnson & Wilson, 1993). Sometimes well-meaning supervisors or employers develop policies based on good intentions but with ignorance of clinical realities or the standards in the APA Ethics Code. At other times the supervisors or employers may be motivated by personal convenience and have less concern for adhering to overarching ethical principles.

For example, psychologists in the military may have to turn over patient records in response to a military directive, even though the patient may refuse to grant permission for the release. Administrators in a correctional facility may ask a psychologist to comment on the discharge of a prisoner, even though the prisoner was never informed that their treating psychologist would be asked to do so. A psychologist in a state hospital might be ordered to prepare a patient for release to the community, even though the psychologist believes that the patient still poses a serious danger to public safety. The standard for psychologists facing conflicts between the APA Ethics Code, treatment goals, and organizational demands is to attempt to resolve the issues in a manner that permits adherence to the Code (Standard 1.03, Conflicts Between Ethics and

Organizational Demands). Psychologists are not automatically subject to disciplinary sanctions by APA because they followed the demands of their institutions, but they must try to correct the problems that give rise to possible ethical conflicts. That is, they may not simply ignore the conflict and cooperate with the institutional policy without trying to change it. Of course, psychologists may never cooperate with any law or organizational policy that involves violating basic human rights (Standard 3.04, Avoiding Harm).

Fortunately, most psychologists face less serious, although nonetheless important, issues concerning conflicts with institutions, such as handling conflicts concerning confidentiality. W. B. Johnson and Wilson (1993) noted that a few military psychologists simply followed military regulations (the military manual approach); a few passively thwarted directives that they believed were unjust by withholding information, deleting reports, or lying to protect patients (the stealth approach); but most tried to balance the needs of the patients with the needs of the military (the best interest approach). The best interest approach allows psychologists to vary their responses depending on the circumstances. Often it is desirable for psychologists to take an educational approach and work quietly with institutional authorities to rectify the problem or, better yet, to anticipate conflicts. Institutional leaders may have an important social goal that they are trying to meet. For example, corrections administrators have the goal of providing as safe and humane a living environment as possible considering the inherent unpleasantness of a prison. Psychologists can often help them think of other ways to meet those goals while still adhering to the APA Ethics Code. The ethical decision-making process described in Chapter 4 may help psychologists generate some useful solutions and balance competing moral principles and institutional demands (Knapp et al., 2007).

CASE EXAMPLE: A PRISON DISCIPLINARY BOARD

A corrections administrator asked a psychologist to participate on a disciplinary board. The psychologist had a concern that such participation might cause him to lose credibility among his inmate patients. Upon speaking with the corrections administrator, the psychologist learned that the administrator was concerned about the wide differences and acrimony among members of the disciplinary board and some apparently capricious decisions. The psychologist offered to meet with the board to discuss ways to improve their internal decision-making process.

Unfortunately, institutions sometimes fail to alter their unethical policies and psychologists must decide whether the good they do by staying in the institution outweighs the harm created by institutional policies. In these situations, it can be helpful to look at both the proximal and distal causes of the conflicts.

When these conflicts occur, it can be helpful to think about the potential application of the theory of moral foundations discussed in Chapter 2. As you may recall, actual decisions are often made by reliance on five moral foundations: caring, respect for autonomy, loyalty to one's group, deference to authority, and preserving sanctity. These moral foundations describe the factors that actually influence decisions, as opposed to overarching ethical principles that describe the factors that should be considered when people make decisions. Attitudes toward the authority of the institution or loyalty to the group that the institution represents may influence how individuals respond to institutional demands that contradict the APA Ethics Code or overarching ethical principles. Those who give more weight to authority or group loyalty in making decisions may be more inclined to defer to the institution, whereas those who give less weight to authority or group loyalty may be more inclined to challenge the institution.

Organizational Conflicts Within APA Concerning Allegations of Torture

After the United States military invaded Afghanistan following the attacks of September 11, 2001, it captured a number of enemy combatants and imprisoned them in various locations including facilities in Guantanamo Bay in Cuba. Because they were not fighting for an organized political state, these individuals were not covered by international agreements concerning the humane treatment of prisoners of war. It was believed that some of them possessed important information concerning the nature of the organizations intending to commit further terrorist attacks on the United States and other democracies. In order to obtain this information, the administration of President George W. Bush redefined the standards prohibiting torture to permit the use of certain techniques, such as sleep deprivation and waterboarding, which most international bodies defined as torture.

Military psychologists were involved in some of these interrogations. There were reports of military psychologists who intervened to stop torture when they saw it, but there were also reports of contractors who participated in torture or trained military interrogators on how to torture these detainees.

In the midst of the debate over appropriate interrogation techniques, Department of Defense (DoD) officials asked APA for guidance on appropriate standards for psychologists to follow during these interrogations. In 2004, APA convened a task force named Psychological Ethics in National Security (PENS) with the goal of developing standards for the application of ethical standards for the conduct of psychologists during interrogations. The document was endorsed unanimously by a task force that included both military and civilian psychologists and explicitly denounced torture. APA's Board of Directors adopted it as APA policy (although it was later withdrawn).

On the surface, the conclusions of the PENS report seemed uncontroversial. It clearly stated that "psychologists do not engage in, direct, support, facilitate, or offer training in torture or other forms of cruel, inhuman, or degrading

treatment" (APA, 2005, p. 4). Nonetheless, the issues were more complicated. Although the PENS document contained words that denounced torture, the report appeared to permit actions against detainees that were not torture from the standpoint of the administration of President George W. Bush but that would be considered torture by many scholars of international law.

In addition, the task force consisted of six DoD psychologists (and three voting civilian representatives) and many of the votes were split along those lines. These DoD psychologists were in an apparent conflict of interest situation wherein they had incentives to support the policy of their employers (Zimbardo, 2007). Although the APA Board of Directors adopted this document as APA policy in 2005, the report did not go through the usual process of being reviewed by the elected APA representatives, and the general membership of APA did not have an opportunity to debate the issues. In addition, APA did not solicit advice from advocates of the rights of detainees, such as the International Red Cross or similar organizations.

Furthermore, the civilian members of the task force allegedly had agreed to the conclusions found in the PENS report with the understanding that this would be an interim report and that a case book would be developed that would explain how the general principles would be applied in actual cases. In reality, the report was not adopted as an interim report but as APA policy. No case book was forthcoming, although, in 2011, APA's Ethics Office did create a website for comments on difficult ethical issues, including those dealing with torture.

The lack of open debate and discussion on these sensitive issues led to suspicion within APA, which increased even more when the APA Ethics Committee dismissed complaints against APA members who allegedly had engaged in torture. Finally, allegations later emerged that certain APA staff members had worked closely and privately with DoD officials to ensure that APA policy would not undercut the DoD's position on "enhanced interrogations."

As a result of these persistent allegations, APA commissioned an investigation led by David Hoffman (Hoffman et al., 2015) to explore possible misconduct by APA employees and volunteers. It has been alleged that the committee entrusted with recommending changes to the 2002 Ethics Code had made changes with the intention of allowing psychologists to conduct torture; that APA staff and leaders had colluded with the DoD to permit the use of torture, albeit under the euphemistic term "enhanced interrogations"; and that the APA Ethics Office deviated from standard adjudication processes to avoid prosecuting APA members who allegedly participated in torture. Other allegations of misconduct or poor judgment had been made against specific individual APA staff members and volunteer leaders.

The Hoffman report concluded that the first allegation (that the APA Ethics Code was changed to permit psychologists to commit torture) was without merit.[2] No evidence was found that anyone within APA or the Task Force was

[2]I, Samuel Knapp, was a member of the Task Force to revise the APA Ethics Code, cooperated with the Hoffman investigation, and was cited several times in the final report.

influenced by or even anticipated that changes in the APA Ethics Code would have been used to justify torture.

The Hoffman report concluded that APA's Ethics Office did deviate from its usual protocol to avoid disciplining psychologists who had engaged in torture. However, some believe that any possible deviation was less relevant than a basic structural flaw in the adjudication process for the APA Ethics Office. The APA Ethics Office had procedures in place based on the assumption that aggrieved individuals would have basic civil liberties and the opportunity to present their case freely and supply direct documentation or testimony of misconduct. However, in the case of DoD interrogations, the aggrieved individuals had no such access to petition their case and the Ethics Office only had newspaper reports or second-hand information of misconduct.

Finally, the Hoffman Report concluded that certain APA staff members and leaders worked too closely with the DoD with the goal of avoiding criticism of DoD policy concerning torture. It concluded that at least one individual had a conflict of interest that influenced their behavior in a manner contrary to good ethical judgment. Our evaluation of that conclusion is compromised by the recognition that some of the individuals whose behavior was criticized have filed lawsuits, thus allowing for the possibility that more information may come to light.

Although we are deferring comment on several of the conclusions in the Hoffman Report, we nonetheless believe that it is possible to draw the following conclusions concerning organizational citizenship. The organizational processes within APA surrounding the adoption of the PENS report, while perhaps justified from the standpoint of a strict interpretation of APA procedures, appeared to violate the spirit of a democratic organization. It is not an ethics violation under the APA Ethics Code for a psychologist to refuse to listen to critics, ignore contradictory information, or to act in an uncivil manner toward fellow employees. Nonetheless, as noted earlier in the section on organizational citizenship, the atmosphere created by such behaviors can harm others in the workplace. It can degrade the quality of the workplace for others, engender distrust and suspicion, and lead organizations to make less-than-optimal decisions.

Also of interest to this discussion, at its meeting in August 2016, the APA Council of Representatives, which is the major decision-making body of the APA, voted to approve a revision to Standard 3.04, Avoiding Harm, of the Ethics Code to clarify the meaning of torture. The revision adds a section that reads, "Psychologists do not participate in, facilitate, assist, or otherwise engage in torture, defined as any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person, or in any other cruel, inhuman, or degrading behavior that violates 3.04(a)" (APA, 2016b).

Conflicts Between the Ethics Code and Laws

Should psychologists ever violate the law? As we go to press, some states have passed laws making it illegal for health care professionals to assist an individual

in getting an abortion (although courts have yet to define what giving assistance means), and laws or rules have been proposed that would not permit health professionals to assist children in changing their genders. Several years ago, Florida passed a law that prohibited physicians from talking to their patients about firearm ownership, although courts later struck down the law. However, good practice requires that psychologists respond to discussions of abortion if their patients raise this as an issue, that it may be medically reasonable for some children to change their gender identities, and that psychologists should talk to patients about firearm ownership if such discussions are necessary to help ensure the safety of their patients or others.

If such a law violates a fundamental human right, then the Ethics Code requires psychologists to disobey that law (Standard 3.04b, Avoiding Harm). At times it could be difficult to determine whether the unfairness or foolishness of a law rises to the threshold of violating a fundamental human right. We suggest that when psychologists are put in a situation where laws appear to conflict with professional standards, they study the situation to ensure that they understand the law and their professional obligations accurately. If it appears that doing the medically indicated service could be illegal, then it is advisable to seek allies and support when deciding how to respond. Such concerted action will provide support for the psychologists and help them think through their options. Furthermore, psychologists working together or through their professional organizations may be able to challenge the unjust law or at least obtain a restraining order or injunction which would obviate the need to disobey the law.

IDENTIFYING ETHICAL MISCONDUCT

Psychologists occasionally learn from their patients about the ethical misconduct of a colleague. How should psychologists respond to this information? If a patient is intent on seeking redress for serious misconduct, the psychologist can direct them to the APA Ethics Committee, licensing board, or a malpractice attorney. If a patient is concerned about a relatively minor error, the psychologist may, with the consent of the patient, speak to the offending psychotherapist directly and resolve the problem informally.

However, some patients do not wish to file a complaint when serious misconduct (e.g., sexual exploitation) has occurred and other patients may be at risk. Psychologists need to know what state laws govern their responsibilities in these situations. Unless state laws require psychologists to report misconduct, we encourage psychologists to follow the APA Ethics Code and to honor the patient's autonomy and confidentiality rights by not sharing any information that the patient does not wish to disclose. The Code balances general beneficence (or the obligation to protect the public in general) with respect for patient autonomy and confidentiality. Standards 1.04, Informal Resolution of Ethical Violations, and 1.05, Reporting Ethical Violations, require psychologists to report only if the conduct jeopardizes patient safety, cannot be resolved informally,

and confidentiality rights are respected. Finally, it does not apply when a psychologist has been asked to review the work of another psychologist.

Few injured patients follow through with formal complaints. Often patients have positive feelings for the offending psychologist, fail to see the behavior as exploitative, or assume responsibility for what happened. Psychologists who focus too much on the past ethical violation or the desirability of filing a complaint may be perceived by patients as pressuring them (Chapter 7 discusses intrusive advocacy).

Nonetheless, even if patients initially refuse to file a report, psychologists can educate them about proper professional behavior. For example, when therapeutically appropriate, the psychologist can explain to patients how sexual contact between patients and psychotherapists violates the standards of the profession and harms patients. In addition, the psychologist should inform (but not pressure) the patient of the general nature of the disciplinary options available, including the time limits for filing complaints. In these situations, psychologists need to consider respect for patient autonomy, concern for the well-being of the public (public beneficence), and nonmaleficence (harm to the patient if the issue is pushed too strongly). These discussions with patients require therapeutic timing and sensitivity to the patient's preferences.

Psychologists should not adopt a dichotomous attitude in these situations (e.g., either the patient files a complaint or does nothing). Patients may be willing to take other positive actions rather than filing a complaint. The following vignette illustrates how a psychologist was able to help a patient address this issue, even though she was not willing to file a complaint.

CASE EXAMPLE: A CAREFUL DECISION

A patient had sexual contact with a previous psychologist. Although she did not want the stress of filing a formal complaint or malpractice suit, she did write a letter to the psychologist informing him that she believed he had violated professional ethics and noting that she was considering filing a complaint. The patient asked her new psychologist to review the letter, which was subsequently sent. The patient believed that the offending psychologist would think twice about future misconduct after receiving such a letter.

13

Business Issues

Professional psychology has a business as well as a service aspect. Ethical standards apply to collecting fees, billing insurance, and advertising just as much as they do to other aspects of practice. In this chapter, we first cover financial issues concerning informed consent, setting fees, bartering, referral fees, handling debts, and relationships with insurers. We also consider ethical issues and risk management principles concerning advertisements and public representations.

FINANCIAL ISSUES

The rules governing fees and billing come from the American Psychological Association's (APA's; 2017a) *Ethical Principles of Psychologists and Code of Conduct* (APA Ethics Code), regulations of state licensure boards of psychology, and laws in individual states. Although insurance or fee problems constitute only a small percentage of disciplinary actions by licensing boards (Association of State and Provincial Psychology Boards, 2021), billing disagreements are often the catalyst that prompt patients to file complaints for other reasons (Knapp et al., 2013). Some patients who are dissatisfied with services believe they are "leveling the playing field" by refusing to pay an outstanding bill.

The moral principle of respecting patient autonomy is especially important when billing or collecting fees in that psychologists need to inform patients

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ahead of time about the costs involved. Fidelity, or the promise that psychologists follow through with promises, and previous statements concerning their fees and billing practices is also important. Psychologists who understand these moral principles will be better able to develop and implement fair and reasonable billing and fee collection policies.

Informed Consent on Financial Matters

APA Ethics Code Standard 6.04a, Fees and Financial Arrangements, states, "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." According to the principle of informed consent, patients should know the important elements of treatment, including the costs of services. Patients can then decide whether the anticipated benefits of treatment are worth the costs. Discussing these issues ahead of time helps reduce confusion and misunderstandings in the future.

Prudent psychologists inform patients of the relevant financial aspects of their practices, such as the cost per session, the range of services covered (e.g., report writing, testing, phone calls), and office policies concerning the acceptance of credit cards or Venmo payments, assistance with completing insurance forms, billing for missed appointments, when the charge is made (e.g., the day the service is rendered or at the end of the month), when payment is due, or when an interest or service fee begins on delinquent accounts (Zur, 2007). It is wise to give patients a written statement, contract, or service brochure that contains information on fees, billings, and collections at or before the initial office visit. This brochure may be given to patients at the same time that they receive the privacy notice (see Chapter 8), but it must be a separate document. Other psychologists post their financial policies on their websites or email a document that includes these policies to their patients.

Some patients assume that their insurance contract guarantees payment to the psychologist and that any disputes over fees are between the psychologist and the insurance company. However, this is true only if the psychologist has a special arrangement with the insurer or managed care organization. Of course, the psychologist or office staff may assist patients in completing insurance forms. The very act of receiving this assistance, however, may lead patients to believe that they have no responsibility for the cost of services. Nonetheless, the patient, not the insurance company, is responsible for paying the psychologist, unless the psychologist has signed a contract with the insurer specifying otherwise. This expectation should be made clear to the patient at the outset of treatment.

Absent an insurance contract that specifies differently, psychologists may charge any amount for any professional service as long as they have explained fees and billing procedures to the service recipients ahead of time. Absent a contract with an insurer that specifies otherwise, psychologists may charge for a missed appointment, additional time if a session runs over an hour, phone

contacts, time spent in preparing reports and professional consultations and collateral contacts, and any other professional activity if patients have been informed ahead of time. However, psychologists should not assume that insurance companies will reimburse them for such services. For instance, most insurance companies will not pay for forensic services. Unless it is clear that an insurance company will reimburse for missed appointments or a company has given advanced approval, psychologists should not bill an insurance company for missed appointments.

Furthermore, some patients may forget the financial policies of the psychologist. Although psychologists may legally bill for a wide range of services, sensitive psychologists show restraint and prudence. Patients who are charged for a 10-minute emergency phone call may feel that they are being "nickeled and dimed" by the psychologist. They may even suspect that the psychologist prolonged the phone call to get more money. Although the option of billing for those services may have been stated in a service brochure, many patients will not remember all of the details in that brochure. Although it may be legal for a psychologist to charge for an emergency phone call, such a practice may reduce the trust and goodwill of the patient. Also, patients with financial concerns may not make a needed emergency phone call if they know they will be charged. This may place the patient at further risk. Of course, for some patients who may misuse the option of emergency phone calls, charging for the phone calls may be clinically indicated as well as being fair to the psychologist.

CASE EXAMPLE: A DISCERNING PSYCHOLOGIST

The service brochure of one psychologist states that he bills for all phone calls exceeding 20 minutes. Nonetheless, he routinely tells patients that he is making a one-time exception for the first long phone call. Such a policy engenders goodwill on the part of patients and alerts them to their responsibility for future phone calls.

Psychologists should anticipate that they will increase their fees to keep up with the cost of doing business. Sensitivity should be shown toward ongoing patients, however, so that they do not feel trapped by the fee increase and their financial investment in psychotherapy. At the least, we recommend that psychologists give long-term patients considerable advance notice about the increase in fees.

Standard 6.04d, Fees and Financial Arrangements, states, "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." It would not be desirable for psychologists to skim the cream (i.e., billing the patients until their insurance or their funds run out) and then refer their patients elsewhere (i.e., "creaming and dumping").

CASE EXAMPLE: A THOUGHTFUL ACTION

A psychologist accepted a patient but after several sessions realized that she had minimized the extent of her problems in the initial session. In reality, she had pervasive and chronic mental health problems. Although she had enough resources to pay for 20 to 30 psychotherapy sessions, the psychologist correctly recognized that she would need many months (perhaps years) of treatment. He immediately focused the next session on helping her to develop a long-term treatment plan and to identify an agency or service provider that could provide the long-term continuous treatment she needed.

Billing Accurately

Standard 6.06, Accuracy in Reports to Payors and Funding Sources, states, "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." Also, Standard 6.04c, Fees and Financial Arrangements, states, "Psychologists do not misrepresent their fees." The underlying principles in billing insurance companies are honesty and accuracy. Standard 6.06 establishes a realistic perspective on billing. Accordingly, a psychologist would not be subject to a disciplinary action only because a clerk made a simple billing error. Of course, psychologists should not willfully misrepresent their fees to third-party payers, and they need to use reasonable diligence in monitoring their billing services.

In 2021, Congress passed the "No Surprise Act" (implemented January 1, 2022), which required, among other things, that health care professionals give patients a good faith estimate of their total costs for the treatment. This can create problems for psychologists who often cannot make a good estimate of the needs of their patients until they have completed a more thorough evaluation. As we go to press, APA and other mental health organizations are seeking to repeal or amend this law, as it does not appear to have its intended impact at least for the delivery of mental health services. In the meantime, psychologists can follow guidance from APA concerning the implementation of this law (APA, 2022b).

In recent years, insurers, including Medicare and other government insurance programs, have been giving special scrutiny to insurance fraud and abuse. A clear bright line distinguishes fraud from abuse. *Fraud* means a deliberate and systematic effort to obtain money through deceit (Kalb, 1999). Fraud investigators are not interested in rare billing errors or in legitimate ambiguities in the use of specific procedure codes. In contrast, *abuse* refers to a pattern of errors in billing. Psychologists who submit thousands of bills in their career can be expected to make some mistakes. Although all psychologists should bill

carefully, they should not be unduly worried that a rare honest mistake will lead to an allegation of fraud.

Some insurers require physicians or other large health care institutions to develop compliance plans that include, among other things, a process to check on the accuracy of their billing. Although many psychologists do not have contracts that require similar compliance plans, we note that there may be some value in periodically checking the accuracy of billing. That could mean, for example, double-checking that there is a psychotherapy note that meets the standards of the insurer and justifies the procedure code billed for that day. It could also mean adding start and stop times to every psychotherapy note to justify the length of time as reflected in the billing.

Diagnostic Accuracy

Psychologists should ensure that they can justify and that they document the diagnosis given to their patients as this may reflect eligibility for insurance reimbursement. For example, a patient may have a diagnosis of borderline personality disorder, but the insurer may refuse to pay for services for patients with that diagnosis. However, these patients usually have coexisting disorders (e.g., major depression, conduct disorder) that are reimbursable. In such cases, psychologists may bill for the coexisting disorder, as long as the treatment is focused on addressing that disorder.

Few insurance policies cover problems in living, such as marital discord, career dissatisfaction, or parent–child problems in the absence of a diagnosis. Nonetheless, psychologists may receive requests from patients who ask for couples counseling or marital therapy. Sometimes these individuals are relatively healthy but only wish to enrich their relationship. However, usually they are in great psychological distress and meet the standards for a disorder the standards for a disorder reimbursable by an insurer. For example, Tambling and Johnson (2008) found that persons seeking couples counseling had scores on tests indicating psychological distress comparable to other patients seeking outpatient therapy. Couples counseling often reduces symptoms of psychological distress (e.g., Tilden et al., 2020).

If a partner has sufficient emotional turmoil to meet the standards for a diagnosis covered by the insurance company, and if couples counseling is clinically indicated to treat that diagnosis, then the medical necessity standards of the insurer have been met and the services may be billed to the company. However, patients with "only" a problem in living that is the focus of treatment should be reported as such even if it means losing insurance reimbursement.

Billing for Supervised Services

Supervised services are those in which the supervisee is legally an agent of the supervising psychologist. Whether insurers will reimburse for the services provided by supervised psychologists-in-training or unlicensed employees

depends on the contract and the policies of the insurance company. Some companies such as Medicare will permit psychologists to bill for services provided by supervisees, if they meet certain conditions. However, most commercial insurers do not permit psychologists to bill for supervised services. The underlying rules are to check state laws and insurance company policies to avoid misrepresentation. Unfortunately, some psychologists erroneously assume that it is acceptable to sign insurance paperwork as if they actually performed the service, without verifying the policies of the insurer.

Bartering

Standard 6.05, Barter With Clients/Patients, states, "Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services." Psychologists may not barter if it is clinically contraindicated or exploitative. Bartering can be either ethical or unethical depending on the circumstances.

CASE EXAMPLES: A FAIR EXCHANGE AND A PROBLEMATIC EXCHANGE

A patient owed a psychologist about $200 and appeared unable to pay it. However, he offered the psychologist a gift certificate worth $200 off an electronic appliance at his brother's electronics store. There were no apparent clinical contraindications to this arrangement, and both the psychologist and patient were satisfied.

In contrast, another psychologist hired a patient to do yard work in exchange for receiving psychological services. The yard work was sloppy, and the patient was inconsistent in showing up for work. The patient insisted that the psychologist knew that he had physical limitations and could not be expected to perform optimal services.

In the second case, the psychologist and patient disagreed about the extent to which the sloppy work was the result of his physical limitations. However, this vignette shows the risks that may arise when psychologists barter for services.

From a practical perspective, psychologists who barter for goods have a lower risk of exploiting or harming patients than those who barter for services (Zur, 2007). Psychologists may inspect goods ahead of time, and along with the patient, predetermine their economic value. Although the value of the goods (e.g., an electronic appliance) in the first example was predetermined, the value of the labor in the second example was open to debate. Even with the bartering of goods, Woody (1998) recommended having a written agreement that specifies the worth of the object being bartered. Bartering is similar to

other multiple relationships in many ways in that it should generally be avoided but can be acceptable if it is the only way for patients to receive services.

Referral Fees

Referral fees, sometimes misnamed *fee splitting,* involve the acceptance of reimbursement for referring a patient to another practitioner for professional services. Standard 6.07, Referrals and Fees, permits referral fees only if payment "is based on the services provided (clinical, consultative, administrative, or other) and is not based on the referral itself." The prohibition against referral fees does not preclude employers from dividing fees with employees, nor does it preclude payment for services rendered, such as rent, secretarial services, or professional consultation. The prohibition against referral fees exists to ensure that referrals are made based on patient need, not based on financial gain for the psychologist. It prevents psychologists from making referrals to less competent or less appropriate professionals to collect a fee even though it means that patients will not receive the best care available.

Handling Debts

Patients are only responsible for payment of services that they agreed to before the services begin. The two broad rules for handling patient billing are to have explicit rules and to use fairness and tact. Cautious psychologists make certain that unpaid bills do not accumulate. A pay-as-you-go policy can resolve this issue. Psychologists who allow debts to occur should address these debts early in the treatment relationship before they accumulate to large levels. Unfortunately, we are aware of well-intentioned psychologists who, in a moment of excessive empathy or pity for a patient, told them, "Don't worry about your debt for now," or some similar words without clarifying what they meant or without considering how the patient may have interpreted those statements. However, the psychologists may begin to feel resentment or anger toward the same patients to whom they felt such generosity weeks or months before. Although it is commendable to provide psychotherapy at a low cost for selected patients, psychologists should think through these decisions ahead of time and make explicit arrangements with their patients.

Patients may develop unforeseen financial problems that limit their ability to pay for psychotherapy. It is not unethical, per se, to terminate a nonemergency patient who cannot or will not pay for services. Nevertheless, psychologists could be liable for charges of abandonment if they precipitously discharged patients who were in crisis or psychologically vulnerable at the time that services were terminated without ensuring viable treatment options. In these cases, a psychologist may consider reducing the fee, extending the length of time between sessions (if clinically indicated), or providing pro bono services until the patient has established services from an agency or provider who will accept the lower fee. At the very least, the psychologist should be available for emergencies until the patient is seen elsewhere.

Psychologists are not obligated to treat nonemergency patients who refuse to pay for services. If patients with adequate resources fail to pay for services, the psychologist should inform them of the consequences of nonpayment. Some patients express their dissatisfaction with treatment through the nonpayment of a bill. Problems with paying bills need to be discussed with the patient in terms of the overall satisfaction with and perceived value of psychotherapy.

Standard 6.04e, Fees and Financial Arrangements, states, "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." Nonetheless, psychologists should be aware that legal opinions may differ from patient expectations. Psychologists may avoid misunderstandings and ill feelings if their patients understand the consequences of nonpayment ahead of time.

Many psychotherapists use collection agencies routinely with no problems. Much depends on the specific agency used and its practices. Nevertheless, attempts to collect unpaid bills may precipitate a malpractice charge or licensing board complaint. Occasionally writing off an unpaid bill may be more expedient in the long run than facing allegations of misconduct, even if those allegations are frivolous.

Psychologists should choose a bill collection agency carefully because unprofessional or abusive behavior on the part of the collection agency reflects badly on them and the profession. Psychologists using collection services should limit their disclosures to collection agencies to the minimum necessary to collect the debts, such as client name, dates of services, and the amount owed, and provide no clinical information.

Health Care Delivery Systems

The delivery of health care has changed substantially over the last 40 years. In the 1980s health care policies often paid adequately and did relatively little monitoring of the frequency or quality of services. However, many policies failed to include good mental health benefits, and some even excluded psychologists from reimbursement entirely.

During the 1990s many insurers adopted managed care practices to coordinate treatment, in an attempt to reduce unnecessary expenses and ensure the wisest use of limited health care dollars. Purchasers of health care insurance wanted some evidence that they were spending their money wisely, especially when health care expenditures were rapidly increasing. Nothing in the aims of managed care is inherently in conflict with the goals of good psychological practice.

Nonetheless, under many managed care plans, the quality of services offered declined while the paperwork and administrative burdens on health care professionals increased. Policies ostensibly designed to eliminate waste ended up restricting patient access to needed services or created unusual burdens for patients to get the services for which they or their employer had paid indirectly

through their insurance premiums. Patient and provider pushback eventually pressured managed care companies to end some of their worst abuses.

Health care again started changing with the passage of legislation to expand mental health parity, expand health care coverage and encourage integrated health care systems (through the Affordable Care Act), place performance-based payment incentives in Medicare, and encourage the use of electronic health records. The impact of these changes has been mixed, and psychologists through their professional associations should advocate for policies that promote the triple aims of health care: quality of service, a good patient experience, and affordability. Unfortunately, the current incentive system in health care has not favored mental health treatment, resulting in a huge amount of unmet mental health needs that were exacerbated by the COVID-19 pandemic.

One of the recent changes is that some insurers now require or encourage the use of outcome measures as a condition of reimbursement for services. Medicare has adopted some payment systems based on the quality of services. On the surface, such programs seem fair, in that the more competent practitioners should receive more reimbursement for their services, and outcome measures could ensure that psychologists are addressing their patients' presenting problems.

However, much depends on how insurers implement such outcome or performance measures. It is not wise to create an outcomes program that would penalize psychologists based on a small and unrepresentative sample or encourage psychologists to selectively advertise for patients with favorable prognoses, or to avoid those with complex problems who will likely show modest improvements or stabilization only after a long period of time. In addition, it is not always clear that a particular outcome measure will provide the most useful feedback. That is to say, not all outcome measures capture information that would help psychologists understand the reasons for treatment improvement or failure. Because of these and other concerns, we encourage psychologists to work through their professional associations to clarify and modify pay-for-performance programs to ensure that they actually reach their desired goals.

As described in Chapter 3, it is desirable for psychologists to seek equity in the delivery of their services, but this is difficult when the economic structure of health care places economic disincentives on psychologists who dedicate themselves to serving the underserved. As a result, we believe that psychologists have a moral obligation to address harmful practices of insurance companies and government-supported health care programs. It is desirable for psychologists to treat some of their patients at a low fee or pro bono, contribute to public projects, and otherwise donate services to others. However, these psychologists could be shortsighted if they believe that these efforts compensate for the greater injustices caused by insurance laws or insurance practices. Meaningful change will not occur unless psychologists engage in systematic advocacy to address these shortcomings and such advocacy occurs through professional associations. Chapter 3 discusses advocacy in more detail.

Often the advocacy goals of psychologists involve both public interest and guild goals (e.g., promoting parity in insurance coverage for physical and mental illnesses). Nothing is wrong with promoting one's self-interest politically as long as such promotion is also in the public interest and is done in accordance with ethical standards of political conduct.

ADVERTISING AND PUBLIC REPRESENTATIONS

Psychologists communicate to the public through advertising or other public statements. *Advertising* refers to the use of public representations intended to attract clients or patients. Many psychologists advertise through media such as websites.

The moral principles of integrity and respect for patient autonomy require psychologists to be accurate in their advertising. This honesty helps to ensure public confidence in the individual psychologist and the profession as a whole. Properly informed patients can make better decisions about psychological services. Advertising is regulated primarily through the APA Ethics Code and state licensure board regulations as well as through state and federal laws.

Psychologists also communicate to the public through talks with groups of laypersons; radio or television interviews; and articles in newspapers, magazines, and on websites. The moral virtues of integrity, nonmaleficence, and general beneficence require psychologists to make accurate public statements. Properly educated members of the public can make better decisions for themselves. Public statements are regulated primarily through the APA Ethics Code and the regulations of state licensure boards of psychology.

Advertising

Standard 5.06, In-Person Solicitation, prohibits psychologists from soliciting business from persons who are vulnerable to undue influence because of particular circumstances. This standard prohibits the psychological equivalent of "ambulance chasing." It does not preclude contacting significant others to benefit a current psychotherapy patient. In addition, this standard allows psychologists to participate in disaster relief services through the Red Cross or other agencies in which they may encourage individuals to receive mental health services. Psychologists may also participate in community outreach programs, such as those designed to assist persons experiencing homelessness who have serious or persistent mental illnesses (Knapp & VandeCreek, 2003).

Psychologists have wide discretion in what they may include in their advertisements and how they advertise. Nothing prohibits advertising through television, radio, billboards, leaflets, the internet, business cards, brochures, newsletters, or other media. Although most psychologists would not advertise on a billboard, it is not inherently unethical. While gaudy or ostentatious advertisements are not unethical, we encourage psychologists to avoid such advertisements because they may lead members of the public to discredit the value of professional services (Knapp & VandeCreek, 2003).

CASE EXAMPLE: A PERCEPTIVE PSYCHOLOGIST

A psychologist had a very successful practice in which he engaged in health psychology where, among other things, he worked on weight control and smoking cessation. He hired a professional consultant who suggested several marketing strategies, including the use of billboards and promotional matchbooks. Although none of these strategies were unethical, the psychologist asked himself whether the use of matchbooks to advertise smoking cessation appeared exploitative.

Advertising may not include false, fraudulent, or deceptive statements (Standard 5.01b, Avoidance of False or Deceptive Statements). Most of the problems with advertising occur because of inadvertent deceptions. Otherwise conscientious psychologists may fail to appreciate the implications of what they put in their public announcements. For example, some psychologists may refer to their practices with such words as "associates" or "international." These words may lead consumers to expect substantial resources on the part of the practice. Such representations are acceptable as long as the psychologists actually have other professionals working with them or have ongoing business activities in other countries. An occasional workshop or consultation in a foreign country, however, does not qualify as an "international operation."

Other psychologists use the term *specialist* inaccurately. The term *specialty* needs to be distinguished from the term *proficiency.* A specialist has more training and expertise in a specific content area than that of the average psychologist and dedicates a large portion of practice to that domain (Knapp et al., 2013). A psychologist with a proficiency has general competence in a particular domain of practice. For example, a psychologist who has advanced credentials and expertise in couples counseling and sees about 60% of her caseload in couples counseling may claim to have a specialty in that domain. However, a psychologist who is competent in, but lacks advanced credentials in, couples counseling and sees about 20% of her caseload for couples counseling may only claim to have a proficiency in that domain. A psychologist who lists several specialties is probably confusing the word with proficiency.

Woody (1997) noted that the term *specialist* has a seductive appeal and may attract consumers who expect a higher level of care. However, those expectations could quickly turn to disappointment if the psychologist lacked the skills that they advertised. Furthermore, in the event of a malpractice suit, a self-proclaimed specialist could be held accountable to the standards of specialists, not general practitioner psychologists.

Standard 5.01c, Avoidance of False or Deceptive Statements, states that psychologists who provide mental health services may only represent academic degrees that were the basis for their licensure or that were earned from regionally accredited universities. Psychologists who are teaching, conducting research,

or providing other services may represent degrees from unaccredited colleges and universities, although some employers may forbid such activities.

Vanity credentials are poorly regulated in professional psychology. A vanity credential is awarded upon the payment of a fee without having been earned through a legitimate examination or peer review process. Individuals can obtain certifications of advanced proficiency in a wide range of areas from impressive sounding groups, even though these credentials have no merit. Psychologists only need to send a resume or claim that they have a certain amount of life or work experience to obtain these credentials. Unfortunately, these credentials deceive the unknowing public into thinking that practitioners have expertise that in fact, they might not have (Woody, 1997).

Psychologists who engage others to create or place public statements that promote their professional practice, products, or activities retain professional responsibility for such statements. They do not compensate employees of communication media for publicity in a news item and clearly identify paid advertisements as such (Standard 5.02, Statements by Others). The acronym ABD (i.e., "all but dissertation") is used informally to apply to students who have completed all of their academic requirements except for the dissertation but have not yet earned their doctoral degree. However, this informal description is not a degree and may not be used in advertising one's services. Most laypersons would not understand what ABD means and could mistake it for an actual credential.

Other misrepresentations can occur when psychologists supervise psychologists-in-training or other professionals. By definition, a *supervising psychologist* assumes responsibility for the work product and public presentations of the supervisee. The supervising psychologist must ensure that supervisees disclose their credentials and supervised status accurately. This can be especially important for psychologists-in-training who have earned a doctoral degree. The term *doctor* may mislead some patients into assuming that the supervisee is already an independently practicing professional.

Some potential patients will look at websites that use terms such as "rate-the-doctor" or other similar descriptions when they search for a psychologist. Although such aggregate reviews may be helpful in learning about good restaurants or plumbers, they have limited value in looking for a good mental health professional. Although most reviews of psychologists are positive (Kolmes & Taube, 2019), sometimes highly dissatisfied patients may post unfair comments, leading to an inaccurate perception of the psychologist. The options are limited for psychologists who have received highly unfair and negative reviews. Some companies will respond to requests to remove inflammatory or disrespectful comments, but others will not.

For example, one site proclaimed that a particular psychologist was the "best psychologist in Pittsburgh" based only on three reviews. On this site, most psychologists had fewer than four reviews, many had one or none. One psychiatrist had more than 30 reviews, leading us to suspect that she had actively encouraged satisfied patients to go on the website and promote her services.

Although naïve members of the public might be impressed by the many testimonials she received, we and other psychologists felt skeptical about the value of these reviews. Such solicitation of positive reviews appears to violate the spirit, if not the letter, of Standard 5.05, Testimonials, which restricts psychologists from seeking "testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence."

Presentations to the Public

Media psychologists may appear on radio or television talk shows; write for newspaper columns; or present information through informational websites, chat rooms, or other media (Standard 5.04, Media Presentations). When they do, they should avoid sensationalism. The information should be reasonably consistent with scientific or professional standards.

Media psychologists do not suggest that a professional relationship exists with the advice seeker. When psychologists establish a professional relationship, they tailor the information to the needs of their patients. However, this is not possible with callers or writers when the real audience includes all of the listeners or readers. In these situations, psychologists need to restrict their comments to general information about the question raised and make clear that their role is informational rather than therapeutic.

CASE EXAMPLE: PSYCHOLOGICAL ADVICE IN AN INAPPROPRIATE CONTEXT

A psychologist hosted a radio talk show that encouraged listeners to call in with their sexual problems. The total context, however, was one of entertainment and not education. The cohost told sexual jokes and belittled the callers when their calls ended. An impression was given that the callers who had the most shocking problems were selected to talk with the psychologist, whereas those with more routine problems were not.

Although the psychologist was proper in her own behavior, a question arose as to whether her participation in the show could be justified.

Often callers expect psychologists working with the media to address complex and important issues in their lives through a few brief sound bites. Psychologists experienced in working with the media can usually reframe the issues in a respectful manner that will provide some insight and education to the caller and the observing public. Psychologists can improve the quality of their media presentations by focusing on public welfare, having peers review their work, doing the necessary research, learning how to respond to journalists, and getting training in dealing with the media (Palmiter, 2012).

Many psychologists develop websites or web pages to advertise their practices or products. The presence of websites has led to increased opportunities to educate the public about psychological issues. However, some websites are more appropriately called *advertorials* because they put advertisements in the context of an informational website. The APA Ethics Code has no specific standards for websites. Instead, the standards applicable to advertising or public statements, in general, apply to websites as they apply to advertisements and public statements presented through other media. Care must be used to ensure that the advertisements are clearly labeled as such, that the information does not appeal to the fears of vulnerable persons, and that the advertisements are accurate. Psychologists with websites that include a number of links need to show special care. Although the content of the psychologist's own pages may be accurate, balanced, and current, the content in the links may not be so. Of course, as described in Chapter 7, professional websites should be distinct from personal Facebook or other social media pages.

14

Psychologists as Educators

Although the teaching activities of psychologists are governed by the same disciplinary bodies as their other activities, state boards of psychology provide little control over teaching psychologists except to the extent that the American Psychological Association's (APA's; 2017a) *Ethical Principles of Psychologists and Code of Conduct* (APA Ethics Code) is embodied in the regulations of the licensing board. Courts also have had little involvement in the conduct of teaching psychologists. The teacher–student relationship is not one in which teachers have a fiduciary duty to their students, and therefore no malpractice can occur. Instead, institutional employers (i.e., colleges and universities) often provide the most meaningful oversight over teaching psychologists.

Even though teaching psychologists experience relatively few ethics complaints, they still face many important ethical issues (Keller et al., 2012). Overarching ethical principles should guide the behavior of psychologists in educational settings just as they do in other venues. Teaching psychologists should promote the welfare of their students by teaching them competently (i.e., beneficence), avoiding harming them (i.e., nonmaleficence), respecting their autonomy,[1] and treating them fairly (i.e., justice). Teaching psychologists have obligations to society at large in that their evaluations should accurately reflect the work of their students, their institutions should only graduate

[1]In this chapter, we use the phrase "respect for student autonomy" instead of "respect for patient autonomy."

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qualified students, and their letters of reference should accurately represent the qualities of the applicants (i.e., general beneficence). Finally, we conceive of psychologists who teach as *educators*, not just teachers, insofar as their relationships with other faculty, administrators, and other members of the academic community have ethical dimensions as well.

GENERAL CONSIDERATIONS IN TEACHING PSYCHOLOGY

Teachers should be competent in the courses they teach (APA Ethics Code Standard 2.01a, Boundaries of Competence); present information accurately (Standard 7.03b, Accuracy in Teaching); present students with the course requirements at the beginning of the course; and if changes are made in the course requirements, ensure that they inform students of the changes and give them an opportunity to meet these requirements (Standard 7.03a). Sexual relationships with students are unethical (Standard 7.07, Sexual Relationships With Students and Supervisees).

Competence

Psychologists must be competent in the areas that they teach (Standard 2.01a, Boundaries of Competence), or they must undertake steps to gain that competence (Standard 2.01c). Psychologists must ensure that their teaching assistants can perform their assigned duties (Standard 2.05, Delegation of Work to Others).

Competence not only means having a mastery of the subject matter but also knowing how to teach. The two are related. Those who have mastery over the content can better focus on the dynamics of the classroom, have more examples to draw on, or can cite personal research when illustrating concepts in class. Good teachers make themselves accessible to students (Zayac et al., 2021). They get their students interested in the material so that their natural sense of curiosity takes over (Servey, 2019) and often the manner of their teaching, such as demonstrating respect for students and sharing personal stories, conveys important lessons. One teacher wrote, "We are often not teaching what we think we are" (Archambault Carlson, 2019, p. 1556). Of course, sometimes unanticipated departmental vacancies occur, and psychologists have to teach courses in which they do not have time to prepare or have the optimal academic background. If this situation cannot be avoided, we urge the teaching psychologist to seek consultation to ensure that the quality of instruction reaches acceptable levels. At other times the quality of instruction is compromised by physical facilities, class size, or other factors outside of the control of the instructor. It could hardly be considered an ethical violation if the department had to cut back on resources and teaching positions because of budgetary reasons. In those circumstances, psychologists should strive to make the educational experience as rewarding as possible for the students.

If class size permits, good teachers know the names of their students, learn something about them, take an interest in their welfare, and focus on the

learning experience. They are approachable and create opportunities for students to talk with them, such as by arriving early for and staying late after classes, keeping office hours, or making themselves available through phone or email. Teachers who communicate via phone or email should communicate clear limits to their availability. For example, one teacher noted that she was available to respond to brief email questions from students, but to avoid unrealistic expectations, she cautioned that she only checked emails once a day during weekdays and once over the weekend. Effective teachers also listen carefully to students and respond thoughtfully and respectfully to their questions and show sensitivity to diversity issues that arise in their classes.

Common courtesy is very important. Teachers should avoid embarrassing their students and ensure that the classroom is emotionally safe for all students. When responding to comments from students, Howe (2001) recommended that instructors "gear how they respond in large groups according to the most sensitive student they can imagine being in the class" (p. 104). For example, even when students give partial or incorrect answers in class, it is often desirable to validate something in the student's response that contributes to the class discussion. Although it is harder for teachers to give individual attention to students in large classes, they can still establish some personal contact by disclosing something about their professional background and interests, using collaborative or cooperative learning exercises, or otherwise interacting with students.

Teaching psychologists can take steps to ensure a high quality of teaching. Many students are experiencing a high degree of stress. Nonetheless, without "dumbing down" the class, psychologists can reduce student stress by giving practice tests, posting lectures online, and being clear about class requirements (Meredith et al., 2021). In addition, faculty members can share their syllabi with other educators, attend continuing education programs in teaching, keep abreast of changes in the content areas in which they teach, participate in an online community for teachers, solicit and share feedback from colleagues on teaching style, and keep up-to-date on developments in teaching methodologies, such as the use of technology or cooperative or collaborative learning. Student ratings are one source of useful feedback for teachers, although these ratings have their limitations (Roxå et al., 2022).

Much classroom instruction shifted to the internet during the COVID-19 pandemic. Although face-to-face instruction has largely resumed, distance learning will now be more common. Online instruction requires a unique set of skills and an understanding of technology that supplements traditional teaching skills. Those who teach remotely ensure that they understand how to use technology to maximize student learning.

Fairness

Fairness is related to the ethical principle of justice in that students are treated impartially and equally. Not only is fairness intrinsically desirable, the perception

of fairness can also influence the teacher–student relationship. Even minor acts, such as a delay in getting tests back to students or adding additional coursework halfway through the term, can lead to a perception of arbitrariness and lack of concern.

Instructors who try to be fair communicate the objectives of the course and select methods of instruction that are appropriate to the goals of the course. They prohibit cheating and do not show favoritism. Of course, it is only natural that teachers like some students more than others. However, at a certain point, the overt expressions of attention may lead to a perception of favoritism, especially if other students feel that their needs are being ignored.

The course content should match the course description in the college catalog. For example, survey courses cover a range of topics rather than just topics of personal interest. The syllabus is an informed consent document that tells students before or at least at the start of the course about its content and requirements. Syllabi are a chance to form a good first impression with students and to focus on learner-centered goals, such as linking course requirements and evaluation processes to learning objectives (Richmond et al., 2019). Tests should reflect the content covered in class and be appropriate for the difficulty level of the class.

Presenting Information Accurately

Standard 7.03b, Accuracy in Teaching, requires psychologists to present information accurately. Being accurate requires, among other things, being current on the professional literature, attending conferences, reading journals, and discussing issues with colleagues.

Some questions studied by psychologists may engender controversy and elicit strong emotions in students. For example, do abortions predispose some persons to develop later mental health disorders? Do subtle biases cause health professionals to undertreat members of historically marginalized groups? Do some people have dysfunctional thinking styles that cause them to misinterpret scientific data concerning vaccinations?

At times these subjects may have personal relevance for the students. Some students may have ended a pregnancy, may have received less-than-adequate health care that they believe was racially motivated, or have taken a public stand against vaccinations. The difficulty of teaching these topics may be increased if students disclose personal information inappropriately or if they show intolerance of those who share other points of view.

Instructors can reduce problems by setting ground rules for treating others with respect during discussions. How they teach these topics can be as instructive as the content that they teach. They can model that respect themselves by showing consideration for the feelings of others and presenting information fairly. Furthermore, teaching about controversial topics has to be done within the context of course objectives.

CASE EXAMPLE: FRAMING AN IMPORTANT ISSUE

On the first day of class, the instructor asked students to discuss the following question: "Are all men rapists?" The few men in the class felt offended that the question was even raised and were defensive. The classroom was quickly polarized.

It is important to ask about the goal of this discussion. Was it to discuss sexual assaults, gender issues, or some other issue? If so, could the goals of the discussion have been met without causing the men to feel defensive? If the goal was to discuss sexual assaults, could the question have been framed differently, for example, "What can be done to stop sexual assaults?" or "What can be done to improve respect and understanding between men and women?"

Students sometimes enter the classroom with strongly held beliefs that contradict basic scientific findings. They may believe, for example, that professionals can "cure" same-sex attraction through reparative therapy, that harsh corporal punishment is an effective way to raise healthy children, or that vaccinations cause autism. Students may react strongly to professors who fail to endorse these particular beliefs. Teachers will be more effective in dealing with these issues if they encourage students to think critically, require them to accurately identify the opposing arguments before offering their own opinions, avoid ad hominem arguments, model critical thinking themselves, and strive to develop a relationship of trust with students.

CASE EXAMPLE: SHOWING CONSIDERATION FOR PERSONAL BELIEFS

A psychologist taught at a religious college that encouraged sexual abstinence. When discussing sexually transmitted infections (STIs)-prevention programs, the instructor accurately noted that abstinence-focused STI-prevention programs usually do not reduce high-risk sexual behaviors, pregnancies, or STIs. However, the instructor did not challenge abstinence as a goal because that reflected a value of many of her students. Also, she appropriately noted the methodological features of these programs that influenced the outcomes.

Here, the instructor both presented accurate information and respected the religious values held by most of the students (and the college). She helped students appreciate that many "easy-solution" or "just-say-no" abstinence-focused programs were ineffective. Those who believed in abstinence as a goal had a better appreciation of the changes needed to give abstinence-focused programs a more realistic chance of success.

Sensitivity to Upsetting Topics

Sometimes psychologists may cover difficult topics in their classes such as sexual assaults, physical traumas, or suicides. Studying these topics is important, but psychologists also should realize that, in any given classroom, one or more of their students may have been the victim of a sexual assault, had a physical trauma arising from an assault or an accident, or had a loved one die from suicide. Discussions of these topics may engender anxiety, fear, or trauma in those students. Many professors anticipate these reactions by offering trigger warnings when such topics are discussed. Only a few studies have been published on trigger warnings, although most students report that they support the use of such warnings (Boysen et al., 2021; Nolan & Roberts, 2022).

Sensitivity to Diversity

Instructors may encounter students who lack sensitivity to cultural or diversity issues. These qualities can be especially problematic for students who are preparing to enter professions in which they will work with culturally diverse groups. It would seem that psychologists, who have an ethical responsibility to refrain from unfair discrimination (Standard 3.01, Unfair Discrimination), should similarly discourage others from unfairly discriminating. However, the principle of respect for student autonomy suggests that professors should avoid using their power and status to influence personal opinions. Consequently, academic psychologists need to balance the moral values of promoting a just society with the value of respecting student autonomy. Consider the following example.

CASE EXAMPLE: AN INSENSITIVE COMMENT

During a class discussion on immigration, a European American student turned to a student with a Spanish surname and asked, "You know a lot about immigration. What are your thoughts?" In fact, the student was from a family that had lived in the United States for several generations.

The comment in this vignette is an example of a microaggression, which is a veiled and sometimes unintentional slight against members of racial or ethnic groups (Williams et al., 2021) or other marginalized groups (e.g., LGBTQ populations, persons with disabilities, women; Sue & Spanierman, 2020). Although on the surface the remark may appear harmless, it assumes that the student with a Spanish surname had personal experience with immigration.

Microaggressions are often subtle and may appear to be compliments on the surface. For example, the supervisor of a Black graduate student asked her how she learned to speak English so well (she said she learned it from her parents).

The supervisor never asked the same question of his White supervisees and appeared to assume that Black Americans typically spoke poor English.

People may disagree as to what constitutes a microaggression. Is using the word "Oriental" a microaggression? What about being called a *haole* (pronounced "howlie")?[2] What about the statements "America is a melting pot" or "The most qualified person should get the job?" Are these microaggressions? Any of these could be a microaggression depending on the context. "Oriental" generally refers to objects (e.g., oriental furniture), not people. Calling a person an "oriental" would be offensive. The Hawaiian word *haole* can be used either as an impartial description ("The store you are looking for is next to the *haole* over there") or a pejorative term ("Dumb *haole*!"), depending on the context. Saying that "America is a melting pot" is partially accurate in the sense that most European Americans shed many traditions of their European immigrant ancestors and adopted a mixed-American culture, but it could be a microaggression if used to minimize the historical exclusion of non-Europeans from mainstream American life. Saying that "the most qualified person should get the job" sounds very reasonable on the surface. However, in some contexts it could be used to imply that applicants from marginalized groups are getting jobs that they do not deserve.

Several considerations can guide psychologists in addressing these challenges. First, the topic of culture will almost inevitably occur in any psychology course because culture is an important determinant of human behavior and an essential component of the science of psychology. A section on developmental psychology could not, for example, adequately cover moral reasoning without pointing out that some cultures may define moral behavior differently than others (e.g., collectivist cultures may interpret behavior differently than individual cultures). In that sense, an understanding of culture is essential for students to accurately understand the discipline of psychology. Although the term *cultural humility* has usually been applied to psychotherapy, it can be applied in educational settings as well. Teachers can also help their students to recognize gaps in their knowledge of different cultures by encouraging self-reflection and a commitment to lifelong learning about culture (Abbott et al., 2019).

Second, all members of the college or university community should ensure that the educational environment is free from intimidation and harassment. Consequently, they should address comments or actions that demean students or others because of race, gender, national origin, sexual orientation, or other factors.

Third, instructors can prepare their students for "race talk" or other difficult discussions by establishing ground rules for such discussions ahead of time. Discussions involving race have the potential to become emotional and personal. Faculty can help make those discussions productive if they keep

[2]*Haole* is the Hawaiian term for a European-American or a person from the American mainland.

in mind a few principles, such as reminding students that all of us (including teachers) are heavily influenced by our own heritage and culture, that people differ in their styles of communications, that making a racial blunder does not mean that the person had bad intentions, and that listening carefully to others is a virtue (e.g., Sue, 2013; Sue & Spanierman, 2020). Psychologists can describe microaggressions at the beginning of the course, including what constitutes a microaggression and ways to ask questions or make comments respectfully.

Microaggressions should be addressed when they occur. Effective interventions generally build on strengths, appeal to ego-syntonic ideals, confront individuals in a supportive and respectful manner, and encourage nonjudgmental self-exploration. Efforts should be made to address the comments in a manner that educates but does not shame others. If instructors fail to address these comments, they may implicitly communicate that they endorse the attitudes behind it, thus marginalizing the targets of the comments. Instructors can best address these comments if they have reflected on their own attitudes and have thought through their reactions and discomfort over such conversations.

Boundaries and Relationships

Relationships between psychology teachers and students differ from relationships between psychotherapists and patients. The APA Ethics Code prohibits exploitative or clinically contraindicated multiple relationships between psychologists and patients. However, in a college or university setting, students can sometimes benefit from certain out-of-classroom contacts with faculty. Part of the overall college experience is to get to know the faculty members and interact with them through Psi Chi (the national honor society in psychology), departmental social events, or other venues. The challenge is to encourage relationships that are productive but not exploitative.

Of course, sexual harassment is always wrong (Standard 3.02, Sexual Harassment), and the APA Ethics Code prohibits sexual relationships with students in their teachers' departments or over whom they have evaluative authority (Standard 7.07, Sexual Relationships With Students and Supervisees). Evaluative authority could even refer to former students who may rely on the professor for a letter of reference.

Some may argue that a prohibition against sexual relationships restricts the autonomy of students to date whom they want. However, dating between faculty members and students creates a greater potential harm for the students. Faculty members have control over students' grades, letters of evaluation, academic advancement, and careers. For these reasons, many colleges and universities prohibit dating between all faculty and students.

Although sexual relationships between faculty members and students are always inappropriate, faculty and students can still mingle in activities such as lunches with a group of students or other activities outside the classroom. These productive relationships can best occur when the college or university creates a supportive atmosphere, as described in the following example.

CASE EXAMPLE: A SENSITIVE PROFESSOR

A young faculty member got along well with his students. He considered asking a student to babysit for him and his wife. The student had taken a course from him the prior semester but was no longer enrolled in his class or likely to be in future classes. However, he wondered if the student would really feel free to decline the offer, so he hired another babysitter and avoided the potential abuse of power.

This instructor was aware that sometimes students may not feel that they have the opportunity to decline these "offers." He was careful to ask a student whom he had not taught so that there could be no implication that her grade was in any way influenced by her decision.

However, the relationship issues in academia involve more than just prohibiting exploitation of students. The broader issue becomes how faculty members can structure relationships with students or other members of the academic community to create an ethical culture that promotes students' well-being, respects their autonomy, and treats them fairly. According to Keller et al. (2012), this

> includes a continuing focus on the ways in which psychologists assess and act on the ethical implications of their interactions with others—colleagues, students, clients, as well as those in the work groups or communities of which they are a part. Further, it includes or at least implies a responsibility to assume leadership roles that encourage others to act in accord with the ethical principles. Finally, it is more powerful when it is focused on a positive sense of doing "good work" . . . that transforms the cultures of which we are a part so that they encourage others to act in accord with the principles that underlie our varied discipline-related professional and ethical commitments. (p. 221)

One way to promote an ethical academic culture is to create a sense of community among students and faculty. Some activities that could promote this sense of community include supporting student organizations, involving students in research, having departmental celebrations and rituals, and sponsoring activities that bring people together to achieve a common goal. These activities are intended to create emotional bonds between students and between students and faculty. However, they also promote student welfare (e.g., by getting students involved in research projects and learning from faculty members through informal settings) and student autonomy (e.g., by ensuring greater student control over their organizations, participation in department activities, and service on departmental committees).

Creating a sense of community can also involve discussions of the atmosphere and goals of the entire department or curriculum. The ideal program challenges students and others to strive to reach their highest potential, to talk openly about their ideals and conflicts, and to contribute to the atmosphere of their training programs.

Good departments facilitate these goals by discussing the values that motivate their behavior and by integrating ethics into all of their classes. A model might be drawn from some undergraduate colleges that have adopted an "ethics-across-the-curriculum" model (Davis, 1993). Although the nature of these curricula may vary, they often require students to take a certain number of classes in which mastery of ethics constitutes a substantial portion of the class grade. Furthermore, they openly articulate the goal of teaching ethics as primary to the education of the students. Finally, extracurricular activities are developed to promote certain values.

General Beneficence

Psychology instructors also have responsibilities to society in general. They are obligated to give grades that accurately reflect the work of their students, take precautions to prevent cheating and plagiarism, discipline students who engage in those activities, and write accurate letters of reference.

Cheating has several harmful effects. Cheating rewards students who made an inadequate effort to master the material, demoralizes those students who were honest, and undercuts efforts to improve the moral character of all students. Professors can address cheating proactively. They may forbid students from wearing caps during examinations, require students to sit two seats apart from each other, have multiple forms of exams, or increase classroom monitoring during tests. Other instructors emphasize the moral reasons why cheating cannot be permitted and attempt to get students to "buy into" the concept of academic integrity. Some colleges and universities develop honor codes in which the students participate in determining the definition and consequences for cheating. Ideally, these codes clearly define cheating. Is it acceptable, for example, for students to study from tests given in previous terms? Is it acceptable for students to collaborate on presentations or research papers? Monitoring tests closely or having students commit themselves to academic honesty may reduce cheating (Schild et al., 2019).

Letters of reference should be written accurately. Unfortunately, they sometimes inflate the qualities of the students. Certainly, students want to have strong letters of reference, but if a faculty member cannot write a positive letter of reference, then they should tell the student about their concerns or offer to share a draft of the letter and then let the student decide whether it should be sent.

One way to address the twin obligations of faculty is to consider the communitarian reformulation of the Golden Rule by Etzioni (1996), "Respect and uphold society's moral order as you would have society respect and uphold your autonomy" (p. xviii). That is, the best way to promote the welfare of the students may focus them on goals that promote the welfare of society.

From this perspective, students should not only be instructed to not cheat or plagiarize but also should be taught why cheating and plagiarizing harm society in general. Just as students want to be treated with respect, they should also

treat others with respect. They should be encouraged to adhere to standards of academic integrity because, among other reasons, such standards assure the public that the grades accurately reflect the degree to which the course content was mastered.

Some plagiarism occurs out of ignorance. Students need clear direction on what plagiarism is and how to cite sources properly. Plagiarism has become an especially salient issue with the proliferation of information on the internet that can be easily downloaded. The emergence of artificial intelligence apps, such as Chat GPT, has created more opportunities for plagiarism. Consequently, many professors use services that can identify portions of the student paper that were taken from outside sources. Chapter 16 covers plagiarism in more detail.

Other Ethical Issues

Every day, academic psychologists make decisions that have ethical implications. They need to decide classroom policies on makeup tests, missed classes, and extra credit and make sure they are clearly communicated and applied fairly. They need to create courses that have the appropriate difficulty level for the students. Courses that are too hard or too easy are unfair to students. They need to balance the price of textbooks against the benefit that students will receive from purchasing them to ensure that students do not incur an undue financial burden.

Teachers decide what kinds of relationships they will have with other faculty members. Do they have obligations to intervene if they hear a student complain about another faculty member? Certainly, they have an obligation if the complaint involves physical or serious emotional harm to a student or a clear violation of a university rule. Teachers may inform the students of the policy of their university concerning grievances and direct the students to the appropriate administrative officials. However, should the faculty member intervene if the allegation involves lectures that are not interesting or course material that is not perceived as relevant to the department's goals or students' needs?

These questions do not have easy answers. Conscientious psychologists may disagree as to the optimal answer. For example, Keith-Spiegel et al. (2002) described the case of a student who brought to the attention of the instructor that her test had been graded incorrectly, and she should have received 3 fewer points. She recommended that the teacher should reduce the student's grade by the 3 points. However, I (Samuel J. Knapp) had adopted a policy that I did not penalize students who informed me when I made errors in their favor (but I did alter grades when my error would have lowered their grades). My reasoning is that I did not want to penalize honest students who identified these errors when less honest students with similar errors are not penalized. Nonetheless, I reviewed tests carefully to reduce the likelihood of an error. Keith-Spiegel et al. and I agree that these errors can usually be avoided by double-checking hand-scored tests.

SPECIAL CONSIDERATIONS IN PSYCHOLOGY TRAINING PROGRAMS

Some standards of the APA Ethics Code appear applicable primarily to psychologists involved in programs that train future psychologists. Such training programs have the twin responsibilities of empowering students and facilitating their development while protecting the public from incompetent psychologists.

Competence

Faculty must ensure that their students will be competent professionals. Throughout the program, faculty need to ensure that the students are acquiring factual information, problem-solving skills, technical skills, and judgment to assume a professional role. Fortunately, psychology training programs have become more explicit about the skills and benchmarks for reaching competence (e.g., Rodolfa et al., 2005; Rubin et al., 2007).

In addition, programs should try to inculcate professionalism in their students, which involves, among other factors, "a commitment on the part of the individual practitioner to self-monitor and improve" (Wilkinson et al., 2009, p. 551). It also involves adherence to the standards of ethical practice; effective interactions with patients, collateral contacts, and other health care professionals; reliability (accountability); and a commitment to continuous improvement (Elman et al., 2005). Growth in professionalism and productive self-reflection is most likely to occur among psychologists who are connected within a professional community because they are more likely to get feedback useful for their professional growth (see the discussion in Chapter 5 on the "competent community"). As health care is changing, part of professional development may, for some students, mean learning to work with other health care professionals through interprofessional education. Faculty need to take the lead in understanding the roles of other professionals, providing opportunities for mutually rewarding learning experiences, and cultivating an attitude of respectful cooperation.

Despite efforts to promote professionalism, graduate clinical programs will sometimes need to terminate students for lack of clinical skills or because of a serious ethical violation. It makes intuitive sense that students who committed unethical acts during their training would be more likely to commit unethical acts when they become professionals. Some evidence supports this assumption. For example, Papadakis et al. (2008) found that a low professionalism rating during medical residencies increased the risk of a medical board disciplinary action.

Current criteria for the accreditation of doctoral programs by the APA include the requirement that students receive written feedback at least on an annual basis "on the extent to which they are meeting the program's requirements and performance expectations" (APA, 2015c, p. 12). Students' factual knowledge is less difficult to assess than their technical skills and emotional competence. Students may be strong academically but fail to show the compassion, sensitivity, or common sense needed for them to do well as practitioners.

CASE EXAMPLE: A MARGINAL STUDENT

A psychology department was perplexed with how to deal with a second-year doctoral student who did well in his coursework but had a distant and detached interpersonal style. He often seemed to miss social cues and engaged in role plays and other clinical skill activities in a mechanical fashion. The faculty seemed unsure of his ability to do well in a practicum, let alone to do well as a professional. However, they had no documentation to rely on to deny him a practicum placement.

The marginal potential of the student raises the question as to whether the department failed in its obligation to the public and the student. Perhaps they could have screened applicants more thoroughly for interpersonal skills and informed them that they would evaluate their clinical skills throughout the program. The departmental catalog could have emphasized the importance of demonstrating competence in clinical skills as a requirement for practicum placement. The department could have evaluated students yearly on professional demeanor and competence in clinical skills or could have made competence in clinical skills an essential requirement of their clinical classes.

Informed Consent

Informed consent takes on special importance for those who work in psychology graduate training programs. Psychologists responsible for educational programs must take reasonable steps to ensure that they provide the experiences necessary for students to obtain the credentials advertised by the program (Standard 7.01, Design of Education and Training Programs). The descriptions of programs (Standard 7.02, Descriptions of Education and Training Programs) and individual classes (Standard 7.03, Accuracy in Teaching) should accurately inform students ahead of time of any requirement for mandatory psychotherapy (Standard 7.05a, Mandatory Individual or Group Therapy).

Programs may not require students to disclose sensitive personal information unless the program identifies requirements for such disclosures in advance in their admissions materials or unless such disclosure is necessary to evaluate a student who appears to be impaired (Standard 7.04, Student Disclosures of Personal Information). Faculty may not provide mandatory group or individual psychotherapy to students whom they also may be required to evaluate (Standard 7.05b, Mandatory Individual or Group Therapy). Psychologists who are supervisors inform students and supervisees of the procedures for evaluation at the outset of their work together (Standard 7.06a, Assessing Student and Supervisee Performance).

An essential part of the education of psychologists, especially of professional psychologists, is to ensure that students can demonstrate the emotional competence and technical skills necessary to be effective professionals. Part of emotional competence may include self-understanding, including the cultural

traditions and family dynamics that influence behavior, values, or perceptions of events. Some of the technical skills include the ability to communicate empathically. Often these are demonstrated by classroom assignments that require a certain amount of self-disclosure. Graduate programs vary to the extent that they require these self-disclosures. The APA Ethics Code does not prohibit such self-disclosures as part of the graduate program; it only requires that graduate schools inform students of these requirements before they apply to the program.

Sometimes students may be asked to treat patients whose moral codes are significantly different from their own, meaning that they endorse beliefs or lifestyles that may be morally offensive to some psychologists (this could include having sexual relations with members of the same sex, engaging in extramarital sex, agreeing to an arranged marriage, or vigorously opposing any of those situations). We believe it is appropriate for training programs to require their trainees to learn to work with patients with various moral perspectives, and they should explain this expectation to prospective applicants to their program. However, programs should also focus on ensuring that their trainees have the appropriate skills. Some trainees may understandably feel inept or uncomfortable when dealing with sensitive lifestyle or sexual issues where they have had little experience. A good program will help trainees feel more confident in their skill levels.

Relationships and Boundaries

The APA Ethics Code prohibits sexual relationships with students. We lack comparative data on the frequency of such relationships between faculty members and undergraduate or graduate students, but historically it appears to have been more common among graduate students. In 1996, Hammel et al. found that 15% of recent women graduates from psychology programs reported having had a sexual relationship with an educator and 84% of those students who had sexual relationships with educators viewed the relationship as coercive and harmful to their working relationship. Not only do these relationships risk the emotional harms that could occur in any romantic relationship, but they are also especially emotionally risky because of the power imbalance between the partners and the fact that faculty often have control over the quality of students' work life and careers.

Even a coexisting social or business relationship may compromise the objectivity of a student evaluation. Students may fear adverse consequences if they refuse the offers for multiple relationships. Whereas undergraduates can usually just drop out of courses, graduate students have fewer options when a disagreement or friction occurs between them and a faculty member.

Of course, relationships with students should be guided by more than just the axiom "Do not have sex with students." Multiple roles as mentor, instructor, supervisor, coauthor, and research supervisor allow the opportunity for enriched educational experiences if handled properly. Some encounters are desirable,

such as talking to students at colloquia, receptions, and other special events. Other encounters are benign, such as going to dinner with a group of students or sharing rides with students going to conferences.

Indeed, mentoring is viewed as an essential component of graduate education. In a mentoring relationship, a mature psychologist takes an interest in and promotes the career of a younger apprentice and goes beyond routine advising. However, astute mentors are concerned that these encounters could be construed as favoritism or could influence the evaluation process. Other students may ask if one of their peers is getting preferential treatment or if they themselves are being denied equal access to a faculty member because of the attention given to a classmate.

The rapid growth of social networking sites such as Facebook and Instagram has opened the doors to new types of faculty–student relationships and potential boundary violations. Most students and many faculty members have profiles on these sites, but it is not yet clear what the boundaries should be for student–faculty relationships. Malesky and Peters (2012) found that over one third of the students and one fourth of the faculty in their survey believed it was inappropriate for faculty members to have social networking accounts that were accessible to students. Significant disagreements were reported between the faculty and student participants regarding appropriate interactions. As a starting point, faculty members and institutions should be proactive in underscoring the ethical principles highlighted throughout this book. However, one option for social networking is to use LinkedIn, ResearchGate, or similar sites that promote academic exchanges but do not cross personal boundaries.

Unethical Conduct by Students

Faculty members have an obligation to protect the public and hence need to be alert to cases of unethical conduct on the part of students. Fly et al. (1997) used a critical-incident-technique survey with the training directors of clinical and counseling psychology programs. Their survey generated 89 incidents of student ethical misconduct, of which 25% involved breaches of confidentiality, 20% breaches of professional boundaries, 15% plagiarism or falsification of data, 10% threats to patient welfare, 10% a procedural breach with ethical implications (e.g., taking a patient chart home against facility regulations), and issues of competency (9%), integrity or dishonesty (8%), and misrepresentation of credentials (3%). More than half of the students had already completed a course in ethics. More than one fourth of these cases resulted in a student leaving the program.

Ethical infractions by students are usually considered on a case-by-case basis. More serious consequences can occur for violations that risk harm to patients or reflect defects in character. However, often an educational approach is desirable. The infraction may have occurred because the student used poor judgment during a period of stress, failed to think through or consult when faced with an ethical dilemma, or simply made an all-too-human error. The

goal is not to shame the students, but to use the experience as a sentinel educational event (Bynum et al., 2019) wherein they can use the experience to improve the overall quality of their work.

Creating a Positive Environment

Of course, universities should have clear policies and procedures to address problems of exploitation or misconduct when they occur. However, creating a positive environment also involves considering proactive ways to improve the experiences of students. For example, the process of ethics education can be improved by making ethics courses supportive and relevant to the needs of the students (Anderson & Handelsman, 2021; Gottlieb et al., 2008; Knapp et al., 2019). In addition, the program can further the training of competent psychologists by creating an ethical milieu in the graduate program. Currently, ethics is typically taught both formally through a compartmentalized course and informally or through an "implicit" or "underground" curriculum, which refers to the institutional atmosphere within the program. Students quickly learn about the milieu within their institution and what they need to do to survive or thrive in this environment. The stories, jokes, and anecdotes of the program function as part of the oral tradition that may either reinforce or undercut moral behavior. This underground curriculum may teach students more about ethics than the ethics course they take.

Any effort to provide a comprehensive education must address the underground curriculum or the broader milieu in which training occurs. Students notice whether faculty members are courteous, promote student welfare, and model collegiality, integrity, and hard work. Every faculty member and student should ask whether the messages being taught informally are congruent with the messages being taught through formal instruction.

In the ideal training program, faculty members model ethical behavior through their sensitivity to students and their willingness to talk openly about their ethical ideals and conflicts. The goal is to create patterns of self-reflection and ethical awareness that students will retain throughout their careers. The ideal training program also challenges students to uplift others and to talk openly about their ethical ideals and conflicts. Students are not only passive recipients of the atmosphere of their training program but also responsible participants who can improve the program by the nature of their attitudes and their conduct.

15

Consultation and Clinical Supervision

Clinical supervision is an ongoing relationship between senior and junior members of the profession. In this relationship, the supervisor monitors the quality of the services given by the supervisee, enhances their professional functioning, and may ensure the qualifications of the supervisee to become an independently practicing professional (Goodyear & Rodolfa, 2012). Clinical supervision differs from *consultation,* in which psychologists provide expertise to other professionals who retain control over their final work product. Sometimes psychologists mistakenly use the term *peer supervision* to refer to peer consultation. However, unless individuals have surrendered their professional autonomy to a supervisor, discussion of cases with peers is more accurately called consultation.

In this chapter, we review the general nature of consultation and supervision, describe applicable ethical and legal standards, and make risk management suggestions for psychologists. We describe the need for supervisors to be competent and to ensure competence on the part of supervisees. We also address the need for informed consent procedures for the supervisees as well as for their patients. Finally, we review multiple relationship issues in the supervisory relationship. Chapters 5, 7, and 16 have also made references to supervisory responsibilities.

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CONSULTATION

Psychologists often seek consultation to ensure that they are delivering their best services. No psychologist can be expected to be able to handle every case, and it is only reasonable to seek additional resources or information when working with certain patients. Psychologists should seek consultation when they believe it would meaningfully enhance the quality of services they deliver. Consultation is one of the quality enhancement strategies listed in Chapter 9. In Chapter 4, we discussed how consultation can improve the quality of ethical decision making by providing information, reducing emotional arousal, and checking the thinking of the consultee psychologist.

The nature of the consultation may vary from being a direct request for specific information (e.g., "What is the age of consent for treating adolescents in my state?") or guidance with highly complex cases involving legal, ethical, and clinical issues. These cases can be made even more complex if the consultees do not appreciate the severity of the issues or the extent of their professional obligations (Gottlieb et al., 2013).

Psychologists benefit most from consultations if they allow enough time to process complex cases, make a commitment to transparency (which may entail admitting they did things that, in hindsight, were less than optimal), and consider the advice they receive. Psychologists should document consultations with difficult cases as evidence that they tried to adhere to acceptable standards of care. They should document their reasoning if they decide not to follow the advice given.

The choice of a consultant depends on the nature of the issue (e.g., primarily legal or clinical) or the patient's needs. Good friends may be good consultants for some issues, but consultants should ensure that they are honest and objective, even if it requires telling their friend that they made a substantial error.

According to the American Psychological Association's (APA's; 2017a) *Ethical Principles of Psychologists and Code of Conduct* (APA Ethics Code), psychologists may use consultations without patients signing a release as long as they "do not disclose confidential information that reasonably could lead to the identification of a client/patient" and "they disclose information only to the extent necessary to achieve the purposes of the consultation" (Standard 4.06, Consultations).

Consultation engenders few legal risks because consultation, by definition, occurs between legal equals and the consultee has the responsibility to decide which recommendations to accept or reject. Psychologists who provide consultations help elevate the quality of services delivered by the psychological community. Often psychologists provide brief consultations to colleagues for free, although they may charge for extensive consultations as long as fee arrangements are made clear ahead of time.

CLINICAL SUPERVISION

Clinical supervision differs from administrative supervision, which deals with nonclinical aspects of management, such as business promotion, scheduling, salaries, or general record keeping. In clinical supervision, the supervising psychologist retains authority over and responsibility for the services delivered. The supervisory relationship has an immediate impact on the patients seen by the supervisee because the supervisors are legally responsible for ensuring the quality of the services provided.

The supervisory relationship can have a long-term impact on a supervisee's life. Many supervisees recall encountering difficult patients and determining how to respond to these cases by "hearing the voice" of their supervisor. As role models, supervisors often help their supervisees form their professional identities. The senior psychotherapists interviewed by Rønnestad and Skovholt (2001) reported that their supervisors had left an internalized influence on them. These senior psychotherapists reported "powerful, passionate, and appreciative descriptions of professional elders" (p. 184).

Supervision is more effective when it is conducted proactively, deliberately, and thoughtfully (Cummings et al., 2015). Several sets of rules govern the supervisory relationship. The entire APA Ethics Code applies to all areas of professional practice, including supervision, and has several standards specific to supervision. Also, state psychology licensure boards develop regulations that specify the conditions required for supervising psychologists-in-training and other supervisees. Finally, malpractice courts require that supervisees and their supervisors adhere to minimal standards of professional competence.

Although they may not necessarily physically see their supervisees' patients regularly, supervising psychologists still have fiduciary responsibilities to them. In their relationships with patients who are being treated by their supervisees, supervising psychologists are guided by beneficence (i.e., ensuring that the quality of treatment is good), nonmaleficence (i.e., ensuring that patients are not harmed), respect for patient autonomy (i.e., ensuring that patients of their supervisees are informed about the salient features of supervision before agreeing to treatment), and the other ethical responsibilities that exist between psychologists and their patients.

In their relationship with their supervisees, psychologists are guided by the principles of beneficence (i.e., promoting the welfare and competency of the supervisee), nonmaleficence (i.e., avoiding harmful multiple relationships with supervisees), fidelity (i.e., being explicit about the nature and standards for supervision ahead of time and providing accurate and timely feedback), and general beneficence (i.e., fulfilling obligations to society in general). General beneficence is especially relevant when psychologists are supervising psychology trainees because they need to ensure that these trainees have the necessary skills to practice independently.

Conflicts may arise between the supervisor's obligations to their supervisees and their obligations to their patients. On the one hand, supervisors want to

enhance the welfare of their supervisees. On the other hand, they must protect the welfare of their patients. If the supervisee is an apprentice intending to become a licensed professional, the supervisor also has a responsibility to future patients of that supervisee. Usually, but not always, these goals are congruent. Although their primary responsibility is for patient welfare, good supervisors know that they can generally promote patient well-being by supporting their supervisees.

COMPETENCE

The concept of *competence* can refer both to the competence of the psychologist as a supervisor and to the competence of the supervisee. We review the concept of competence as a supervisor first.

Competence as Supervisors

Psychologists must demonstrate competence in all professional tasks they undertake, including supervision (Standard 2.01, Boundaries of Competence). The competent supervisor has both the skills to perform the services required of the supervisee and the skills to supervise effectively (Barnett & Molzon, 2014). Given the proliferation of telepsychology services, supervisors should have some proficiency in telepsychology if they want to prepare their supervisees for the current work environment. Supervisors should also be able to teach students to use telepsychology services appropriately, including ensuring their competence in managing the technology involved, understanding the unique informed consent and confidentiality issues involved with telepsychology, understanding APA guidelines on telepsychology (Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013), and knowing the rules regarding interjurisdictional practice (Baier & Danzo, 2021).

Some of the skills of a good psychotherapist, such as listening, conceptualizing cases, and communicating empathy, are also good skills for supervisors. Goodyear and Rodolfa (2012) found that excellent supervisors respected their supervisees, oriented them to the supervisory relationship, had a well-defined evaluation process, and balanced challenge and support for their supervisees. They should also be culturally competent (Vandament et al., 2022). However, competence as a psychotherapist does not ensure competence as a supervisor.

Many psychologists get thrust into the role of a supervisor with no training or experience other than having been supervised themselves at one time. However, good supervisors should know the literature on supervision and use it to ensure the professional development of their supervisees (Falender, 2018). No proficiency credential, sequence of courses, or continuing education programs exist that can completely ensure competence as a supervisor. Although the literature on supervision has many gaps (e.g., Watkins, 2020), much is known about supervision, and beginning supervisors can benefit from knowing

that literature (e.g., *Guidelines for Clinical Supervision in Health Service Psychology*; APA, 2015a). Fortunately, many doctoral programs now include coursework in supervision. Of course, psychologists should become familiar with the requirements for supervision as specified in their licensing laws and regulations.

Competent supervisors clarify the goals of supervision and the means for reaching those goals through an informed consent process. Ideally, this is done by including input from the supervisee as much as is consistent with promoting patient welfare. Competence as a supervisor requires consideration of the ethical principles underlying the supervisory relationship, the theoretical orientation used both in the treatment of patients and in the development of clinical skills in the supervisee, the means of assessment (e.g., process notes, videotapes, audiotapes, viewing live treatment), and the criteria for feedback.

Supervision models vary considerably. No one supervisor is highly effective for every supervisee, and supervisors may vary their style according to a supervisee's personality and skill level. Nonetheless, effective supervisory strategies tend to be strength-oriented, developmental (modifying supervision to the skill level of the supervisee), encourage self-reflection, and offer helpful feedback (APA, 2015a).

Often supervisors and supervisees come from different cultural backgrounds, have different sexual orientations, or otherwise differ on significant life experiences. For example, a straight supervisor may supervise a gay supervisee, or a White supervisor may supervise an Asian American supervisee. These mixed dyads occur commonly because, due to the demographic changes in the profession, a higher percentage of older psychologists are White, compared to psychology students and trainees.

The background or life experiences of the supervisees may make them more attuned to the needs of some of their patients than their supervisors. Consequently, in some cases, supervisors may want to defer to the perceptions and life experiences of their supervisees, and they may model the characteristics of a good professional who is always striving to learn more and to expand their skill set. Supervisees reported more satisfaction with supervision when their supervisors showed cultural humility and attended to cultural opportunities (i.e., were open to talking about cultural backgrounds; Vandament et al., 2022; Wilcox et al., 2022).

The best supervisors promote self-reflection. Self-reflection occurs when "individuals engage in a critical evaluation of their affective, cognitive, and behavioral experiences, and through dialogue and generalization, produce insight and fundamental shifts in their original assumptions and beliefs" (Orchowski et al., 2010, p. 51). Ideally, supervisees will learn to routinely reflect on their own abilities and behaviors.

Supervisors may encourage reflection by adopting a stance as a learner themselves, modeling self-reflection, discussing the impact of their own race or culture on psychotherapy, looking at parallel processes between supervision and psychotherapy, engaging the supervisee in open-ended or Socratic questions, requiring trainees to keep a journal of their growth, and otherwise

gradually shifting the responsibility of self-reflection to the supervisee (Neufeldt et al., 1996; Orchowski et al., 2010). Supervisors may inadvertently discourage supervisee self-reflection by going off on tangents, avoiding discussions of sensitive topics, telling personal stories unrelated to supervisees' experience, and more. Consider the following example of a supervisor who encourages self-reflection.

CASE EXAMPLE: A SUPERVISOR WHO PROMOTES SELF-REFLECTION

The internship supervisor at a university counseling center expected his students to know the outcome literature and treatment techniques. However, he always asked his supervisees, "How does it feel?" or "What does your gut tell you?" His favorite phrase was "This isn't a math problem, you know."

As a consultant to many training programs over the years, I (Samuel Knapp) have listened to many supervisors and supervisees talk about their experiences. Informal comments from supervisees showed that they liked supervisors who took supervision seriously, had a sense of humor, and focused on their strengths. Good supervisors had a good grasp of patient problems and could suggest alternative ways of approaching clinical problems when necessary. They appreciated the developmental nature of the supervisory process. One supervisee stated, "He believed in me even at times when I didn't believe in myself." Another said, "She taught me the overwhelming importance of kindness." The best supervisors appeared to create a supportive environment and a positive working alliance where the supervisees felt valued and both supervisors and supervisees shared a belief in the importance of their work.

To achieve their fullest potential as supervisors, psychologists can read, consult, and take continuing education workshops on supervision. They can also form peer consultation groups about their supervisory activities or participate in an online supervision community. The environment should provide a feedback loop whereby psychologists continually review and modify their procedures and protocols. The various forms of external feedback include, but are not limited to, consultation, supervision of supervision, feedback from supervisees, and gathering systematic data on outcomes or patient satisfaction. Finally, quality supervision means attending to details, such as arriving on time, keeping scheduled appointments, making notes, filling out reports diligently, remembering the names of the patients seen by the supervisee, and so on.

Competence of Supervisees

Psychologists only delegate work to supervisees that they are competent to perform themselves. They avoid assigning supervisees to patients when a

multiple relationship risks exploitation or the loss of objectivity (Standard 2.05, Delegation of Work to Others). *Competence* means emotional competence, technical skills, an understanding of the unique cultural issues in the population receiving services, and socialization to the roles of a professional.

Regardless of their work setting, psychologists can be held responsible for the actions of their supervisees under the doctrine of vicarious liability. This doctrine was originally applied to medical settings in which physicians were assumed to be the "captains of the ship" and responsible for all the actions of persons working under them. Just as captains are ultimately responsible for the actions of every crew member and surgeons are responsible for the actions of every member of their surgical teams, supervising psychologists are responsible for the actions of their supervisees.

Unfortunately, some individuals interpret the word "supervisor" loosely. One psychologist was investigated by a licensing board for misconduct of an employee in the agency where he worked. Although the individual who committed the misdeed referred to the psychologist as her supervisor, the psychologist had only provided some general information to the individual upon request, never had line authority over this individual, and never had the responsibility to monitor her behavior. Eventually, the psychologist was able to remove himself from this investigation.

Under limited circumstances, supervisors following reasonable standards of practice may be unaware of supervisees' actions that were done counter to instructions or behind the supervisor's back. Under those circumstances, a supervisor may be exonerated from any wrongdoing. Nevertheless, these exceptions are limited, and most aggrieved patients will assume that the supervisor knew or should have known of the negligent actions of the supervisee.

Psychologists should screen prospective supervisees carefully. In addition to information on academic credentials and work experience, it is important to know if their present skill level is consistent with the supervisor's expectations.

Psychologists evaluate supervisees based on their actual performance (Standard 7.06b, Assessing Student and Supervisee Performance). Oral feedback should be given frequently. Written feedback should be given periodically to all supervisees and more frequently to supervisees who are experiencing difficulty.

Standard 2.05, Delegation of Work to Others, requires psychologists to ensure that their supervisees follow all ethical rules, such as those requiring the informed consent of patients. Supervisors should take whatever actions are necessary to ensure the quality of services delivered to the patient. The extent of the monitoring will depend on several factors, including the skill level of the supervisee and the type of services being performed.

Because supervisors are responsible for the treatment of patients, it appears essential that they regularly review the records of all of their supervisees. They should teach what they expect to find in a patient's record, including what information should and should not be included in the notes and how certain information should be phrased.

Prudent psychologists also document all of their supervisory sessions (Barnett & Molzon, 2014). State Boards of Psychology may describe the elements that must be included in the documentation of supervisees who intend to use their supervised experience to become licensed psychologists. The documentation could include some information on each patient, the training goals of the supervisees, whether they are meeting their goals, and if not, what needs to be done to meet those goals.

Salient Professional Events and Stressors

Supervisors can prepare trainees for salient professional stressors and life events. Some of the common professional stressors for psychologists include dealing with difficult and draining patients, managing multiple responsibilities with little time, dealing with difficult institutional policies, and treating patients who assault or threaten to assault them or who threaten to harm others or themselves. A 2020 survey found that, in the previous year, 29% of psychologists had a patient attempt suicide while in treatment and 6% had a patient die from suicide while in treatment (Leitzel & Knapp, 2021). Patient suicides are especially stressful and often psychotherapists feel complicated grief, anxiety, or depression following a patient suicide.

Consequently, supervisors should ensure that their students have the skills to work with patients who are suicidal or aggressive. Fortunately, researchers have developed core competency frameworks for training doctoral students on suicide prevention (e.g., Cramer et al., 2013). Supervisors can also ensure that supervisees are instructed in the agency protocols for dealing with suicidal patients.

Trainees especially need strong support when facing difficult patients, including sometimes having the option of accessing outside consultants. Patients with frequent crises may distract the psychology trainee from long-term treatment goals. In addition, countertransference feelings, unless processed carefully, may sabotage the treatment relationship.

CASE EXAMPLE: A PAINFUL DECISION

An intern entered her supervisor's office and announced in an almost mechanical manner that she was leaving her internship and intended to leave the field of psychology entirely. Upon further discussion, the supervisor learned that a patient had died from suicide several months earlier, and the intern had never been able to regain confidence in her therapeutic skills. She reported that she was frequently anxious, had trouble sleeping, and had to force herself to come to work.

The announcement shocked the supervisor because he had no idea of the depth of her anguish. The deceased patient was a highly disturbed young man,

and the psychologist believed that the intern had acted appropriately in assessing the degree of dangerousness and fashioning a reasonable treatment plan. On further discussion, it appeared that the presence of another recent patient with suicidal ideation had triggered memories of her traumatic experience with the patient who died from suicide. The death of a patient by suicide is one of the worst, if not the worst, professional experiences a mental health professional can have.

The supervisor acknowledged that he had not adequately appreciated the impact of the loss on his trainee. Although he had reviewed the case with his supervisee after the suicide and concluded that she had acted appropriately, he had not seen the depth of her anguish behind her brave mask. The supervisor apologized to the intern for his failures and helped the intern process her experiences and reflect on her reactions. The supervisor also changed program protocols to reduce the likelihood that future situations like this would occur, including enhancing training on suicide prevention. He emphasized the point made by Jobes (2016) that "while I cannot guarantee a nonfatal outcome, I can nevertheless provide *the best possible clinical care* to the suicidal patient" (p. 49).

With his encouragement, she delayed her decision to leave the field, entered short-term individual psychotherapy, and received additional training in suicide prevention. Years later, when she received a prestigious award, she publicly thanked her supervisor. Only she, the supervisor, and a few close friends understood the depth of her appreciation.

Ensuring a Productive Relationship

The best way for supervisors to ensure the quality of their supervision is to have an honest and open relationship with their supervisees. From the standpoint of the supervisee, the biggest dilemma is how to be honest and open to feedback while at the same time appearing competent. From the standpoint of the supervisor, the biggest dilemma is how to support the intern while at the same time correcting shortcomings and promoting professional growth. The difficulty of managing these dilemmas should not be underestimated. Many supervisees fear the evaluation or judgment of their supervisors. Perhaps they fear looking inept or incompetent before their supervisors or fear that a negative evaluation will harm their careers. Although it is natural for everyone to put their best face forward, at a certain point the internal pressure to look good can affect the quality of patient care and limit the benefits of supervision.

Supervisors should expect some degree of nondisclosure among their supervisees. Nonetheless, they can address this issue directly at the start of supervision, emphasizing that everyone has limitations on what they know, that everyone will take a clinical step which, in hindsight, they determine wasn't the optimal way to intervene, and that self-reflection is to be valued. Supervisors can encourage their supervisees to be compassionate toward themselves,

recognizing that unrelenting perfectionism can predispose psychologists to burnout and career dissatisfaction (Kaeding et al. 2017). They can minimize the likelihood of an impasse in their competing obligations by screening intern applicants carefully, being clear about expectations, and being supportive whenever possible. Supervisees can minimize the likelihood of an impasse by discussing their supervisory goals, being honest about their abilities and limitations, and not being afraid to tell supervisors about their uncertainties or clinical errors.

Trainee Ethical Errors

Trainees will make clinical errors and ethical misjudgments. Errors may become *teachable moments* as long as the supervisor and supervisee have an open relationship. Sometimes these errors involve violations of obvious rules, such as having multiple relationships with patients, or more subtle problems, such as defensiveness in supervision, poor clinical skills, or poor clinical judgment.

For example, we noted in Chapter 7 that all psychotherapists run a risk of eroticizing relationships. Supervisors who recognize this as a natural phenomenon are more likely to have interns who discuss these issues with them openly and seek guidance on how to handle these feelings in a manner that best promotes patient welfare. The last thing a supervisor should want is supervisees who harbor intense, forbidden, and hidden feelings. Many supervisees are reluctant to self-disclose their mistakes, worries, or unwanted feelings. Nonetheless, supervisee self-disclosure increases when the supervisor and supervisee have a good working relationship and the supervisor models this behavior (Mehr et al., 2015).

Trainees With Health-Related Competence Problems

One of the goals of supervisors is to help trainees understand how personal issues could harm the quality of their services. Supervisors may become aware of pervasive and substantial limitations that prevent trainees from performing at minimally acceptable levels of behavior. The student may have done well academically, but in the practicum or internship setting the supervisor can see that the student lacks the qualities necessary for effective functioning as a mental health professional.

The internship year provides an important opportunity for interns to identify and address any emotional or physical problems that may limit their ability to practice effectively. The internship year is inherently stressful as it often involves the relocation of one's family, low pay, and, in effect, starting a new "job." A high percentage of graduate students in psychology reported elevated levels of anxiety and depression (Hobaica et al., 2021). While not all of these students have an impairment or a disability so severe that it keeps them from meeting their minimal obligations as psychologists, some will.

Training programs have a responsibility to deal with trainees who fail to acquire the needed competence. Ideally, the supervisor will establish clear

goals for the trainee, give consistent feedback, document any problems, and give the trainee a chance to address these issues early and respond to a remediation plan, if needed. The preferred goal is to have remediation programs in place so that students with personal needs can get assistance. In rare cases, programs may have to dismiss students.

CASE EXAMPLE: POOR JUDGMENT

A local newspaper reported that an intern had been arrested for soliciting a prostitute. This was his first offense, and he was assigned to the Accelerated Rehabilitation Diversion program, which, if he successfully completed it, would enable the misdemeanor to be erased from his record after several years.

The supervisor later learned that the student was depressed following the breakup of his marriage. His behavior was very atypical for him, but he agreed to an evaluation by a psychologist not affiliated with the internship setting. The evaluating psychologist reported that the student had an adjustment disorder with a depressed mood and recommended treatment. The incident did not otherwise disrupt his internship. Fortunately, this setting had the authority to order the evaluation and treatment because the program had made it explicit at the outset of the supervision that it could require psychological or medical evaluations and psychotherapy for any interns who appeared to have a condition likely to impair their ability to perform their professional duties competently.

Problem Supervisors

At times trainees may encounter supervisors who, for whatever reason, are not performing up to the minimal obligations of their supervisory role. Perhaps they lack training in supervision, have overextended themselves, and cannot dedicate the time necessary for supervision, or perhaps they have mental health or emotional problems that keep them from performing at an acceptable level of competence. The trainee is at a disadvantage when dealing with such situations because practica and internships are often hard to find and faculty may be reluctant to challenge a supervisor and lose a potential placement for the future.

We recommend that the trainee attempt to address any problems early in the supervisory relationship in a respectful manner. If that does not work, the training faculty should attempt to resolve the situation. If necessary, the trainee can be removed from the training site. If the behavior of the supervisor is especially egregious, then a report to a disciplinary body could be made.

We have seen both sides of the story. We have seen trainees who were, in our opinion, unnecessarily demanding. One, who worked in a poorly funded mental health center, complained that her office was not up to professional

standards (the furniture was old and unappealing) and that she had to share her office with another intern. The harsh reality is that many nonprofit agencies have limited budgets and cannot afford pleasing office spaces. But that does not mean that the quality of service or the quality of supervision is poor.

On the other hand, we have seen supervisors who neglected their supervisees, failed to show up for supervisory sessions, gave perfunctory supervision, tried to have supervisees do clerical work unrelated to their training, or otherwise misused their trainees. We have even heard credible reports of supervisors falling asleep during supervisory sessions.

Enhancing Supervisee Excellence

Usually, training programs do a good job of preparing their interns for entry into the profession. From the acculturation model discussed in Chapter 2, one of the tasks of supervisors is to enhance the movement of trainees toward integration strategies of the model so that they can understand professional ethics and interpret ethics in light of a strong personal moral code. Explicitly teaching the ethics acculturation model to trainees may be helpful, as this model appears to anticipate many conflicts that interns may experience (e.g., Hambrick et al., 2009).

CASE EXAMPLE: ENCOURAGING REFLECTION

On the first day of their internship, a supervisor asked the interns to write down what they expected would be the most difficult and most rewarding situations they would face in their internship year. After they had done that, he gave them a list made by the prior year's interns on the last day of their internship listing the most difficult and most rewarding situations they faced during the past year. He then asked the interns what they could do to anticipate, prevent, or mitigate those negative situations and what they could do to foster those positive situations.

The supervisor was trying to encourage the virtue of self-reflection as well as self-care. The exercise had a profound impact on the supervisees, who often referred to "the list" during their entire internship year.

INFORMED CONSENT

The concept of *informed consent* can refer both to consent for the supervisee and consent for the patients being treated by the supervisee. We review the concept of informed consent for the supervisee first.

Informed Consent With Supervisees

Psychologists inform supervisees of the standards for feedback at the beginning of supervision, and they also give timely and specific feedback (Standard 7.06a, Assessing Student and Supervisee Performance). Although not required by the APA Ethics Code, written agreements with supervisees minimize the risk of misunderstandings. The agreement could clearly specify the nature of the supervisory relationship, the types of services that the supervisor will provide, the conditions of termination of the supervisory relationship, record-keeping obligations of both parties, rules governing the use of the supervisor's name, and a requirement that the supervisee follows the APA Ethics Code and relevant state laws and regulations. The agreement could also specify the backup procedures for supervisees in case of emergencies. The agreement may also include the means used to evaluate the supervisee, such as audio or video recordings, case summaries, case presentations, joint psychotherapy with the supervisor, or other means (Barnett & Molzon, 2014). Such agreements should have some flexibility to account for the changing needs or skills of the supervisee. Psychologists should also check with their malpractice carrier to be certain that their supervisory functions are covered. Supervisees should ensure that they are covered by professional liability insurance as well.

For supervisors, the informed consent process helps them think through issues ahead of time, and, for supervisees, it helps them understand the ground rules of the supervisory process from the beginning. Issues to be considered could include learning goals, strategies, methods of evaluation, expectations of the trainee, agency policies (including confidentiality), documentation requirements, and other information (Thomas, 2007).

Informed Consent With Patients of Supervisees

Supervisees must inform patients of the supervised nature of the relationship and provide the name of their supervisor (Standard 10.01c, Informed Consent to Therapy). Psychologists need to ensure that supervisees do not engage in other activities that could mislead patients about their supervised status. For example, office stationery, professional business cards, billing statements, signatures, and other announcements should accurately reflect the supervised status of trainees. Misleading stationery or public announcements can give patients the impression that the supervisee is providing services independently. These practices protect the supervisee and the public. Knowledge of the supervised status of the trainee may also protect the supervisor. It is preferable that patients call the supervisor with a concern early in treatment rather than having the supervisor learn about the discontent through a formal complaint. Furthermore, the trainee status may be relevant to the patient's ability to receive insurance reimbursement. Some insurers may also require that supervisors countersign any notes in the medical record.

MULTIPLE RELATIONSHIPS AND PROFESSIONAL BOUNDARIES

Psychologists take reasonable steps to protect their supervisees from harm (Standard 3.04, Avoiding Harm) and exploitation (Standard 3.08, Exploitative Relationships) and do not have sex with them (Standard 7.07, Sexual Relationships With Students and Supervisees). Although supervisors may not have the same degree of control over supervisees as psychotherapists have over patients, there is still the potential for abuse.

A number of supervisees have reported having had sexual relationships with their supervisors sometime during their careers. These relationships diminish or eliminate the effectiveness of supervision because they threaten to reduce the objectivity of the supervising psychologist and the quality of patient care.

Furthermore, supervisors have power over the supervisees, suggesting that supervisees might not be able to enter into the sexual relationship voluntarily given the possibility of retaliation if the supervisee said no. In addition, many psychologists and supervisees who participated in these sexual relationships came to see them as increasingly negative over time, although more than half continued to view them as positive (Lamb & Catanzaro, 1998). Finally, these relationships may convey a message that boundary violations are acceptable and may increase the likelihood that the trainees will, as psychologists, engage in harmful boundary violations themselves. However, the data on this are mixed.

Lamb and Catanzaro (1998) suggested that the harmful impact of relationships between supervisors and supervisees could be minimized if the parties considered the length of their initial relationship and the circumstances of their termination, the power differential between the individuals (e.g., whether the supervisor is still expected to write letters of recommendation), and the likely impact on the parties involved (e.g., whether one of the individuals is in crisis or in a vulnerable life situation). Chapter 7 has more information on multiple relationships with trainees.

However, multiple relationships between supervisors and supervisees involve other, more subtle boundary issues. The potential for harmful social relationships is probably not as great as it is for psychotherapy patients. Certainly, social encounters can help make the work atmosphere more enjoyable for everyone. However, the objectivity of the supervisor may be compromised by a friendship, and the social relationship may not be entirely voluntary on the part of the supervisee.

The supervisor–supervisee relationship has some of the elements of a teacher–student relationship and some of the elements of a psychotherapeutic relationship. The educational relationship has a goal of promoting the competence of the student, usually requires little self-disclosure on the part of the student or self-disclosure limited to certain domains in the training program, and involves dual obligations to teach the student and to represent mastery of material accurately. The therapeutic relationship has the goal of promoting the well-being of the patient, requires extensive self-disclosure by the patient, and involves

a primary obligation to the patient with limited exceptions, such as when a patient is an abused child. The supervisory relationship stands in between educational and therapeutic relationships. The goal is to promote the well-being of supervisees and to ensure their competence to practice. It involves dual obligations to supervisees and the public, and it may, depending on the supervisory style, require self-disclosure, although not to the same extent as in the psychotherapeutic relationship.

Good supervisors create a relationship in which their supervisees can engage in meaningful and honest self-exploration. They convey to the supervisee that the supervisory sessions are important to them. They are quick to praise supervisees for good work and honest effort. When it is necessary to criticize, they do so tactfully and clearly prescribe alternative behaviors.

16

Research and Scholarship

All psychologists need to know something about scientific research. Some psychologists will focus their careers primarily on conducting research. Other psychologists will teach students how to conduct research, how to think clearly about scientific issues, and how to consume research. Professional psychologists, who dedicate their careers to the delivery of services to the public, also need to understand how research is conducted, its limitations and strengths, how it can be utilized, and how it can be abused or misinterpreted. We do not want professional psychologists to make important decisions about health care on the basis of an article—or worse yet—a report of an article in the public media, without asking about the sample size, the population studied, whether the finding has been replicated, or other factors that would influence the strength of the conclusions or their generalizability.

Research in psychology has led to substantial advances in mental health treatment, educational practices, health care, child-rearing, and other important domains of life. However, at least three major ethical questions emerge when reviewing past psychological research. First, did the psychologists conduct the research in an ethical manner? Consider the following example.

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CASE EXAMPLE: AN EXPERIMENT OUT OF CONTROL

In the infamous Stanford prison experiment, a prison simulation experiment got out of control. The "guards" became increasingly callous, and the "prisoners" became increasingly demoralized. The primary investigator became so engaged in his role that he initially failed to appreciate the harm his experiment could have on the participants. To his credit, he terminated the experiment and subsequently used his experiences to teach about ethical issues in research (Zimbardo, 1999).

Although most of the ethical issues that emerge during the conduct of psychological research are not as dramatic as those that occurred during the Stanford prison experiment, they nonetheless do arise consistently. Researchers should protect the well-being of their research participants, even if the study does provide socially meaningful information.

Second, did the study adequately consider the impact of multicultural variables on the study? For example, Obermeyer et al. (2019) found that an algorithm used to assess the health of an HMO population, had underestimated the rate of illness among its Black beneficiaries because it determined health based on health care expenditures and did not account for underutilization by Black patients. Studies that do not identify the race or gender of the participants are also problematic. Unfortunately, such nonreporting is common in psychological studies (Does et al., 2018).

Finally, did the psychologists ensure that the results were reported accurately and thoroughly? According to principle-based ethics, the overarching ethical principle of general or public beneficence requires that the researchers reach conclusions that accurately reflect the data generated. Educational, health care, and public policy decisions are often based on psychological evidence. Flawed evidence could lead to decisions that harm people or squander resources.

According to principle-based ethics, the other moral principles relevant to research and scholarship are respect for research participants' autonomy[1] (e.g., through informed consent requirements, freedom from coercion, and limitations on the use of deception) and fidelity/integrity (e.g., standards require accuracy in awarding authorship and in reporting data). However, beneficence and nonmaleficence apply here as well, especially if the researchers are providing health care treatment. Although beneficence and nonmaleficence are usually applied only to humans, the principles also could be interpreted to mean that psychologists have an obligation to treat animal subjects humanely. Justice could also be relevant to research ethics to the extent that research participants are recruited

[1]In this chapter, we modify the principle "respect for patient autonomy" to read "respect for research participant autonomy." Some research participants are patients, but many are not.

from all segments of society and treated fairly, such as by using linguistically appropriate informed consent forms. Given the relevance of these overarching ethical principles, psychologists should integrate ethical considerations into the development and implementation of any research design (Fisher & Vacanti-Shova, 2012).

Standards governing the conduct of psychologists in research come from the American Psychological Association's (APA's; 2017a) *Ethical Principles of Psychologists and Code of Conduct* (APA Ethics Code). Other APA publications relevant to research are the *Publication Manual of the American Psychological Association* (7th ed.; APA, 2020) and *Guidelines for Ethical Conduct in the Care and Use of Animals* (APA, 2022b). APA's *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality* (APA, 2017b), and *Guidelines on Race and Ethnicity in Psychology* (APA Task Force on Race and Ethnicity Guidelines, 2019) also include discussions of multicultural issues when conducting research. Institutional policies, decisions by institutional review boards (IRBs), and federal regulations may apply to some research psychologists as well. Educational and other institutions establish IRBs to review and, if necessary, recommend modifications to research projects. Federal regulations on research, which apply to researchers using federal funds, are also important because federal funds support much of basic and medical research. The federal regulations are based on the recommendations found in the Belmont Report (U.S. Department of Health and Human Services, National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979).

The scientific enterprise is not a disembodied search for truth. Like all human activities, it includes a mixture of self-interest and altruism as well as arrogance and humility, with both risks and benefits to society and individuals. The reward structure of our social institutions promotes science and research. Psychologists who produce valued research can gain tenure, promotions, money, power, or reputation. Therefore, conscientious researchers are alert to how the reward structures may sometimes provide incentives that conflict between the needs of the research participants and other stakeholders in the research enterprise.

Conscientious psychologists also try to show sensitivity to the impact of race, culture, and gender on the scientific enterprise. Although women make up over three fourths of graduate students in psychology, only one third of psychology professors are women (Odic & Wojcik, 2020). Women and people of color are underrepresented among authors of academic publications in scientific journals in general (Kozlowski et al., 2022). In addition to issues of distributive justice (i.e., equal access to societal resources), this lack of gender and cultural representation influences the topics that researchers choose to study and how they conduct research. For example, Does et al. (2018) found that women were more likely to enroll in a breast cancer study if a woman recruited them as opposed to a man, and hypothesized that low rates of participation of people of color in research may be influenced by the fact that the recruiters are usually White. In addition, all researchers can be sensitive to ways that bias may permeate the entire research process including, but not limited to, an overreliance on

White samples of convenience, failure to identify the race, gender, or ethnicity of the participants in the study, the keywords chosen to describe the study, or a low priority given to research on issues important to persons of color (Buchanan et al., 2021).

In this chapter, we review the minimum ethical standards first. Special attention will be given to the need for accuracy in reporting scientific findings. Then, we review how researchers and scholars can strive for their highest ideals.

MINIMUM ETHICAL STANDARDS IN RESEARCH AND SCHOLARSHIP

At a minimum, researchers and scholars show respect for research participants' autonomy and dispense with informed consent only in limited circumstances permitted by the APA Ethics Code. They should make special efforts to protect vulnerable populations. Minimum standards of conduct also exist concerning debriefing, deception in research, animal welfare, publishing, and reporting research results, awarding authorship, deciding on student authorship, duplicate publications, plagiarism, and confidentiality in the peer review process.

Respect for Research Participants' Autonomy

Research participants should give informed and voluntary consent. According to Standard 8.02a, Informed Consent to Research:

> 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. (APA Ethics Code, 2017a)

Psychologists also allow prospective participants opportunities to ask questions about their research participation and to receive answers.

Research participants may benefit either directly (e.g., if the participant is receiving treatment) or indirectly (e.g., if the participant is receiving course credit or payment). University participant pools provide participants for the research projects of other students and faculty members. Their use is often justified in that the students are learning something by participating in the research. This may be especially true if the students receive meaningful debriefing after the experiment or discuss their research experiences during their classes.

To protect research participants who are subordinates of psychologists, Standard 8.04a, Client/Patient, Student, and Subordinate Research Participants, states, "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." Standard 8.04b states, "When research participation is a course requirement or an opportunity for extra credit, the prospective participant is given the choice of equitable alternative activities." These standards give students some leverage in the research process. Researchers know that students will decline to participate or will withdraw from unnecessarily unpleasant experiments. Research participants have a choice and control over any recording of their voice or image. This rule does not apply to naturalistic observations of behavior in public places or to research involving deception for which the psychologist obtains consent during the debriefing (Standard 8.03, Informed Consent for Recording Voices and Images in Research).

Naturalistic studies of behavior on the Internet present unique challenges when obtaining informed consent. It could be argued that anything posted on the Internet constitutes public behavior and is, therefore, available for archival research. Researchers could, for example, report a summary of the data on the postings on an electronic mailing list or e-group even if they dealt with highly sensitive issues. However, researchers may want to consider the participant's expectations of privacy when they determine how to treat these communications. The expectations may vary according to the nature of the communication (e.g., a message posted on a chat room vs. a one-to-one communication) or where it was posted (e.g., a Listserv open to all the residents in one's community vs. an online forum restricted to participants with sensitive health care issues). Researchers should consider precautions to limit the potential for harm to those unknowing participants. For example, they could seek their permission to gather data or heavily edit or disguise the responses (Hoerger & Currell, 2012). Also, researchers will have a more difficult time verifying the accuracy of the eligibility requirements such as the age or gender of the participants.

Even with adult participants, psychologists cannot guarantee that they have read the informed consent materials, and participants with questions would have to wait until the researcher responded to their email. Furthermore, some participants may log off the experiment before they have had an opportunity to read debriefing or dehoaxing information. To fulfill their ethical responsibilities, Internet researchers could require participants to give them e-mail addresses before they start the experiment, thus ensuring that they would be sent the debriefing materials even if they logged off prematurely. The exact procedures to ensure informed consent may vary according to the degree of risk to the participants. When the risk of harm is high, researchers should take special precautions or avoid using the Internet altogether (Hoerger & Currell, 2012).

Dispensing With Informed Consent

Researchers can dispense with obtaining informed consent during "the study of normal educational practices, curricula, or classroom management methods conducted in educational settings" or "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" (Standard 8.05, Dispensing With Informed Consent for Research). In addition,

psychologists may gather data from "anonymous questionnaires, naturalistic observations, or archival research" only if the "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" (Standard 8.05). Prospective informed consent can also be waived in experiments involving deception (Standard 8.08, Debriefing; see the section on deception later in this chapter). The APA Ethics Code requires researchers to demonstrate that the study "would not reasonably be assumed to create distress or harm" before they can dispense with informed consent.

In recent years, some researchers have gathered data from publicly available sources on the internet, including social media sites. One could argue that these public postings fall under the category of a naturalistic observation and are exempt from the necessity for informed consent, insofar as they are available to the public. Of course, interactive studies conducted with individuals over the internet—whether using social media or not—still generate the need for informed consent and other research participant protections. Even when working with populations such as adolescents in situations in which psychologists may not have a legal obligation to obtain informed consent, they may wish to get their assent. This shows respect for the adolescent and may help ensure fuller participation in the research process.

Participant Recruitment

According to Standard 8.06a, Offering Inducements for Research Participation, "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." Psychologists can reduce the likelihood of coerced participation by emphasizing the freedom of the person to decline participation, noting the availability of services elsewhere if participation is declined, and having a readable consent form. An example of an excessive or inappropriate inducement to research might be to give money to homeless persons who misuse alcohol or other drugs knowing that they are likely to use the money to buy alcohol or other drugs. An alternative may be to give the participant a voucher or gift certificate that can be redeemed at a restaurant or grocery store.

Researchers should generally strive to have a diverse participant pool to improve external validity, unless the study is directed toward a specific homogenous sample and a more diverse sample would undercut the purpose of the study. Recruiting diverse samples of research participants may not be easy. Members of marginalized groups often have had unpleasant or stressful encounters with health care personnel. Their encounters with physicians or other health care providers may be sporadic or largely confined to emergency room visits. Also, a lack of trust or the stigma of getting mental health treatment contributes to the reluctance of some people of color to participate in mental health research (G. Brown et al., 2014). This fear of mistreatment has historical roots.

CASE EXAMPLE: A SERIOUS INJUSTICE

During the 1930s, a group of African American men with syphilis were followed longitudinally to observe the impact of that disease. At the time the study was started, there were no effective treatments (antibiotics did not become available for the treatment of syphilis until 1943). However, these treatments were not provided even after they became available. A government panel reviewed the Tuskegee experiment in the 1960s and approved its continuation with minor changes. It was not until 1972 that the experiment was stopped following a media exposé (Pritchard & Goldfarb, 2000b).

Later it was discovered that American researchers had conducted research in Guatemala in the 1940s, where they had intentionally infected prisoners and others with syphilis (Reverby, 2011).

Competence

Research psychologists must show minimum standards of competence (Standard 2.01, Boundaries of Competence). However, no predetermined sequence of courses or examinations automatically qualifies or credentials an individual to conduct research, although universities usually assume that the attainment of a doctorate and success in getting one's research published constitutes satisfactory evidence of competence. In addition, federal and state granting agencies, foundations, and other financial supporters of research provide external validation of researchers' ideas and work. Nonetheless, much of the responsibility for the quality of research rests with self-regulation. Of course, if the research entails the delivery of health care services, then researchers will be held to the standards of minimum competence required of all practitioners who deliver such services. Psychologists should ensure that their assistants have the skills necessary to fulfill their responsibilities and follow applicable ethical standards (Standard 2.05, Delegation of Work to Others).

Research involving members of communities of color requires consideration of the characteristics of the population under study. Researchers need to ask themselves if (a) the study adequately describes the background of the participants (and avoids the assumption that all members of an ethnic group are basically alike), (b) the assessment instruments have been standardized with the population under study, and (c) the informed consent procedures are linguistically and culturally appropriate (Fisher et al., 2002). If the population under study represents a marginalized cultural or racial community, then it is desirable to consider cultural factors throughout the entire research study from participant recruitment to interpretation (Talbert, 2019).

Standards Especially Important for Protecting Vulnerable Participants

The need for safeguards becomes heightened when experiments involve health care or involve vulnerable populations, such as persons who lack financial

resources (e.g., persons experiencing homelessness), belong to a group that experiences social stigmas (e.g., LGBTQ+ persons), live in institutions (e.g., prisoners), or have intellectual limitations (e.g., those with serious mental illnesses, developmental disabilities, or dementias; Sieber, 2012). IRBs typically require a full review of the protections offered to vulnerable individuals. What makes a person a vulnerable research participant depends not so much on a given list of demographic characteristics as on the match between the person's vulnerabilities and the nature of the research project.

It would be necessary to ask, for example, if it is ethical to assign individuals with serious eating disorders to a placebo group. Would it be ethical to assign individuals with a history of alcoholism to a controlled drinking treatment group? Could individuals with apparent dementia give informed consent? In these situations, researchers should take greater efforts to protect the research participants because the potential for harm is greater. Some experiences in the recent past may be instructive for psychologists today.

During the 1940s and 1950s, neurosurgeons conducted thousands of surgical brain operations on patients with serious mental illnesses. They proclaimed great success in these operations, although the outcome evaluations were shoddy and superficial and often relied on brief secondhand reports from hospital personnel. Long-term follow-up evaluations were rarely conducted; however, today we see them largely as failures (Valenstein, 1986).

Can we be less critical of these experiments if we view them in their historical context? At that time, psychiatric hospitals were overcrowded, and the available treatments were poor or nonexistent. Some of the patients might have benefited from neurosurgery. Standards for outcome research were not as sophisticated as they are today. Nonetheless, Valenstein (1986) cautioned that the same forces that led to the misuse of psychosurgery in the past exist to some extent today as well. There are today no fewer desperate patients and desperate families; premature reports of spectacular cures with minimal risks are still accepted uncritically; the popular media promote innovative therapies even more enthusiastically; [and] economics is no less an influence on the selection of treatment (p. 291). Although Valenstein wrote his observations more than 35 years ago, they still apply today.

Informed Consent With Vulnerable Participants

If the research involves treatment, then the researchers need to adopt additional safeguards for the research participants. As with nontreatment research, psychologists must obtain the informed consent of the participants. Although informed consent does not ensure that the research will be ethical, it nonetheless safeguards the welfare of the participants (Fisher & Vacanti-Shova, 2012). When conducting intervention research involving the use of experimental treatments, psychologists should explain

> (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. (APA Ethics Code, 2017a, Standard 8.02b, Informed Consent to Research)

Informing prospective participants of the possibility that they may be assigned to a control group is important. Assignment to a placebo or no-treatment group may benefit the researcher, but not the participant. Although not required by the APA Ethics Code, at times researchers may want to provide treatment later to those participants who were initially assigned to a control group.

Psychologists need to think through the specifics of how to obtain informed consent from vulnerable populations. For example, prospective participants with intellectual disabilities may not be able to understand the salient features of what is being asked of them. However, the mere presence of an intellectual disability or a mental illness does not automatically mean that an individual lacks the ability to consent. Even persons with intellectual disabilities, age-related cognitive decline, or serious mental illnesses, are often able to give informed consent if researchers explain the concepts to them adequately and take time to answer their questions. If the researcher suspects that an individual has an impaired ability to decide, then they can use educational programs to increase the participant's competency to decide. These may include one-to-one educational sessions with teaching aids (e.g., videotapes, flip charts, diagrams), group instructional sessions, written materials, computer programs, using family members as educational aides, or involving the prospective participant in a dialogue over time (Roberts, 2000). If vulnerable persons appear incapable of giving consent, then researchers may rely on family members as a proxy, although this could create ethical problems if the family members do not act as bona fide fiduciaries for the research participant.

Other Protections for Vulnerable Research Participants

The obligations to research participants do not end once they have enrolled in the study. Other ethical considerations include a fair process in the selection of treatment or control groups, a favorable benefit–risk ratio (i.e., a reasonable expectation that the benefits of treatment outweigh the risks), and respect for the research participants after they have enrolled in the study (Emanuel et al., 2000). Psychologists should especially scrutinize participant well-being when they use placebo groups or designs involving treatment-as-usual, dismantling, additive, or wait-list controls. Heightened scrutiny should be given to studies that are designed to provoke symptoms, withdraw participants abruptly, or use placebo groups. Researchers should debrief participants after the study; monitor their welfare throughout the study; protect participants from physical, psychological, or social harm; and allow them to withdraw.

Researchers may occasionally see the quality of their research at apparent odds with the welfare of the research participants. Consider the example of

psychologists studying the natural development of girls (Fisher, 1994). During their research, they may learn that a girl may be in the early stages of developing anorexia. Should the researchers emphasize the welfare of the girl and intervene to get her a more thorough evaluation or medical services, or should they emphasize the integrity of the research study and allow her to develop without any professional intervention? Of course, the decision is influenced by the strength of the evidence suggesting a medical problem, the impact of such a medical problem on the long-term health of a child, the nature of the promises made to the child and parents about their participation, and other facts unique to the case.

Nonetheless, Fisher (1994) argued that a strict act utilitarian analysis may lead to a solution that is contrary to the best interests of the research participant. According to an act utilitarian perspective, it could be argued that the social benefit of the research project would lead, overall, to more benefit than caring for the needs of a research participant, which risks contaminating the study.

However, a rule utilitarian perspective would consider general rules of utility. Accordingly, a utilitarian rule might be that researchers have an obligation to assist participants when necessary to protect them from serious harm. A deontological perspective would consider that research participants should never be used only as a means to an end, but that their intrinsic worth needs to be considered. Consequently, rule utilitarian or deontological perspectives would give more weight to the needs of the participants and less to the social utility of the research project (Fisher, 1994).

Protecting the privacy of research participants is important as well. Ensuring privacy not only is fair to the participants but also enhances the credibility of the results by increasing the willingness of participants to give accurate information (Blanck et al., 1992). Standard 6.02, Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work, requires psychologists to keep information on research participants private and to protect confidential information in databases. Researchers can remove or code identifying information as well as names. They should discuss limitations of confidentiality with participants, including mandated reporting laws. Federal certificates of confidentiality can be obtained that would waive the requirements to respond to subpoenas on certain information, but these do not apply to mandated reporting laws.

Psychologists should consider how they will store or share data. The research information should be kept secure, and psychologists need to be aware of any limitations to the electronic storage of data (Standard 6.02, Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work).

Debriefing Research Participants

Psychologists should give participants the opportunity to be debriefed or "to obtain appropriate information about the nature, results, and conclusions of

the research" (Standard 8.08a, Debriefing). They also "take reasonable steps to correct any misconceptions that participants may have of which the psychologists are aware" (Standard 8.08a). However, Standard 8.08b acknowledges that at times debriefing may be delayed or withheld for scientific or humane reasons. If research participants appear to have been harmed by the research, then, "psychologists [should] take reasonable measures to reduce the risk of harm." If psychologists become aware that research participants have been harmed, "they take reasonable steps to minimize the harm" (Standard 8.08c).

Ideally, debriefing should benefit both the researcher and the participant. In some studies, researchers have learned information during debriefing that assisted in interpreting the data and in planning for future research (Blanck et al., 1992).

If psychologists used deception or a reasonable possibility existed that the participants might have misunderstood the nature or conclusions of the study, then psychologists need to attempt to correct these misconceptions unless there are humane or scientific reasons for not doing so. For example, a child might not have the capacity to comprehend the research rationale and the debriefing may cause confusion, embarrassment, or a sense of betrayal (Fisher, 2012). Finally, debriefing allows researchers to learn if the experiment harmed participants and provides an opportunity for them to mitigate the harm.

Brody et al. (2000) found wide variability in the content, format, and time allotted for debriefing (i.e., between 2 and 20 minutes). Participants often felt dissatisfied with the debriefing. Their results suggest the need to give more attention to how researchers could better use debriefing to educate participants about the nature or value of the research.

Deceiving Research Participants

Deception may mean different things, such as hiding the purpose of or deliberately misrepresenting facts about an experiment. Frequently, deception ensures that the participants will not be influenced by knowledge of the real purpose of the study.

Boynton et al. (2013) found that some benign deception studies pose little harm to participants. Nonetheless, even more benign forms of deception have been criticized on deontological grounds (i.e., it is intrinsically undesirable to deceive people) and utilitarian grounds (i.e., deception significantly influences the way participants act and undermines the trust that the public has in the discipline and profession of psychology; Kimmel, 2012). This *reputation spillover* may contaminate the participant pool, as more participants expect to be deceived in their experiments.

Accordingly, Standard 8.07, Deception in Research, limits the use of deception in research. Researchers must justify the use of deception and debrief research participants as soon as possible. This standard requires psychologists to weigh the costs and benefits of deception and consider other nondeceptive research designs, such as role plays, naturalistic observations, or self-report

CASE EXAMPLE: A DECEPTIVE EXPERIMENT

Psychologist Stanley Milgram recruited participant "teachers" for a series of purported studies of memory involving electrical shocks to another individual identified as a "learner." However, the teachers received instructions in which they perceived themselves as creating increasingly painful electric shocks for the learners. The teachers were not aware that the shocks were, in fact, not being administered; that obedience, not human memory, was being studied; and that the learners were confederates in the study. Despite the apparent anguish created in the participants, Milgram (1975) claimed that the social benefit of his study justified any problems created for the participants.

Milgram (1975) provided participants with an extensive debriefing session that included a "friendly reconciliation with the unharmed victim and an extended discussion with the experimenter," and "in some instances, additional detailed and lengthy discussions of the experiment were also carried out with individual subjects" (p. 24).

The study did produce socially useful information on why people participate in atrocities such as political torture, which they ordinarily would not do. However, Milgram's (1975) experiment raised several ethical issues, such as whether other nondeceptive techniques could have been used to study obedience, whether Milgram should have terminated the experiment when it became obvious that the participants were suffering, and whether some participants might have experienced enduring psychological harm. Burger (2009) completed a partial replication of Milgram's study in which he tried to minimize the harmful aspects of the original study. His findings substantially replicated those of Milgram. Deception experiments today are usually far less dramatic than the ones conducted by Milgram.

data. However, the cost–benefit analysis is only self-monitored, and researchers may overestimate the scientific importance of their work or may not be as scrupulous as they should be in considering nondeceptive alternatives. This standard may best be read in the context of a cultural tradition in which European American researchers have been viewed suspiciously—with good reason sometimes—by research participants of color. The harm that deception has on intergroup relationships and trust should be a factor in determining the degree of harm from deceptive techniques (Behnke, 2014). Regrettably, Hilbig et al. (2022) found that many researchers who used deceptive strategies had clearly feasible nondeceptive alternatives available to them.

Nonetheless, "psychologists do not deceive prospective participants about research that is reasonably expected to cause physical pain or severe emotional distress" (Standard 8.07b, Deception in Research). As early as is feasible, psychologists explain that deception is an integral feature of the design or conduct of an experiment. Preferably, the debriefing occurs when the participants

finish with the experiment, but no later than after the data collection. Psychologists also permit participants who were deceived to withdraw their data (Standard 8.07c).

The issue of deception involved an unusual twist when researchers used Facebook to study emotional contagion. In this study, they decreased either the negative or positive responses that participants received following their postings (Kramer et al., 2014). Although the manipulation was consistent with Facebook's policy, it raised questions as to whether the intervention, which had the potential to harm the emotional state of the participants, should have required informed consent (Kleinsman & Buckley, 2015).

Protecting Animal Welfare

Some wish to abolish animal research entirely. Others believe it is acceptable for limited purposes if basic protections are in place. All would agree that, especially in the past, researchers did not always protect animals adequately.

Supporters of animal research argue that humans benefit from the knowledge gained by animal research, that animals do not experience discomfort or restrictions in freedom in the same manner as humans, and that they are not sentient beings that have basic rights. Opponents argue that the knowledge gained often has limited applicability to humans and that animals do have feel pain (although we cannot understand their subjective experience as well as we can understand that of humans). Furthermore, some opponents claim that a pattern of cruelty or insensitivity to animals may establish a precedence of cruelty or insensitivity to humans. Finally, some argue that animals do have some rights that need to be considered when making decisions about research (Beauchamp & Childress, 2019).

Research on animals is governed by the APA Ethics Code (Standard 8.09, Humane Care and Use of Animals in Research) and various state and federal laws. In addition, a private organization, the Association for Assessment and Accreditation of Laboratory Animal Care International, sets standards for research facilities using animals. Researchers must ensure the welfare of animal subjects and may only inflict pain, stress, or privation on them when no alternative research procedure is available and can be justified by its prospective social value. When it is necessary to kill animals, it should be done rapidly with an effort to minimize pain. State and federal laws regarding the care of animals must be followed. Nonetheless, researchers should not assume that adherence to minimal standards of animal care ensures that they are acting in accordance with the highest standards of ethical behavior. "The ethical care of animals requires more than simply following or rejecting recommendations and rules" (Perry & Dess, 2012, p. 435). Instead, it requires a concern for animals, including efforts to enrich their lives and their psychological well-being.

One experiment on learned helplessness involved shocking dogs. The researcher conducted a cost–benefit analysis before initiating the research. He sought consultation and was asked, "First, is there a reasonable chance that

you will eliminate much more pain in the long run than the pain you cause in the short run? Second, can scientists ever generalize from animals to people?" (Seligman, 1991, p. 21).

Although some might not have reached the same conclusions as he did, the researcher asked some of the right questions. We would also add other questions, such as whether the researcher could gain the same information through other means and whether the researcher minimized the discomfort (or repaired the harm) done to the animals.

PUBLISHING AND REPORTING USEFUL RESEARCH

The scientific enterprise assumes the accuracy of the data reported. Psychologists harm the discipline of psychology and the public when they present inaccurate data, do not guard against subtle influences that threaten the quality or accuracy of their work, deny access to data for reanalysis or verification, fail to consider cultural factors that influence their research conclusions, do not award credit for authorship accurately, or exploit student authors. Psychologists harm the discipline of psychology and the public when they publish information as original that has been published elsewhere, engage in plagiarism, or do not respect the confidentiality of the peer-review process.

Inaccurate, Misleading, or Incomplete Research Results

Scientific advances typically occur slowly over time as a series of studies gradually builds upon the existing knowledge base to identify or clarify psychological phenomena. As in other fields of science, the field of psychology has had trends, fads, and dead ends; these are inevitable in the progress of any field of science.

Inaccurate results may occur because of deliberate fabrications of data (called fraud) or errors in research that were probably not intentional. Falsification of data is a serious ethical violation that can cause substantial damage to the public. Falsification of data can involve completely making up data or deleting or modifying participant responses to skew the data. Falsified data mislead future investigators and cause them to go down blind alleys and follow bogus research leads. They also demean those who gather data honestly. Furthermore, the falsification of data can directly harm the public.

Scientific papers can be retracted for data fabrication. Steen (2011) found that the discovery of scientific fraud is increasing, although it is not clear if there is more fraud or whether there are more efforts to uncover fraud. A review of some major scientific journals found that it took almost 3 years between the publication of a study and its retraction (Liu et al., 2022). However, in the meantime, the original article could have been cited many times, thus allowing inaccurate information to permeate the scientific community.

CASE EXAMPLE: COSTLY MISREPRESENTATIONS

A psychologist falsified data dealing with the use of psychotropic medications with institutionalized persons with intellectual disabilities. His publications could have led many physicians to alter their prescription habits based on this falsified research. Researchers who collaborated with him had their reputations tarnished by association. Doubts were cast on his other studies, even though allegations about the fabrication of the data in those articles were never proven or admitted (Pritchard & Goldfarb, 2000a).

In another situation, a researcher claimed that vaccinations were the cause of autism, although later evidence suggested that the methodology was flawed and the conclusions were unwarranted. However, many parents believed in the original study and refused to get vaccinations for their children. The result was a series of measles outbreaks and deaths of children in the United States. Available data show that more than two thirds of the cases occurred among unvaccinated persons who had no medical justification for failing to get vaccinated (Phadke et al., 2020).

Retractions may also occur if the study contains serious errors. Despite efforts by conscientious researchers, mistakes in the design or the reporting of data may creep into a publication. When that occurs, the authors should take steps to correct the errors (Standard 8.10b, Reporting Research Results).

Threats to Accuracy[2]

Despite the great harm that can occur because of scientific fraud, even more inaccurate information may be disseminated by research and publishing practices that reward what appear to be innovative breakthroughs, even if the methodology used is weak. Starting in 2011, the Center for Open Science assembled an international network of psychological scientists who attempted to replicate previously published studies in psychological journals. *Replication* refers "to testing the reliability of a prior finding with different date" (Nosek et al., 2022, p. 721). Of the first 100 studies that were replicated, less than one half were able to confirm the positive results found in the original study. The reviewers noted that no one standard can be used to determine whether a replication was a success. Nonetheless, when looking at probabilities (*p* values), 36% of the replicated studies found a statistically significant effect. When looking

[2]Portions of this section were adapted from "Restoring the Credibility of Psychological Research," by S. Knapp, 2016, *The Pennsylvania Psychologist*, *76*, 5–6. Copyright 2016 by the Pennsylvania Psychological Association. Adapted with permission.

at effect size, 47% of the replicated studies found a statistically significant effect (Open Science Collaboration, 2015). Studies that were replicated successfully were more likely to be published in cognitive psychology journals as opposed to social psychology journals, and the studies that were replicated were more likely to show more robust findings in the original study.

The striking implications of this project are that much of what is assumed to be true in psychological science might, in fact, not be true. The authors noted that the progress of science necessarily involves efforts to falsify hypotheses. "Reproducibility is a defining feature of science. . . . Scientific claims should not gain credence because of the status or authority of their originator but by the replicability of their supporting evidence" (Open Science Collaboration, 2015**,** p. 943).

It is possible that the findings from many of the original studies were inaccurate. However, those conclusions should not be drawn from the results of one failed replication. First, replication is never completely perfect. No study can be replicated with complete fidelity; there will always be differences in the populations from which the experimental sample was drawn, and unnoticed differences in the implementation of an experiment can influence its results. For example, the gender or race of the experimenter could influence the nature of the response of the participants, yet the race and gender of the experimenters are seldom reported in the literature (Does et al., 2018). Also, the replication study may be a false negative (i.e., failure to find a result that exists).

The Open Science Collaborative represents the most prominent example of a movement toward greater transparency in science. Psychologists can improve the quality of research if they preregister their studies, which reduces fears that they will engage in postexperiment hypothesis searching or delete nonsignificant findings from their published findings. In addition, researchers could make their data available for sharing. Recent technological changes have eliminated the problems once associated with retaining and sharing data. One of the benefits of open data is that it may allow for the reanalysis of the original data set. Often researchers make reasonable but undisclosed methodological decisions (e.g., Should outliers be removed from the data analysis? Should all data analyses be reported? Should all dependent measures be reported?). Using data from medical trials, Ebrahim et al. (2014) found that the reanalyses sometimes changed the direction of the findings with implications for patient care. Sharing data or otherwise being transparent in one's research reduces the likelihood of errors or misinterpretations of data (Bosma & Granger, 2022).

The Open Science Collaborative project also helped to elucidate a major problem with the existing publication system, which prefers studies that find significant results, even if the study involved weak methodology and a small sample size. Research with small sample sizes, for example, runs a greater risk that significance will be found, even if the findings are false. This is not to imply that all studies with small samples are bad, only that they risk overestimating the effect size and need to be interpreted with caution (Ioannidis et al., 2013). Alternatively, studies with nonsignificant findings have a lower

likelihood of being published. This "file drawer problem" can artificially inflate the efficacy of studied treatments (Nosek, 2022). For example, researchers found that when they added unpublished studies to meta-analyses of medication and psychological treatments for major depression, the effect size decreased by 25% (Driessen et al., 2015). The reward system for publishers "incentivizes quantity more than quality, novelty more than reliability" (Ioannidis et al., 2014, p. 166).

Issues related to the accuracy of published data are not unique to psychology. All fields of research have the same issues. In the field of psychiatric research, the methodological problems associated with drug studies are so substantial that some researchers have questioned the efficacy of many commonly used psychotropic medications (Davis et al., 2011).

Reanalyzing or Verifying Data

As noted previously, some journals now require authors to make their data available for reanalysis in a specific format that is easily accessible to other scholars. The APA Ethics Code states that psychologists should not withhold data needed for reanalysis or verification (Standard 8.14, Sharing Research Data for Verification). Although the Code does not set a specific time frame, if the data contain protected health care information, the data need to be kept for at least 6 years according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and institutions may have requirements for other research records. A prudent rule is to also keep treatment manuals and other information related to the research for 5 years after publication. The person requesting the information generally should bear whatever costs are involved in sharing the data, although advances in technology have greatly reduced the financial costs that were once associated with data sharing. Although not required by this standard, it may be prudent to receive written approval to use the data for purposes other than reanalysis. The sole reliance on oral communication can sometimes lead to misunderstandings. Of course, the sharing of data assumes that the confidentiality rights of the participants and any proprietary rights of the funder of the research remain protected.

Considering Cultural Factors

For most of the history of psychology, Europeans or European Americans conducted most of the research using European or European American subjects. Now that psychology has become more global, more psychologists are questioning the extent to which they can generalize the findings with European or European American participants across all cultures. Henrich et al. (2010) referred to most research participants in North American and European studies as WEIRD (Western, educated, intelligent, rich, and democratic), and their responses in experiments may not be representative of other populations.

For example, American children reportedly are more likely to thrive when their parents adopt an authoritative parenting approach. Similarly, across

cultures, authoritative practices (clear rules administrated with flexibility and sensitivity) tend to benefit children and authoritarian practices (clear rules administered with rigidity and harshness) tend to harm them, although the strength of the associations varied between individualistic and collectivist cultures and the impact of a permissive style of parenting varied according to the culture (Pinquart & Kauser, 2018).

Promoting the Well-Being of Students, Research Associates, and Junior Colleagues

Psychologists who manage research teams can create positive and collegial environments. Of course, the minimum standards of the APA Ethics Code apply to research psychologists to the same extent as they apply to other psychologists. For example, prohibitions against sexual harassment apply to research psychologists as they do to other psychologists; nevertheless, allegations of hostile environments for young scientists (especially young woman scientists) have recently become known in many areas of science (Witze, 2016).

Beyond avoiding harm to their junior research associates, psychologists can also strive to make their work environment friendly, cooperative, and mutually beneficial, and work to promote the careers and skill levels of their junior colleagues. Psychologists can share their enthusiasm for research, identify the public benefit of what they are doing, and share with students the benefits of productive collaboration (Naji et al., 2021). Psychologists can also ensure that they create an atmosphere that welcomes women and people of color as full participants in the research process.

One of the most obvious ways to do this is through fairness in assigning research or publication credit. Academic psychologists publish to receive academic advancement and to be competitive for grant funding. Senior authorship is especially important. However, the self-interest of individual psychologists is subordinate to the need to reflect contributions accurately. The integrity of the scientific or scholarly enterprise is protected when authors receive credit for the work they do and the ideas that they develop.

According to Standard 8.12b, Publication Credit, "Principal authorship and other publication credits accurately reflect the relative scientific or professional contributions of the individuals involved, regardless of their relative status." The criteria for authorship are described in more detail in the *Publication Manual of the American Psychological Association* (7th ed.; APA, 2020). Some activities that could warrant authorship include developing the idea for a study, developing the design, conducting the literature review, performing a pilot study, coordinating the collection of the data, analyzing the data, writing a first draft, critically reading a manuscript, or making substantial contributions to the final draft. Other contributions probably would not warrant authorship except in unusual situations.

According to Standard 8.12b, Publication Credit, "Minor contributions to the research or to the writing for publications are acknowledged appropriately,

such as in footnotes or in an introductory statement." Running participants and assisting with the statistical analyses typically do not warrant authorship in and of themselves. However, no algorithm can determine authorship in all situations, and authors may vary in their perception of the value of the different contributions. It shows foresight to talk about authorship issues early in the writing or research process to clarify expectations.

Articles in some medical journals contain a footnote that lists the contributions of the different authors in study concept and design, acquisition of data, statistical analysis and interpretation of data, drafting of the manuscript, critical revision of the manuscript for important intellectual content, and other contributions. Such a list may assist psychologists in determining who should be authors and their relative ranking in authorship. Standard 8.12b, Publication Credit, states, "Mere possession of an institutional position, such as department chair, does not justify authorship credit." This standard prohibits honorary authors (i.e., those who receive authorship because of their status but who did not do enough work to merit it) and ghost authors (i.e., those who receive no authorship credit but who did enough work to merit it). Determining authorship may be difficult when working with scholars from other disciplines who may have different standards for authorship.

Awarding Authorship to Students

According to Standard 8.12c, Publication Credit, students are usually listed as the "principal author on any multiple-authored article that is substantially based on the student's doctoral dissertation." In addition, advisors should "discuss publication credit with students as early as feasible and throughout the research and publication process as appropriate." This standard creates a presumption that the dissertation student will get first authorship. However, that presumption can be overturned by the facts of a given situation.

This rule protects students who are at a power disadvantage and at risk of having professors usurp authorship for their work. A recent graduate may depend on a dissertation advisor for a letter of reference or for other help in getting future employment and may fear reprisals for disagreeing with the authorship decision. In some situations, the student may have written the proposal, run the participants, analyzed the data, and written the report and article with little contribution from the advisor. The contribution of the advisors may warrant the second authorship, if any.

In other situations, students depend more on the knowledge, experience, and work of their advisors. For example, the advisors may identify key research areas, direct the students to the relevant sources (or even give them copies of key articles or chapters), direct or approve the research design, help solicit participants, and assist in writing the article. The contributions of the faculty members may be such that they deserve to be the primary authors. At other times, the students may lose interest in the topic after finishing the dissertation, and the faculty members become the primary force in preparing the article for

publication and making necessary revisions. It is especially common in master's theses for advisors to contribute more to the research project and therefore become more deserving of primary authorship. In either case, it is desirable for collaborators to discuss their expectations for authorship well ahead of time.

Duplication in Publications

According to Standard 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." The usual assumption is that journal articles contain original data unless otherwise specified. This standard prohibits authors from essentially publishing the same article in two different publication outlets. However, this standard does not preclude using portions of the data in subsequent publications if appropriately noted.

Avoiding Plagiarism

Standard 8.11, Plagiarism, forbids plagiarism. Psychologists or psychology students should not appropriate sentences, charts, graphs, pictures, computer programs, innovative terminology, or original ideas of others without giving proper acknowledgment.

It is not necessary to footnote or reference information that is "common knowledge." Usually, what constitutes common knowledge is obvious. For example, the fact that Wundt established a psychology laboratory in Leipzig, Germany, in 1879 is common knowledge. It can be found in literally thousands of sources and is taught to approximately 100,000 introductory psychology students every year. However, authors should reference unique terminology or ideas that are not well-known.

Plagiarism has become especially problematic in recent years with the proliferation of documents available on the internet and the availability of ChatGPT and other artificial intelligence services (although programs are available to help teachers identify plagiarized material). It most commonly involves copying portions of materials written by somebody else and not identifying the original author. Plagiarism among students differs from other forms of cheating in that plagiarism may be due to a misunderstanding of what plagiarism is, an inadequate knowledge about when and how to document sources, or unintentional errors caused by a failure to document sources conscientiously. It is further complicated by the fact that the line between plagiarized and not plagiarized is not always clear, and senior faculty may not always agree on where to draw the line. Faculty members who address plagiarism directly and explain its standards clearly, can substantially reduce the amount of plagiarism (Belter & du Pré, 2009).

However, even accomplished scholars can plagiarize inadvertently. These speculations are not made to excuse the author's plagiarism but to indicate that it can happen to "good" people who fail to attend to the risk of accidental plagiarism.

CASE EXAMPLE: A HIGHLY PUBLIC ERROR

A famous historian had copied excerpts from other authors without giving proper acknowledgments (Lewis, 2002). It is very unlikely that this author, who knew that his work would be widely read, deliberately stole paragraphs from others. Perhaps he relied on professional researchers and never saw the original material, or perhaps the pressure of meeting time schedules caused him to be too lax when checking sources.

Ensuring Confidentiality in the Peer Review Process

Editors and authors may not reference works submitted for publication without the consent of the author until they are published (Standard 8.15, Reviewers). Manuscripts commonly change considerably from the time they are first submitted to the time they are published. It is not fair to the author to reference an earlier and less polished version of the work. Reviewers should also respect the originality of ideas found in the manuscripts or proposals that they review.

STRIVING FOR THE HIGHEST IDEALS AS A RESEARCHER

Striving for the highest ethics as a researcher means, of course, following the minimum standards required in the APA Ethics Code and federal regulations. It also means being sensitive to the ethical implications of one's research and scholarly activities. Psychologists who strive for the highest ideals as researchers and scholars give research expertise away, are concerned about the social usefulness of their research, try to humanize the peer review process, and are sensitive to the impact of external sources on their research activities.

Give Research Away

Psychologists can give away their expertise by providing consultations to publicly oriented community agencies or by encouraging scientific activities such as science fairs. They can also direct their research activities toward issues involving members of historically underrepresented groups or toward issues involving health care services. They can share data, treatment manuals, and their expertise with other researchers.

Psychologists can share their expertise with the public and policy makers. During the height of the COVID-19 pandemic, psychological scientists assisted public officials in developing messages that would increase the likelihood that members of the public would wear masks when indicated or get vaccinations (Abbasi, 2020). When advising members of the public or policymakers, psychologists should be simultaneously bold, humble, and transparent. They should

not feel inhibited about informing others of their research findings. On the other hand, when they do so, they should clarify the limitations and caveats of their knowledge with an appreciation that "science is messy and provisional" (Jamieson, 2021, p. 48). Most psychological knowledge is provisional and evolving. Psychologists should not say, "The research study conclusively shows that . . ." but rather say, "The best evidence we have right now is . . ."

Conduct Socially Useful Research

Probably all psychologists believe that their research has social significance. However, it may be useful to consider ways to make research even more socially significant. It may be useful to ask what are the pressing problems that health care professionals, teachers, makers of public policy, police, engineers, financial analysts, and ordinary people face in their lives. What issues do they consider important? It may be especially helpful to consider the perspectives of those who have not traditionally been consulted about research.

For example, recent research has focused on the experiences of suicidal patients who received mental health treatment (e.g., Hom et al., 2021), and these studies are often conducted with the involvement of organizations for survivors of suicide attempts. The conclusions of researchers looking at objective measures of suicidal behavior and aggregating patient responses to standardized measures are very important in determining what is helpful in treating suicidal patients. Nonetheless, practitioners can get a more thorough understanding of treating suicidal patients by gathering information on patients' perspectives of their experiences in treatment and their perceptions of what was helpful or not helpful for them in treatment.

Another example involving applied research concerns the way that psychotherapy researchers can incorporate practitioners' insights into their research designs or protocols. Because the half-life of psychological knowledge is only 9 years (Neimeyer et al., 2014), professional psychologists run the risk of relying on an obsolete database over time. One of the problems in keeping up with the knowledge base is that practitioners do not always use research as much as they should, and researchers do not always address the needs of practitioners as much as they should. Finger-pointing ignores the complexity of the problems and does little to generate satisfactory solutions. Furthermore, finger-pointing ignores the underlying fact that both practitioners and applied researchers have the same goal: to develop and implement the best treatments for their patients.

Researchers and practitioners can best move toward that shared goal if they engage in ongoing dialogues and cooperate with each other. Practitioners can inform researchers of the issues that are most salient to them, and researchers can inform practitioners of the latest scientific evidence and help formulate research questions. Practice–research networks that involve practitioners and scientists in collaborative projects have been used to address this issue (Castonguay et al., 2010).

Humanize the Peer Review Process

Psychologist reviewers can make the peer review process more humane and helpful. Many psychologists receive gratuitous and destructive criticisms or ad hominem attacks in reviews of their writings (Hadjistavropoulos & Bieling, 2000). Reviewers can fulfill their primary obligation to ensure the quality of journal articles by helping authors to improve the articles that they submit. Unnecessarily harsh reviews detract from substantive comments.

Cooperate With Others

Researchers can feel a strong commitment to the significance of their findings and the methodology that they use. They may find it difficult to have their work criticized. Those research psychologists who share their data for reanalysis or who share their research procedures with another researcher doing a replication study may feel a temptation to view the reanalysis or replication as a personal attack. A better attitude is to view it as one step in the scientific enterprise that benefits when multiple eyes look at the same data or when more data are being collected (Nosek, 2022).

Researchers benefit when they talk to and collaborate with researchers who have other perspectives. For example, research teams led by Galynker (2018) and Joiner (e.g., Rogers et al., 2017) developed overlapping but different ways to operationalize the emotional states that people feel before they attempt suicide. Instead of bickering over whose approach was superior, they pledged an open-minded attitude and a commitment to using scientific data to further their understanding of this phenomenon (Rogers et al., 2017).

The salience of ethical issues dealing with research has changed over time. Ethical issues in research have always emphasized the need to protect research participants, use prudence when engaging in deception in research, and follow authorship rules conscientiously. However, recent years have seen an increased awareness of how the White male–dominated research enterprise may have skewed the selection of research topics and the interpretation of data and led to a research workforce that does not represent an adequate cross section of American society. In addition, recent years have seen a substantial increase in concern about the accuracy of many research findings. This is not a new issue; psychologists have always been concerned about replicability. However, the awareness of the magnitude of the problem has increased substantially in the last 10 years. We hope that new efforts at replication, reasonable uses of statistical tests, data sharing, and other methods will increase the confidence that psychologists and the public can have in published findings.

Afterword

Fulfilling Psychology's Ethical Ideals

We all want a society characterized by mutual cooperation and respect for all persons. We wrote this book to help psychologists use their professional roles to promote these values. In doing so, of course, they should avoid professional misconduct. However, focusing only on misconduct is a skeletal form of ethics that fails to consider the many ways in which psychologists can achieve their highest ethical aspirations. We do not dismiss the floor approach to ethics; indeed, we believe that disciplinary bodies do have a role to play in protecting the public. Moreover, most of these standards reflect the cumulative wisdom and reflections of psychologists on those activities that promote the well-being of individuals and society and those that do not. Conscientious and prudent psychologists can improve the quality of their services by relying on this extensive tradition.

However, we have also emphasized the limits of looking only to disciplinary standards to guide psychologists' conduct. Throughout this book, we have emphasized the strategies that psychologists can use to help them to fulfill their ethical ideals, including the ethical acculturation model, the five-step ethical decision-making model, and the ethically based quality enhancement strategies. We have looked at the application of overarching ethical principles and standards to various aspects of relationships in psychological practice (e.g., boundaries, informed consent) and the work of psychologists in various roles (e.g., educator, supervisor, researcher, citizen advocate). However, this short volume can only begin to identify the many ethical issues that can arise in psychology or the many implications of positive ethics on the practice of psychology. We hope that reflective readers and scholars, working within a collaborative and supportive environment, will increase the extent to which they can live out their ethical ideals and expand on and clarify the applications of positive ethics to the professional activities of psychologists.

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