

Fourth Edition

ETHICS *in* PSYCHOLOGY
and the MENTAL HEALTH
PROFESSIONS

Standards and Cases



Gerald P. Koocher
Patricia Keith-Spiegel

ETHICS IN PSYCHOLOGY AND THE MENTAL HEALTH PROFESSIONS

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Fourth Edition

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To our colleagues who have the courage to consistently uphold ethical standards and who teach them to their students.

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Preface

It seems bewildering that individuals in government agencies, corporations, academia, religious institutions, and other entities responsible for the well-being and safety of our citizens should engage in acts that ultimately destroy their careers or dishonor everything they or their employers vowed to stand for. Sadly, it is not difficult to generate unsettling accounts of deceiving the public trust, leading to an impression that our moral compass has spun out of control. Here are just a few examples:

Pharmaceutical giants spend billions of dollars every year for allegations of data misrepresentation, fraud, promoting drugs for conditions beyond those for which they were licensed, withholding safety data, bribery, and corruption. In 2013, GlaxoSmithKline pled guilty to three criminal counts for promoting drugs for unapproved uses and failing to report safety data warnings to the Federal Drug Administration. The company paid \$3 billion in fines, the largest pharmaceutical

payout to date. Other pharma giants caught up in bribery, misrepresentation, or data fraud include Takeda, Merck, Pfizer, and Abbot (Sukhija, 2013).

Jeanette M. Boxill, a philosophy lecturer and former academic athletic counselor at the University of North Carolina at Chapel Hill, played a key role in steering athletes in need of maintaining eligibility requirements into fake classes and allowing passable grades for little or no work and then obstructing attempts to uncover the practices. Although many others were implemented in a practice that spanned over many years, Boxhill stands out because she also directed the university's Parr Center for Ethics (Wolverton, 2014).

At least 35 United States Armed Forces veterans died while awaiting care at a Veterans Affairs (VA) hospital in Phoenix, Arizona. An internal audit of VA facilities discovered at least 120,000 veterans were either waiting for appointments or were never seen.

The majority of schedulers in 93 VA hospitals under investigation were pressured to intentionally manipulate data. For example, an appointment would be cancelled and rescheduled for the same day, making the wait time appear shorter (Carney, 2014). Top VA officials resigned, and more investigations ensued into what has been described as a “corrosive culture” inside the Veterans Health Administration.

Instances of child sexual abuse by Catholic priests and attempts to cover them up continue to be revealed amidst sluggish attempts to deal with the inflicted harms. The scandals went to the top of the hierarchy as former and defrocked Vatican ambassador, Archbishop Jozef Wesolowski, faced criminal charges while serving in the Dominican Republic. He allegedly picked up young shoeshine boys and paid them to engage in sexual acts, according to a local deacon, who was also arrested while trying to procure victims for the priest. Wesolowski’s trial was the first of its kind to be held in the Vatican (Goodstein, 2014).

Forensic chemist Annie Dookhan, who worked for the Department of Public Health Laboratory in Massachusetts, forged colleagues’ signatures and falsified records on evidence and samples assigned to her, placing up to 34,000 criminal drug cases into question. Some criminal defendants may have been wrongly convicted and others wrongly freed. Police warn of a crime spike due to the high number of drug offenders who will be released (Grant, 2013).

Rick Renzi, a Republican U.S. congressman representing Arizona’s First Congressional District from 2003 until early 2009, was found guilty of 17 felony counts, including wire fraud, conspiracy, extortion, racketeering, money laundering, and making false statement to insurance regulators. He was sentenced to 3 years in prison (Wagner, 2014).

Oncologist Farid Fata, M.D., schemed to defraud Medicare and insurance companies of millions of dollars while delivering treatments to over 500 patients who did not

actually have cancer, putting other cancer patients in remission through unnecessary infusion treatments, and pumping chemotherapy into others he knew were terminally ill. He even forged a “research” paper proving the merits of a particular drug. He was found guilty of health care fraud, money laundering, and conspiracy and sentenced to 45 years in prison (Cara, 2015).

Former Virginia Governor Robert McDonnell was found guilty of 11 counts of conspiracy, bribery, extortion, and financial corruption. He was expelled and sentenced to 3 years in prison. McDonnell’s wife was also convicted. Governor Mitt Romney’s once-touted potential running mate is left instead with expulsion, a ruined career, an exposed disastrous marriage, and prison time (Gabriel, 2014).

The best-known military commander of this generation, General David Petraeus, pled guilty to providing top secret documents to his mistress while he was director of the Central Intelligence Agency (Miller, 2015).

Perhaps concern for the bad behavior of some mental health professionals seems trivial in comparison to those whose misconduct caused widespread harm and betrayal of the public trust. Nevertheless, maintaining the highest professional standards, even while the values around us often appear to be tumbling, is a noble personal goal. We may never directly know the long-term impact of our exemplary work, but surely it was paid forward in some fashion. A competently and compassionately treated seriously depressed teenager goes on to become a surgical nurse. An estranged couple changes course after counseling and enjoys their children and eventually grandchildren as an intact family. A veteran with posttraumatic stress disorder (PTSD) emerges with newfound strength and resolve. These stories do not make headlines, but they do make a difference, one person at a time.

Mental health professionals have their work cut out for them. A supplement by the U.S. Centers for Disease Control and Prevention

(Reeves et al., 2013) reported that mental illnesses account for a larger proportion of disability than any other illness grouping, including heart disease and cancer. Approximately 25% of adults have a mental illness, and nearly half of adults will develop at least one mental condition during their lifetime, with anxiety and mood disorders accounting for the most common diagnoses. Up to 20% of children and adolescents have a mental disorder in any given year, with mood disorders and attention deficit/hyperactivity the most common diagnoses. The desperate need for competent and ethical mental health professionals is obvious.

PURPOSE AND GOALS OF THE FOURTH REVISION OF *ETHICS IN PSYCHOLOGY AND THE MENTAL HEALTH PROFESSIONS*

The contents of this revised volume reflect the changing scope of what mental health professionals do on the job. They continue to fill their traditional roles as psychotherapists and counselors, social workers, teachers, researchers, diagnosticians, measurement consultants, curriculum designers, and so forth. However, increasing numbers of mental health professionals work as managers, organizational and agency consultants, elected officials, public policy makers, foundation heads, entrepreneurs, and university administrators, as well as in a host of new specialties and niche practice areas.

When we published the first edition of *Ethics in Psychology* in 1985, the editor of *Contemporary Psychology*, a discontinued American Psychological Association (APA) journal featuring book reviews, rejected including our book because, and we quote, "This is not a subject of sufficient interest to our readers." In the 30 plus years since, ethics has become a primary focus of every mental health and behavioral research profession, bringing with it high visibility and new challenges. Yet, back in 1985, microcomputer technology remained an expensive novelty, no one had heard of the Internet, and newly licensed practitioners seemed eager to enter the private practice of long-term

psychotherapy. Deinstitutionalization had become a buzzword; people rarely sued mental health professionals; few people connected physical health with mental well-being; managed care, social media, and "telemedicine" had not yet appeared on our event horizon; and no one spoke of "evidence-based practice." The "hot button" controversies of the day focused on such issues as therapists giving advice in the broadcast media and professional advertising. Most ethics violators remained virtually unknown to the public or even to their own colleagues, whereas today even minor transgressions and other missteps of an individual may be permanently posted somewhere on the Internet and readily discoverable by anyone Googling the person's name.

We seek to cover the full range of contemporary ethical issues in the mental health professions, not only as relevant and intriguing but also as integral and unavoidable aspects of the our complex professional roles and social responsibilities. Regardless of one's training specialty or the work setting, critical dilemmas will arise—probably with some regularity—and challenging decisions or interventions require action, sometimes right on the spot. By providing an awareness of the ethical expectations of mental health professionals, and by revealing how they apply in specific situations, we hope to achieve an informative and practical guide for education and decision making.

After serving for many years on ethics committees and credentialing bodies, we began to realize that numerous people already functioning as fully trained therapists do not have an accurate understanding of how mental health professions monitor themselves. Too many who contact us for general advice are often late in the game or the damage has already been done. Often, the resolution of the problem becomes primarily reactive or remedial rather than proactive and preventive. Mental health services have won greater public acceptance and have become less stigmatizing, meaning that consumers have also become more likely to step forward and file complaints when they feel aggrieved. As a result, mental health professionals now have a far greater likelihood of facing a

licensing board complaint and losing their ability to practice than being sued. Consequently, this revision aims to sensitize readers to the monitoring and redress mechanisms available when ethical violations occur and to provide information and decision-making strategies to assist in avoiding or preventing ethical misconduct.

We cannot, of course, provide solutions to every conceivable ethical problem that might arise in psychotherapy practice, assessment, research, supervising, or teaching. Many specific situations become so complicated that no ethics code, policy guideline, or law can deftly point the way to a satisfactory and ethically correct resolution. In some situations, for example, one ethical principle may seem pitted against another. Or, upholding an ethical principle may seem at variance with a legal requirement, leaving the therapist stuck somewhere in the middle. Moreover, the mental health professions as well as our society in general constantly evolve, causing profound ethical dilemmas that neither the ethics codes nor the professions can fully prepare to handle. We do assume, however, that more information and sensitization to issues will lead to better professional practice and decision making. We aim to help both trainees and senior colleagues sort out even the most complex ethical problems to make the best possible judgments that will result in positive outcomes.

SOME SPECIFIC FEATURES

In recognition of the wide range of professionals providing behavioral health and mental health services, we have broadened the scope of our book beyond psychology to include other professional groups. Readers will note that the cases include counselors, social workers, marriage and family therapists, and physicians, as well as psychologists. An Instructor's Manual provides classroom activities for every chapter and hundreds of suggestions for exam questions.

This edition further expands the enormous impact of technology on mental health professions and those practicing within them. Every chapter updates the advances, advantages, and

downsides of electronic media relevant to the chapter topic. We have added a chapter on serving diverse populations and include relevant information about multicultural issues throughout. The chapter on decision making is expanded to include newer literature on irrational and emotional components. The role of self-care in maintaining both competence and ethical behavior is emphasized. And, although we believe that being an ethical professional is the most satisfying way to lead one's life, risks have increased in recent times. We believe it is our responsibility to speak to them honestly and directly.

We reference throughout the text of the book the four most recent ethics codes of major national organizations: the American Psychological Association (APA), the American Association for Marriage and Family Therapy (AAMFT), the American Counseling Association (ACA), and the National Association of Social Workers (NASW). When referring to the enforceable standards of the codes we use the parenthetical notation followed by the numerical location to identify the relevant ethical standard (e.g., APA: 3.1). Whenever an organization's code is not referenced relative to a certain point, readers should not infer that the relevant issue is considered to be unimportant. Codes differ in lengths and specificity, and the overarching themes in every code are integrity and competence, even if every facet of these ethical mandates is not further delineated. We hope our code-referencing scheme will make it easy to look up the exact wording of the codes, all of which are readily available online.

Ethical problems often overlap or cluster around several principles, making it challenging to create neat categories of material from which to develop discrete chapters. We use substantial cross-referencing to alert readers where additional information may be found. Readers should not regard the omission of specific topics as suggesting that we think them unimportant or assume the neglect of some forms of questionable conduct means that such behaviors are implicitly condoned.

We make ample use of brief case vignettes to illustrate ethical problems. We adapted our case examples from ethics committee

case files, licensing board decisions, news accounts, case law, public records, and actual incidents known to us. Except for public information (e.g., news stories, public Internet postings, and case law with the actual source cited in the text), we have disguised the material in a variety of ways. Sometimes, we combined the details of one case with another, switched the sex of one or more principals, changed the professional degree or licensing status, or altered contexts in which the activity occurred. Please also note that we often “trimmed” cases by focusing on only one key element of the ethical charge or violation. In fact, many cases brought to the attention of ethics committees, licensing boards, and the courts involve charges of violating simultaneously two or more ethical principles.

As in our three previous editions, we continue to avoid traditional naming methods (e.g., Dr. A. or “the client”) for designating the principal characters in our case material. We also aim to reduce the risk of using names that might correspond to those of real people. Hence, most of our pseudonyms are highly contrived. In using clearly bogus names, it is never our intent to trivialize the seriousness of the content under discussion but rather to enhance interest and aid recall of specific cases. Students report that this technique makes the content both more readable and memorable. Any resulting resemblance between the names of our characters and those of actual people with similar names is purely coincidental. We took care to ensure that the names used in any particular case do not even remotely resemble the names of the actual people involved. When we do use actual names of the principals, the case material includes citation in the text of the relevant legal case or other public source.

For the sake of simplicity, we also adopted a set of degree-labeling conventions by limiting ourselves to Ph.D. or Psy.D. for psychologists; D.S.W. or M.S.W. for social workers; L.M.F.T. for licensed marriage and family therapists; L.M.H.C. for licensed mental health counselors; and M.D. for psychiatrists. We know that some psychiatrists have D.O. or European

medical degree designations; that some social workers use L.C.S.W. or other designations; and that many different types of master’s degrees qualify for professional licenses with letter designations that vary widely from state to state. We intend no disrespect if we have omitted your particular degree, board certification, or other hard-earned professional credential.

In addition, we randomly distributed the professional designations and degrees of the professionals portrayed, except when circumstances specifically called for a particular profession, such as a psychologist in the case of neuropsychological assessment. For general references, the terms *therapist*, *practitioner*, *clinician*, and *mental health professional* are typically interchangeable.

An Instructor’s Manual is available that contains True-False, Multiple Choice, and Essay questions as well as ideas for classroom activities for each chapter. To obtain the Instructor’s Manual, please visit <http://global.oup.com/us/companion.websites/9780199957699>.

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G. P. K., Chicago, Illinois
P. K.-S., Walnut Creek, California
December, 2015

ETHICS IN PSYCHOLOGY AND THE MENTAL HEALTH PROFESSIONS

On Being Ethical

Always do right; this will gratify some people and astonish the rest.

Mark Twain

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WHAT WOULD YOU DO?

Welcome to the fascinating study of professional ethics in the mental health field. Whenever we help alleviate emotional distress or teach new skills, we fulfill the dual mission that attracted us to the helping professions, namely, making a difference for others while leading our own meaningful lives. Upholding ethical principles is an integral feature of a successful career as a psychologist, social worker, counselor, or other mental health practitioner. Thinking positively about ethics by aspiring to the highest professional standards should always guide our actions.

However, despite striving to be responsible, competent, and dedicated to integrity, uncertainties are bound to arise. Heading off such problematic situations before they have a chance to materialize is the preferred response. Throughout the book, we identify hazards indicating the potential for trouble ahead and suggest ways to manage risks while remaining compassionate and involved.

One way to demonstrate the importance of how to respond to situations occurring in everyday practice is to share vignettes adapted from actual cases. We start with several scenarios, all of which require a response either on the spot or within a limited time frame. Each could play

out with relatively benign or more serious repercussions, depending largely on how the therapist responds. So, imagine what you might do.

Holding On

After 5 months, your client's mental state continues to worsen. You have begun to doubt whether you can do any more for him. You are seriously considering a referral to a colleague with experience treating chronic depression, but your gentle suggestions are vehemently rejected. The client likes you and firmly rejects starting over with someone new. You are also fond of this client and would prefer to remain an active ally.

Are a mutual positive regard and the client's steadfast reluctance to be transferred to another therapist sufficient reasons to keep working with a client who is not improving? If so, what would you try to do differently? If not, how might you proceed?

Let's Dance!

A high-spirited client enters your office, yanks a smart phone from her purse, turns on music, and announces, "I won a tango contest last night!" She bounces over, puts her arms around you, and squeals, "Let's dance!"

What will you say to her? Her arms are already around you, so what do you do with them? Might this behavior signal a borderline personality manipulation? Or, is she only in an exceptionally good mood today? Can you tell the difference? How would your response differ depending on the client's motivation?

Scary Guy

Your new client always looks brooding and is difficult to engage. He is new to this country, is anxious, and sought therapy at his brother's insistence. He sits sullenly, answering your questions with few words, often while looking down at his feet. You admit to yourself that you find his enormous size, darting eyes, and foreign accent intimidating. You realize you are afraid of him, even suspecting he is on some "wanted-for-questioning" list.

Are you overreacting? Would you terminate treatment with him? If so, how would you proceed? Are you sure you possess enough information and competence to make the best decision regarding how to proceed? Do you see him as a danger to others? On what basis?

Don't Call Me "Shrink"

You have tried to remain objective and compassionate for the last 4 months, but you dread this client's appointment. He calls you "Shrink," which you find annoying. The sexist and racist comments he interjects into the therapy hour are the most aggravating of all. You want to dump him, but worry you might be faulted for abandonment given that he has many issues requiring therapeutic intervention.

Did you let his annoying behavior go on too long? How could you change things around to avoid setting yourself up for an ethics complaint? Will you terminate treatment with him, despite his many remaining issues? If so, how? Should you have challenged his sexist and racist comments even though they seem unrelated to his reasons for seeking counseling? What is your own role in the dilemma?

The Help

Imagine your surprise when you arrive at the office after teaching a month-long seminar in another town and your office mates introduce you to the new receptionist, who, unbeknownst to them, just happens to be your ex-client. They say right in front of both of you, "We are so lucky to have found her." However, the ex-client left her last session in a rage, calling you demeaning names because she objected to your interpretations of her self-destructive behavior. You have not been in contact for over a year.

This is awkward at best, but this kind of unexpected encounter can happen, especially in smaller or self-contained communities. What are you going to say right then and there? How will you handle this matter with your office

partners in a way that protects the ex-client's confidentiality? Does that last session need to be dealt with now? And, given your clearly visible name on the office door, does the ex-client have an agenda?

The Gift

Your client owns an electronics store and shows up at a session with a large carton. He hands you a new printer, saying, "Your printer is an antique. I have a gift for you." He is offering the exact make and model you would purchase for yourself if you could afford it.

OK, you want to take it. That is only human. But, should you? What do you say to your client right now?

Splitting

Couples counseling terminated with your clients' mutually agreeable decision to dissolve their marriage despite lingering resentments. The wife calls you 3 weeks later to engage your services as a witness on her behalf in an upcoming child custody dispute.

Let us assume you see the wife as the better parent. Do you accept her request? What ethical problems lurk? What are the risks to you? Do you trust your competence to engage in forensic work?

All in the Family

Your sister suspects her daughter of having unprotected sex and taking drugs. She asks if you will take the teenager on as a client. The girl has refused to talk to anyone else, but she will talk to you. Your sister is wealthy and insists on paying your full fee. You could use the money.

This tempting offer makes some sense on the face of it. After all, you know this girl, and she likes you. So, what do you say to your sister? What problems could arise from accepting your niece as a client, even if you would not be compensated?

Wild Eyes

After venting anger against her boyfriend for most of the entire session, your client's eyes flash with rage. She rises from her chair and before turning toward the door whispers, "He's done for!" You are pretty sure she owns a gun.

Is the client just venting, or was the threat authentic? How do you make that decision? If you are concerned, what exactly should you do now?

These are the kinds of situations we explore in considerably more depth. We cannot offer answers to every ethical dilemma or advise on every circumstance in which an ethical dilemma arises. We do strive to provide clues to help you recognize, approach constructively, and reconcile potential ethical predicaments while remaining attuned to the well-being of those with whom you work. (For a complete discussion of decision making under varied conditions, see Chapter 17.)

Actual Story Outcomes

The reactions to the incidents on which our examples are loosely adapted could have been resolved reasonably well if only the therapists had made better decisions and communicated them in a way that would not significantly diminish the client's self-esteem, arouse anger, or heighten insecurities. Or, each situation could turn into a disaster. Although not every story resulted in a disciplinary hearing, the actual outcomes were all unfortunate.

In "Holding On," despite the therapist's concerns about the client's lack of progress, he decided to continue with the severely depressed client without consulting colleagues, who may have been able to advise him on the best course of action. The client's condition continued to deteriorate, and he made a serious suicide attempt. The client's family attempted to bring a malpractice suit against the therapist. (The client who does not improve and indications for ethical and sensitive termination are considered in Chapters 2 and 3.)

In “Let’s Dance,” the moment created a spark that soon led to a sexual relationship, followed by the client filing charges with an ethics committee after the therapist abruptly broke off the affair. This therapist eventually lost his license. (How to handle clients whose behavior takes therapists by surprise is presented in Chapters 8 and 9.)

The “Scary Guy,” despite his size, turned out to be a shy and frightened man who was not yet ready to open up. The therapist’s cultural ignorance and fear-based judgments led to a regrettable act. He called the police to check out this client and express his suspicions. The authorities made contact with the client and divulged the therapist’s identity. The client’s brother then talked the client into bringing a malpractice complaint. (Multicultural competence is discussed in Chapter 5.)

“Don’t Call Me Shrink” resulted in an abrupt conclusion when the therapist lost his temper and called the client an “inane redneck” and other colorful pejoratives before telling him to find another “shrink.” The client complained to a licensing board, charging abandonment and incompetence. (A discussion of clients one does not like appears in Chapter 2.)

“Splitting” resulted in an ethics charge against the therapist by the now ex-client’s husband. The therapist was not well informed about how to deal with child custody evaluations and made a number of missteps. Charges were sustained for breach of confidentiality and conflict of interest. (Qualifications for working with child custody cases appear in Chapter 13.)

“All in the Family” resulted in the dissolution of the sibling relationship. When the disgruntled sister believed her daughter was not getting better, she accused her sister (the therapist) of being interested only in the \$150-an-hour fee. (Responding to requests from family and friends for professional services appears in Chapter 8.)

“The Help” resolved poorly. The therapist’s knee-jerk response on learning that his previous client had been hired as the receptionist was to respond, “Well, she used to be my client, and we don’t want this woman working here.” The office mates responded by saying he would be the one leaving, and the client pressed ethics charges for breach of confidentiality. Knee-jerk

responses can have consequences, as is further illustrated in this chapter and Chapter 17.

“The Gift” also came to an unfortunate conclusion. The therapist graciously accepted the printer only to later be accused of manipulating the client into giving expensive gifts when the therapy hit some snags. (Offers of gifts and favors and how to respond are covered in Chapter 8.)

“Wild Eyes” presents the more difficult dilemma, one all mental health professionals need to prepare for by understanding available options whenever clients threaten to harm others or themselves. The therapist in this case was caught off guard. He froze and made no further intervention. The woman did attempt, unsuccessfully, to kill her boyfriend. (The duty of care owed to clients who are considered to be at possible risk for danger to themselves or others is presented in Chapter 6.)

WHAT IS ETHICAL?

Ethics is traditionally a branch of philosophy dealing with moral problems and moral judgments. White (1988) defined ethics as the evaluation of human actions. In doing so, we assign judgments to behavior as “right” or “wrong” and “good” or “bad” according to some socially accepted guideline. To describe an act as “ethical” has little meaning unless grounded in some foundational understanding of what is good (Robertson & Walter, 2007). The ethics codes of professional organizations aspire to create the basis for ethical practice. However, ethical dilemmas are often complex and depend on situational context, and the “the right thing to do” is not always readily discernible. Our assessments of a situation, as seen in the cases presented throughout the book, can be distorted when viewed through our own lenses. Prejudices, overriding personal needs, rationalizations, and insufficient training and experience are among the more common culprits responsible for biased conclusions, bad decisions, and regrettable actions.

Aristotle spoke of the ethical life as a happy life. This makes sense in our framework.

Maintaining high ethical standards may well be the prerequisite to a personally gratifying career. The old saw “Virtue is its own reward” suggests that being a competent, responsible, virtuous human being elevates both self-respect and earning respect from others. Reaching for the highest standards emboldens us in the face of ethical uncertainty. We respect ourselves and what we do if we remain scrupulously self-aware and are confidently practicing within the boundaries of our training. Doing so allows us not to feel embarrassed or “less than” when outside consultation is advisable.

Core Ethical Principles

All of us would ideally conduct ourselves according to the core principles reflected in the ethics codes of all mental health professions. These are as follows:

- *Do no harm* (nonmalfeasance or nonmaleficence). Mental health professionals strive to benefit those with whom we work while taking care to ensure the minimization or elimination of any potential for damage. Whereas we may not be able to help every client, the duty to inflict no harm is paramount.
- *Respect autonomy*. Individuals have the right to decide how to live their lives as long as their actions do not interfere with the rights and welfare of others. Respect for autonomy is accepted by mental health professionals, given that an underlying goal of psychotherapy and counseling is to move those with whom we work toward greater self-reliance and self-determination.
- *Act justly*. The actions of mental health professionals should be fair and equitable. Others should be treated as we would want to be treated under similar circumstances.
- *Act faithfully*. Issues of fidelity, loyalty, truthfulness, and promise keeping converge to form the standards required in fiduciary relationships. The therapy relationship should allow clients to feel safe and as unencumbered as possible by irrelevant and extraneous variables.

- *Accord dignity*. Mental health professionals view those with whom we work as worthy of respect. We must strive to understand cultural diversity and ways others differ from ourselves and endeavor to eliminate biases influencing the quality of our service.
- *Act benevolently* (beneficence). A paramount virtue in any mental health profession is to treat clients with caring and compassion while maintaining appropriate professional roles and boundaries.
- *Pursue excellence*. Maintaining competence, doing our best, and taking pride in our work form the bases of quality mental health services.
- *Act accountably*. When errors have been made, mental health professionals consider possible consequences, accept responsibility for their actions and inactions, avoid shifting blame or making excuses, and take any available steps to minimize or undo harms and wrongs.
- *Act courageously*. Maintaining a steadfast determination to actively uphold ethical principles, including when we observe unethical actions perpetrated by colleagues and others rather than averting our eyes for fear of retaliation, is a challenging mandate. Those with true grit have an advantage in that courage itself emboldens us to do the right thing.

We believe the most useful way to teach sound principles of professional conduct is to ground our discussions in the proscriptions of the ethics codes developed by mental health professional associations. The core ethical principles are clearly reflected in these codes. We interject where to find the applicable principles in the ethics codes of four major professional associations for mental health providers: the American Psychological Association, the National Association of Social Workers, the American Counseling Association, and the American Association for Marriage and Family Therapy. (For a more complete discussion of these ethics codes, their strengths and weaknesses, and the means of enforcement, including ethics committees and licensing boards, see Chapter 18.)

We do note that the application of principle ethics assumes that upstanding ethical behavior can occur solely as the result of deliberate adherence to rules rather than stemming from a virtuous character. For example, a bright but an otherwise selfish and imprudent individual might be able, by dint of focus and constant self-monitoring, to scrupulously follow the rules. However, we doubt that those with character defects would be capable of sustaining satisfactory ethical performances throughout their professional careers. We recall a young psychologist mandated to take an ethics course as part of a sanction for his unethical conduct. His exam scores were the highest in the class, and he could clearly articulate appropriate ethical responsibilities. Yet, less than a year after completing the course, this same individual was again in serious trouble with a state licensing board.

Managing Risk

Risks embedded in mental health practice are sometimes described in chilling terms by forewarning, almost promising trouble ahead. For example, Hixon (2005) wrote the following:

The moment you choose to accept a license you choose to accept the consequences of being licensed. . . Between the lines, around the corners, and in the shadows, risks to our legal and financial position in the marketplace are lurking. (p. 37)

Totally avoiding ethical complaints may be impossible, but preventive steps and thoughtful practice can minimize the chances of having a complaint sustained. A *risk management* approach to ethics prescribes ways to avoid ethical problems. The key to risk management involves scrupulously upholding the tenets of relevant laws, policies, professional standards, and ethics codes and taking as many steps as possible to avoid ever being placed in a precarious ethical or legal circumstance. The central focus becomes self-protection against the hazards of delivering professional services (Adams, 2001; Bennett, Bryant, VandenBos, & Greenwood, 1990; Doverspike, 2008; Harris & Younggren, 2011;

Kennedy, Vandehey, Norman, & Diekhoff, 2003; Knapp, Bennett, & VandeCreek, 2012; Knapp, Younggren, VandeCreek, Harris, & Martin, 2013; Smith, 2003; Walker, 1999). Even if charges are unfounded, undergoing a disciplinary inquiry is time consuming, extremely stressful, and possibly expensive (Grenier & Golub, 2009).

Elements of good practice that reduce risks include the following:

- Refraining from sexual contacts or other intense multiple-role relationships with clients
- Avoiding role changes without documented consent of those involved
- Keeping careful notes and records, including billing and fee collections
- Well documenting diagnoses and client risk behaviors (e.g., suicidal or homicidal ideation), including actions taken or clinical rationales for not acting
- Regularly reviewing client treatment plans
- Documenting reasons for termination and the process followed
- Consulting with colleagues or appropriate others about difficult clients (with confidentiality protection) and carefully documenting such consultations
- Conducting therapy in a professional setting, ideally an office
- Practicing within one's sphere of competence

Avoiding accepting certain clients into one's practice is another way some therapists choose to manage risks due to concerns about possible legal or ethical entanglements down the line. Characteristics and diagnoses of particularly risky clients include those showing indications of

- borderline personality disorder,
- narcissistic personality disorder,
- dissociative personality disorder,
- impulsive acting out,
- complex post-traumatic stress disorder,
- severe depression or suicidality,
- substance abuse,
- being adult victims of abuse as children (especially those seeking to "recover" memories of abuse),

- being in an abusive relationship,
- a history of dangerous or violent behavior,
- characterizing people in their life as either hated or adored,
- rapid and intense development of transference, and
- lack of sources of social support.

Clients who are quick to anger and who might press charges (or give a negative online review) out of spite, clients who are exceptionally articulate and thus capable of pressing a cogent complaint, clients who have been involved in instigating unrelated legal actions, and clients who complain against previous therapists (especially if they also made an ethics complaint) may cause sufficient uneasiness to refuse treatment or to provide quick referrals to someone else. Such fears may be totally unrelated to the therapists' competence to treat these clients.

Higher risk types of practice may also be avoided by some therapists. These include

- forensic work, such as serving as a witness in child custody cases;
- working in a correctional setting;
- conducting mental disability evaluations;
- treating celebrities or public figures; and
- other practice venues where scrutiny will be intense.

Clearly, all of these strategies may avoid many of the risks inherent in delivering mental health services. But who, you may ask, is left to treat? Obsessive, fear-based risk management disadvantages both clients in need of help and the level of our own career satisfaction.

The Perils of Obsessive Risk Management

Why would one choose a career if one's primary concern was to avoid getting into trouble? Although the scrupulous practice of defensive ethics is understandable in a litigious society, scrutinizing every client as a potential land mine may become insidiously instilled. Harboring constant apprehension toward those persons

practitioners are otherwise competent to help creates an unhealthy foundation for an authentic therapeutic alliance and a satisfying career.

We focus on preventing ethical missteps and making the best possible decisions when ethical challenges arise, but we also have concerns about a *too-rigid* approach to risk management. We agree with Zur's (2010) assertion that risk management is not synonymous with ethical principles and good practice. As professionals become more fearful of being brought up on charges, many view the two as one and the same. As we discuss in Chapter 17, rules can be interpreted too rigidly when making decisions and actually create unnecessary barriers despite the therapists' noble intentions (Knapp, Handelsman, Gottlieb, & VandeCreek, 2013).

One unfortunate outcome of overanxious risk management is shutting out those who urgently require therapy. Otherwise-competent but hazard-averse therapists might choose to avoid all high-risk clients and practice areas. Such individuals who are clearly in need of help would have a difficult time finding it should most mental health professionals adopt a strict risk management mindset. Of course, mental health professionals should pay careful attention when a client's behavior suggests that resistances have been mismanaged, that the therapy has reached an impasse, or when the client is deteriorating, as evidenced by such clues as many missed sessions, nonpayment or late fee payments, overt or covert expressions of dissatisfaction with therapy, expressing a desire to see another therapist, or displaying worsening symptoms. We recommend maintaining an awareness of client risks, but balancing these concerns with one's own competence and training when making decisions about accepting a client. Such deliberate ethical mindfulness provides the best protection.

WHO GETS INTO TROUBLE?

Another way to understand ethical conduct is through case examples of improper behavior and looking at what might have prevented

making such poor decisions and how to minimize any damage already done. We begin, however, by offering examples of decidedly unusual and serious cases to illustrate conduct that defies comprehension or remediation and eludes easy classification.

Bad Behavior Off the Charts

Rarely, therapists willfully, even maliciously, engage in acts they know to violate ethical and legal standards. These examples, adapted from actual cases, create appalling impressions of psychotherapists and counselors. Unfortunately, such stories attract media attention that sullies the image of everyone who works in a mental health field.

Case 1–1: Alt Motive, Ph.D., abruptly terminated a client struggling with depression and alcohol dependence. The following day, he called his just-terminated client and invited her to his apartment to watch a movie. Motive served popcorn and wine and, during the movie, sexually assaulted her. The client told her minister about the incident, who contacted the therapist for an explanation. Motive offered the minister a new computer if he could convince the client not to call the authorities.

Case 1–2: Dark Planner, M.S.W., plotted against a former client, who accused him of overbilling and threatened to take Planner to small-claims court. Planner hired a man to burglarize a business and place the stolen items in the ex-client's home. The burglar was supposed to then call the police with a tip that a person fitting the ex-client's description was observed leaving the business in a car with the ex-client's license plate number. Fortunately for the ex-client, the hired burglar repeated the story to others in a bar, leading to an arrest and disclosure of Planner's fiendish plot.

Case 1–3: Dr. Mal Evolent, Psy.D., solicited one of his own clients to kill six people and dump the bodies in the ocean. The client was also instructed to purchase a gun with a silencer, rent a sturdy vehicle capable of holding 750 pounds of body weight, arrange a boat rental, buy bait, and locate

shark-infested waters. The client reported this bizarre offer to the police.

These incidents involve serious crimes and are fortunately extremely rare. Other cases involving *purposeful* exploitation, fraud, and conflict of interest can also have grievous consequences; examples of these cases are defrauding insurance companies, accepting kickbacks, using elaborate bait-and-switch techniques, or making highly misleading claims about the effectiveness of services offered to the public. The next case describes an outrageous swindle.

Case 1–4: Buck Scam, L.M.H.C., prevailed on the husband of a couple he was treating to acquire an unsecured loan of \$150,000 from the husband's pension fund. The wife was not informed in advance and threatened exposure when she discovered the transaction. The counselor promised to repay what he owed if the wife would agree, in writing, never to contact an ethics committee or licensing board. On signing this promise, the counselor presented her with a bill for \$120,000 for sessions the counselor alleged the couple had not paid for.

This contemptible case reveals how communication breakdowns in a marriage can wreak considerable havoc when an exploitative therapist is added to the mix. In this actual case, the couple did complain to a licensing board rather than pay the bill, and the therapist's license was revoked.

Another curious type of offender has behavior that is simply baffling. Individuals on disciplinary boards must just scratch their heads and wonder, "What were they thinking?" These types of acts also attract considerable media attention.

Case 1–5: A psychology professor decided that students in the college where she taught were not sufficiently racially tolerant. Her car was spray painted with racist and anti-Semitic slurs, the tires were slashed, and windows were broken. She complained to the school and to the authorities that she was a victim of a hate crime. Classes were cancelled for a day while students held a rally against hate crimes and discrimination. Later,

witnesses came forward testifying that the car was already painted with slurs when she drove into the faculty parking lot (Buchanan, Sauerwein, & Silverstein, 2004). She was later convicted of filing a false police report and insurance fraud. She was sentenced to a year in jail.

Case 1–6: A psychologist finished his business with a prostitute before paying her fee. He left his laptop containing over 600 unencrypted client files from his employing agency as collateral while he went to an ATM. When he returned 15 minutes later the prostitute and the laptop were gone. The psychologist reported the theft without mention of the sexual activity but eventually replaced his initial false account with the correct one. The laptop was recovered from a pawn shop. Nevertheless, the psychologist lost his job, and his license to practice was suspended pending further investigation (Vaughn, 2013).

Case 1–7: A psychologist masturbated in front of his office window in full view of an all-girls' high school across the street. Students reported his behavior, and the psychologist was arrested for indecent exposure and lewd conduct (Dean, 2013).

The last three scenarios read like outtakes from a *Dumb and Dumber* movie. It is difficult to know for certain if these individuals are impulsive, devoid of common sense, or themselves suffering from an emotional disorder.

Such alarming cases are scarce. In our experience, the more prevailing portrait of the professional who crosses over such lines is muted and complex and often includes people of decency and intelligence who stumble in circumstances they did not correctly evaluate or respond to wisely.

More Common Patterns of Unethical Behavior

The more usual and frequent types of behavior that get mental health professionals in trouble can still cause harms to clients, students, and others. Most ethical violations fit into three broad, although not always mutually exclusive, categories.

- *Competence issues:* lacking sufficient knowledge about, an understanding of, or commitment to ethical principles and standards; inadequate mastery of skills offered to consumers; emotional instability or other vulnerability that interferes with decisions or performance
- *Lack of or lapses in maintaining self-awareness:* engaging in rationalizations to justify decisions and behavior; acting according biases in service to oneself; and other cognitive mechanisms that cloud sound ethical decision making and action
- *Insensitivity:* revealing patterns of indifference or disrespect; unreliability; lack of empathy and paying insufficient attention to the moment or to an issue

We offer examples from these categories, adapted from actual cases and events.

Competency Issues

The Uninformed or Misinformed. This category illustrates why keeping up with ethical standards, extant guidelines, and relevant law is crucial. A substantial number of violators appear to be either naive or uneducated about what conduct is expected of them. Offenses of ignorance can sometimes be minor and cause no serious harm.

Case 1–8: Recently licensed Newt Unworldly, L.M.F.T., accepted the offer of Ad Flashy, his brother-in-law and a marketing specialist, to promote his fledgling practice. An ostentatious advertisement in the local paper was highly misleading regarding Unworldly's professional experience. For example, "interned at University Hospital" referred to a summer of volunteer work that Unworldly performed as a high school senior. Another counselor in the agency pointed out how Unworldly himself retained responsibility for such statements and was lax in allowing his advertising agent to run loose around the truth. Unworldly quickly cancelled the ad.

For minor violators in this category, educative approaches typically prove sufficient to

preclude future complaints. Often inexperienced, these therapists are usually embarrassed on being informed of their obliviousness or shortsightedness. Sadly, they also frequently insist such matters never came up for discussion during training or internship.

Alternatively, mental health professionals sometimes operate under the belief that they are fully aware of an ethical mandate when no such provision exists, at least in the way they understand it.

Case 1–9: When questioned by an ethics committee about a sexual affair with a client he had terminated only 3 months earlier, Romeo Quickie, Psy.D., replied that the ethics code of the American Psychological Association specifically allows sex with former clients.

Dr. Quickie's understanding seems conveniently confused. Not uncommonly, therapists attempt to defend unethical acts by claiming they were unaware of the exact content of the ethics code. Unfamiliarity, however, will not let Dr. Quickie off the hook.

For ignorant or misinformed violators who have more experience but who have lost touch with their professional identity and commitment, remediation can prove difficult.

Case 1–10: Hy Upper, Ph.D. was contacted by an ethics panel regarding his alleged distribution of amphetamines during group therapy sessions. He responded by declaring he was under the distinct impression that psychologists in his state had the same rights to pass out drug samples as do physicians. He claimed to have read about it somewhere.

Occasionally, those who you might think would hold special competencies because of their considerable experience come to see themselves as beyond learning anything new or as above the law. In the actual incident, "Dr. Upper" had been in practice for more than 25 years. However, he had drifted far from an awareness of relevant laws in his state.

The Insufficiently Prepared. Ethical misconduct among mental health professionals can

arise from incapacity to perform the services being rendered or to work with certain types of clients. Sometimes emotional disturbances or substance abuse can blunt the ability to do satisfactory work, even if the therapist has been properly trained. Often, however, inadequate training and experience are the cause. Many therapists who come to the attention of ethics committees, licensing boards, or the courts have vastly miscalculated the level of their overall skills or their ability to apply specific techniques or services, such as a neuropsychological assessment or expert forensic testimony. (See Chapter 2 for coverage of competence issues.)

Case 1–11: A clinic supervisor recognized that many clients seemed to acquire misdiagnoses or inappropriate treatment plans based on the reports of Remi Partway, Ph.D. When the supervisor asked Dr. Partway to detail her background, Partway admitted she had virtually no training or experience in these specific assessments but believed she was "picking up speed" as she went along.

Dr. Partway's circumstance occurs all too frequently. Typical training programs cannot teach every skill or assessment instrument a particular employer or client may require. We have run across cases in which employers wrongly require practitioners to provide services despite having full knowledge that requisite training and experience is lacking.

The Burned-Out and Vulnerable. Therapists suffering from their own emotional or physical challenges, burnout, family crises, and other stressors also reveal themselves in a substantial number of cases involving misconduct (Katsavdakis, Gabbard, & Athey, 2004). Such problems often lead to poor professional judgments and incompetent performances. Although some who fall into this category may be sympathetic characters, they can also cause harm to vulnerable clients.

Case 1–12: Cecila Pow, L.M.F.T., had become frustrated with the lack of progress in many of her

clients. She quit taking any notes, resulting in her inability to keep track of what transpired during previous sessions. At home, she was caring for her ailing mother while also trying to keep her two rebellious teenagers from getting into trouble. One client complained that Pow did not seem to know anything about her issues despite having been Pow's client for 6 weeks.

Case 1-13: Colleagues reported Mordred Gloom, Psy.D., to the clinic manager for failing to keep many appointments without calling to cancel them. A few clients quit coming, complaining to the receptionist that their therapist did not even care about them enough to show up. It was soon discovered that Gloom had become so depressed over the recent breakup with his wife that he could not always pull himself out of bed in the morning.

Case 1-14: Ed Bellevue, Ph.D., physically attacked a client with an umbrella, claiming that he was an agent of Zormont, the sinister charged ion force that dwells on the dark side of Uranus.

Case 1-15: As a sufferer of Crohn's disease, Sally Sick, M.S.W., had abdominal pain and diarrhea that would frequently cause her to excuse herself in the middle of therapy sessions. One client claimed that he resented paying for partial sessions, some of which lasted only 20 minutes, and pressed ethics charges.

Mental health professionals are not immune from emotional disorders, including serious psychopathology. Dr. Pow may have had reason to be disappointed in her clients, but she seemed noticeably affected by burnout; she should have taken immediate steps to refresh herself before her career unraveled.

Obviously, the individuals we call Drs. Gloom and Bellevue were themselves in need of mental health services. Ms. Sick may be viewed as the most sympathetic of the lot because compassion and forgiveness are more readily accorded to individuals with physical illnesses as compared to those inflicted with mental disorders. Nevertheless, the client who protested was not being well served. Ms. Sick should not have attempted to treat clients until her condition had stabilized sufficiently enough for her

to give clients her full attention. (See more on the impaired practitioner in Chapter 2.)

Lack of or Lapses in Maintaining Self-Awareness

Self-awareness is an agreed-on hallmark of a well-functioning mental health professional (Schwebel & Coster, 1998). The lack of self-awareness forms the basis of many types of unethical conduct (Bazerman & Banaji, 2004). Abandonment of self-awareness, allowing for extraneous influences in concert with personal agendas unrelated to professional commitments to sway choices and actions, sets one up for unexpected consequences to both consumers of our services and ourselves.

Numerous nonrational elements affect our decisions (Ariely, 2008; Rogerson, Gottlieb, Handelsman, Knapp, & Younggren, 2011), and these are richly illustrated throughout this book. For example, we tend to overpraise our virtues and yet cheat in small ways when the circumstances seem acceptable (Ariely, 2013). We tend to overestimate our level of competence (Dunning, Johnson, Ehrlinger, & Kruger, 2003). Poor decisions can also result from insufficient cognitive strategies for making them (e.g., Tjeltveit & Gottlieb, 2010). A self-serving bias involves the tendency to gather and process information in a way that advances our self-interest or supports our pre-existing views (Mezulis, Abramson, Hyde, & Hankin, 2004). (For decision-making models, see Chapter 17.)

Therapists Who Rationalize. We humans have a remarkable ability to deceive ourselves. Over the years, we have been dazzled by the array of defenses used by mental health professionals to justify behaviors that objective observers would judge as highly questionable. Self-interest often functions in an automatic, compelling, and often-unconscious manner (Moore, 2004). Self-deception allows one to engage in an "internal con game"—to act out of self-interest while actually believing that one has acted

morally (Bazerman & Tenbrunsel, 2011; Tenbrunsel & Messick, 2004). Complicating matters even further, research reveals morality to not always be consistent from one context to the next (Hutson, 2013). That is, sometimes being good in one arena allows us to feel OK about cheating a little in another, rather like grabbing a cookie when on a diet as a reward for completing a big task. (Read more about justifying dishonest behavior in Chapter 17.)

Ethical missteps can also become a bad habit. The work of Gino, Ordóñez, and Welsh (2014) backs up the warning of C. S. Lewis from *The Screwtape Letters* (1942) that “the safest road to Hell is the gradual one—the gentle slope, soft underfoot, without sudden turnings, without milestones, without signposts.” Gino and her colleagues found that for subjects given a series of problem-solving tasks starting with a lower reward, 50% cheated on the first round. The final round offered a higher reward, and 60% cheated. However, only 30% of those who were not able to cheat in the early rounds cheated for the larger reward on the final round. How incremental steps can lead to a bad decision is illustrated often in this book.

Next are examples of rationalizing unethical behavior in action.

Case 1–16: When asked why he had sex with 12 clients even though he knew it was prohibited, Cloudy Thot, Ph.D., replied: “It was my way of giving generously of myself to women who desperately needed love.”

Case 1–17: Bucks Allgone sued his counselor, Hy Fiber, L.M.H.C., for pressuring him to invest in Fiber’s startup health food company. The company went bust, causing Allgone to lose over a half a million dollars. Mr. Fiber attempted to defend himself by saying the deal should have made millions and he wanted his client to share in the riches.

Case 1–18: Taken Keepit, M.S.W., refused a recently terminated client’s husband’s demand to return the client’s valuable collection of antique figurines. The husband took Keepit to small-claims court, arguing that his wife was distraught and vulnerable and incapable of making

rational decisions. Mr. Keepit asserted that he was under no obligation to return what the client vehemently insisted that he accept as a token of her appreciation, and if the husband wanted redress he should sue his own wife.

The first two cases resulted in sustained legal action against the therapists. However, Mr. Keepit got away with his ill-gained booty.

The next two examples depict therapists who believed they were advocating for their clients, but their actions ultimately caused both the clients and their therapists considerable grief.

Case 1–19: At the close of their third session, Joy Ride, Ph.D., offered to take Royce Turbo, her car-obsessed client, for a spin in her new sports car. She reasoned a little outing just this one time would strengthen the fledgling therapeutic alliance. The brief experience confused Mr. Turbo, who then asked if they could drive to the beach after the next session. When Dr. Ride pulled back, Turbo terminated therapy and accused Dr. Ride of only wanting his money to pay for her expensive new car.

Case 1–20: Tryin Tohelp, Ph.D., wanted to assist his financially shaky client, who had both a troubled marriage and characteristics of an antisocial personality disorder. He decided not to disclose the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013) Axis II diagnosis of a personality disorder or the “V code” of marital problems because the client’s insurance carrier frequently declined to pay for treatment of these conditions.

Rationalization often operates under subtle and seemingly harmless circumstances, sometimes to justify inaction or convenience. Dr. Ride’s field trip had no sound therapeutic purpose and confused her client. Dr. Tohelp has misrepresented a diagnosis and may have committed fraud. More important, if something goes wrong, a record review may suggest that Tohelp made an incorrect diagnosis and offered improper treatment. Therapists need to remain alert because we can all fall prey to talking ourselves into or out of doing something

based on less-than-clearheaded reasoning. (See Chapter 17 for a detailed discussion of the ways therapists have deluded themselves to their own detriment and a list of “red flags” to watch out for.)

Therapists With Too-Loose Boundaries. A great many ethical infractions involve blending the professional role with another form of interaction or connection resulting in harm. Often enough, the therapists also face consequences. While recognizing the impossibility of avoiding all boundary crossings and knowing not all are unethical or harmful (and some may even be beneficial), therapists who are unaware, rationalizing, or malintentioned can inflict wrongs on those with whom they work. Occasionally, cases reveal therapists who are *totally* fluid in their interactions with clients, imposing no restrictions on how they tangle their own lives with those of their clients. Whether this is the result of ignorance, self-absorption, avarice, neediness, or a mental condition is not always clear. However, in most cases clearheaded self-awareness is absent. The next actual case illustrates a “boundary-free” therapist.

Case 1-21: Twofer Junk, M.S.W., often scheduled her client appointments on Saturdays in front of her home, where she also held weekly yard sales, during which she marketed items she had bartered in exchange for therapy sessions with other clients. When a customer drove up, the therapy was interrupted, and the clients were expected to assist with selling items until another lull occurred, at which time therapy would resume. Ms. Junk also hired clients to clean her house, run errands, drive her around, and do her accounting. She also rented an extra bedroom to a client who babysat her two children during the week and while she was running her yard sale/therapy sessions on Saturdays.

An unusual feature of this case is that the therapist argued she was charging her clients only a small amount per hour while allowing them to work off the rest, thus doing clients who could not afford to pay her full fee a favor. However, it might take up to 8 hours for a client to earn what was owed for a 50-minute (often

interrupted) session. Ms. Junk was shocked to be accused of exploitation.

The Oblivious Exploiters. Exploitation occurs when mental health professionals knowingly take advantage of clients, students, or research participants by abusing their positions of trust or authority. The incidence of exploitative therapists who could be described as avaricious and who place financial considerations ahead of professional obligations is low, even though they represent a high percentage of cases brought before adjudicating bodies. More often, trouble takes time to progress.

Here, we illustrate therapists who exploit *without* a preconceived plan or full awareness. The next case reveals how a starstruck therapist allowed “going with the flow” to result in a serious ethical violation.

Case 1-22: Ozzie Oogle, Ph.D., felt self-congratulatory for attracting a client who was a top fashion designer. He routinely complimented Fanci Dresser on her exquisite style. He noted in passing that her outfits were becoming skimpier from session to session but decided to ignore the progression. During their seventh session, Ms. Dresser invited him to one of her shows, an invitation he enthusiastically accepted. After the show, Dresser invited him backstage for the champagne reception. A tipsy Dr. Oogle stayed until everyone but Ms. Dresser left, at which point they engaged in sexual activity on the runway.

Dr. Oogle returned home, drunk and disheveled. He confessed his indiscretion, claiming a client seduced him, but ended up losing his family anyway.

We sometimes refer to inexperienced or novice therapists in a hurry to become wealthy or successful as “green menaces.” They often try a misguided gimmick or overrate their services. Occasionally, as illustrated in the next case, someone calls them on it.

Case 1-23: Jacob Ladder, L.M.H.C., attempted to convince his client, a supporting actor in a long-running television series, to pass out Ladder’s

business cards on the set and to attest to his “magical skills” as a therapist. “We can scratch each other’s back,” he reasoned. When the client expressed discomfort with the request, Ladder became angry, calling the client ungrateful and selfish.

The client complained, and the licensing board assigned Ladder to take an ethics course before he was allowed to resume practice.

Insensitivity

Although insensitivity is rather an elusive category, mental health professionals often exceed the bounds of ethical propriety because of insufficient regard for the needs and feelings of those with whom they work. Reasons include lack of empathy, a need to exercise control, overzealousness regarding a specific approach or technique, self-absorption, and prejudicial attitudes toward certain people. Often, such insensitivities preclude the recognition that an ethical issue even exists.

Offensive Dispositions

Case 1–24: Justin Tyme, D.S.W., was usually late for therapy sessions. When a single mother of four young children complained how she did not like waiting for up to an hour because it threw off her schedule, he responded, “You don’t have a job, so what difference does it make?”

Mr. Tyme appears have revealed a prejudice, perhaps seeing nonworking women with children as having irrelevant schedules and, if receiving assistance, undeserving of respectful treatment. Although this incident did not result in an ethics complaint, the comment reveals lack of empathy and respect.

Case 1–25: Slam Mockery, M.D., told a client who recently underwent brain surgery, “Why don’t you just go shoot your brains out to get rid of the pain?” To an overweight client, he said “Let’s face it; if your husband were to die tomorrow, who would want you?”

Such callous statements violate the dignity and respect due to clients, but whether

anything can be done to rein in a therapist who is complained about for being insulting is uncertain. In the actual case on which Case 1–25 was adapted, the caregiver was a physician. Attempts to hold him responsible for these and other crass remarks made to his patients were unsuccessful. In fact, he vowed to sue anyone who attempted to pursue him (Tirrell-Wysocki, 2006).

The Irresponsible. Ethical infractions based on irresponsible behavior can manifest themselves in several forms, including unreliable execution of professional duties, shoddy or superficial professional work when one knows better, and attempts to blame others or cover up mistakes or inadequacies.

Case 1–26: Janet Turtle, Ph.D., agreed to support her clinical supervisee, Job Hunter, in his quest for employment. However, Mr. Hunter learned that Dr. Turtle failed to return prospective employers’ calls, and the promised letters of recommendation were never written. When Hunter expressed disappointment to Dr. Turtle, she apologized, explaining how busy she was and how she could not even handle her own priorities. In the meantime, the prospective employers offered the positions to others.

Abandonment is a form of irresponsibility and occurs when mental health professionals fail to follow through with their duties in a way that causes clients to become vulnerable, to feel discarded or rejected, or to suffer some other foreseeable harm. Ethics complaints from therapy clients that echo themes of abandonment are not uncommon. Mismanaged termination is often involved, as illustrated in our next case:

Case 1–27: As Amy Falling became increasingly ill, Lucia Panicky, Ph.D., felt uncomfortable treating her. Dr. Panicky informed Amy she could no longer counsel her and she would need to find another therapist. When Amy asked for an explanation, Panicky only replied, “I have my reasons.”

Most mental health professionals have found themselves in situations from which

they wished to exit. In many such instances, they probably should go ahead and disengage. Dr. Panicky may well have lacked the competence to continue treating her client and appropriately recognized this. However, termination of services requires sensitivity and due regard for consumers' needs and welfare (Younggren & Gottlieb, 2008). Dr. Panicky failed miserably in these respects, leaving her client bewildered and adrift.

Momentary Slips. A fairly substantial percentage of individuals who make mistakes with ethical implications appear to conduct themselves responsibly and competently and, under normal circumstances, show sufficient sensitivity to ethical dilemmas. However, conditions can converge to displace one's usual attentiveness with transitory blindness, sometimes due to an inconvenient situation or distraction. Or, as the result of immediate situational demands, therapists commit acts with unintended consequences.

Case 1-28: Skid Greenspace, L.M.F.T., prided himself on recycling anything before disposing of it. Mr. Greenspace was chagrined when a client showed him the scratch paper he left in the waiting room for children to draw on. It had confidential client treatment notes on the back.

Case 1-29: Broma Seltzer, a fragile client, made a frantic call to her therapist, Delta Flyaway, D.S.W., wanting to see her immediately. Dr. Flyaway was running late to catch a plane for a long-anticipated trip to Europe. She informed Ms. Seltzer that her backup therapist would make contact within an hour or so. Dr. Flyaway became distracted by yet another call and left for the airport without contacting her temporary replacement. A week later, while skiing in the Swiss Alps, Dr. Flyaway suddenly remembered the call to her backup that she failed to make.

Every mental health professional is vulnerable to membership in this "Oops!" category, and it is the most difficult type of infraction to predict or prevent.

All of the issues raised in these case examples are discussed in more detail throughout

the book, including what should have been done instead and how such dilemmas may be prevented from occurring in the first place.

Finally, we do not wish to frighten our readers. Few professions are as honorable as those providing mental health services. We want to help you avoid ethical mistakes because once you are in a grievance system—be it an ethics committee investigation or licensing board hearing—due process is not the same as in the traditional legal system. You will be called on to demonstrate by a preponderance of the evidence that you did *not* commit an ethical violation. There are no cuts and bruises, no body, no missing silverware, and usually no witnesses. "Exploitation" and "harm" are at the base of many charges, and it may be difficult to prove that neither one ever happened. This is not because the complainant necessarily lied or distorted what happened, but because both terms are somewhat vague and subject to individuals' perceptions of an experience. Therefore, maintaining self-awareness and knowing and following the ethical rules are the best protections against ever being placed in an adversarial situation.

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2

Competence

Personal Fitness, Qualifications, and Training Issues

There is nothing more dangerous than ignorance in action.

Johann Wolfgang von Goethe

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The quotation from Goethe that begins this chapter stands as a warning to colleagues who believe that they have mastered all there is to know about their specialized field. Truly

competent professionals recognize their limitations and weaknesses as well as their strengths and skills. When we become blind to our areas of inadequacy, we put our clients and the

public at risk. The ability to assess your own competence and explore your motives and relationships insightfully is not easily taught and never perfected, yet these skills count among the most critical to functioning as an ethical professional.

It will become evident that competence-related issues pervade many chapters in this book. Competence issues related to psychodiagnostic assessment and testing are specifically addressed in Chapter 7. Similarly, issues related to competence as a psychotherapist are implied in the details of Chapters 3 and 4. The focus of this chapter is on matters of general competence and weakness and relates chiefly to the personal development and professional behavior of mental health service providers.

Before exploring the problems of incompetent or troubled mental health professionals, it is important to understand basic ethical problems associated with training, credentialing, and maintaining competence at the post-graduate level, as well as recognizing problem relationships when they develop. Differing opinions on the standards and credentials necessary for competent practice exist both within and across professions. However, no one can argue against the critical importance of recognizing the boundaries of one's competence and the limitations of one's techniques (Fouad et al., 2009; Page & Wokset, 2015; Verma et al., 2009).

This chapter focuses on mental health professionals who perform clinical and related services. This is because the discipline has almost exclusively confined its attention to competence evaluation in these areas. State laws do not require specific training or licensing for teaching psychology, social work, medicine, or counseling or for conducting research, despite the fact that most who engage in such work have usually earned advanced degrees or are in the process of earning them. Chapters 10, 14, and 16 cover competency issues in teaching, supervision, and research.

CONCEPTUAL ISSUES

High-quality professional practice demands two very different types of competencies: *intellectual competence* and *emotional competence* (Pope & Brown, 1996). Intellectual competence refers to the acquisition of knowledge based on empirical research and sound clinical scholarship regarding practice with a particular client population. Intellectual competence may also refer to a general ability to assess, conceptualize, and plan appropriate treatment for a particular client or problem. Most important, possessing intellectual competence means recognizing what one does not know. For example, vast experience in treating middle-class American Caucasian clients does not necessarily translate into the special competence needed to treat clients with other cultural or racial identities (e.g., see the discussion of race, ethnicity, and diversity in Chapter 5). This does not mean that therapists should only assess or treat members of their own racial or ethnic groups, but rather that they must strive to recognize all relevant individual differences and seek to acquire any incremental knowledge needed to treat such clients effectively or to make appropriate referrals.

Emotional competence refers to therapists' ability to emotionally contain and tolerate the clinical material that emerges in treatment, their willingness and skill at detecting the intrusion of personal biases into their work, and their capacity for self-care in the context of the difficult work that is psychotherapy (Keith-Spiegel, 2014; Pope, Sonne, & Greene, 2006; Welfel, 2006). A wide range of scholarly papers illustrates that not all therapists can competently work with every type of client or with all kinds of problems (Brenner, 2006; Haldeman, 2006; N. D. Hansen et al., 2006; Keith-Spiegel, 2014; Koocher, 2003; Maxie, Arnold, & Stephenson, 2006; Sue, 1998). Recognizing and acknowledging this fact does not constitute a sign of weakness—quite the contrary. But, unfortunately, many mental health professionals may feel financial, personal, or social pressures to see whoever comes to their office.

Organizations of mental health professionals have long struggled with the problem of defining professional competence and remedies

for incompetence. These efforts have taken many forms. They include the development of ethics codes, standards of practice or practice guidelines, defining core competencies, third-party-payer quality assurance programs, state licensing or certification boards (Fouad et al., 2009; Packard, Simon, and Vaughn, 2006; Page & Wokset, 2015), and other types of credentialing bodies. Despite these prospective gatekeeping efforts, however, none of the extant structures have yet proved fully able to effectively detect and then act in response to incompetent professional behavior or even to routinely enforce sanctions against those deemed incompetent.

Only the most egregious instances of incompetence, those that lead to filing formal complaints, ever come to the attention of licensing boards and ethics committees, as discussed in Chapter 18. Part of the difficulty relates to a general presumption of competence, much akin to the dictum that one is “innocent until proven guilty.” Obtaining a consensus on a definition of competence also has been elusive, both within and across health and mental health disciplines (Claiborn, 1982; Epstein & Hundert, 2002; Kaslow et al., 2004). In addition, incompetence is often difficult to prove, especially when investigators must function under the constraints of due process and the need to accumulate substantial evidence.

Standards of Practice

From the perspective of professional competence, we recognize that perfection is not the accepted standard of care. Rather, we expect each practitioner to function as a “good-enough therapist,” as judged by peers who understand the standards of care expected in the context of each case. The American Psychological Association (APA) and many other professional groups have promulgated documents that represent significant and comprehensive attempts to codify both general standards of practice and guidance in specialty areas. These range from conducting psychotherapy or assessment with special populations (e.g., by gender, ethnicity, or sexual preference); in special contexts (e.g., child custody or other

forensic activities); or with respect to particular activities (e.g., record keeping or obtaining consent). In general, such documents help to define minimum levels of competent professional practices and procedures, both generally and within specific specialty areas. Although worthy efforts, these documents often do not carry specific enforcement weight unless some type of formal complaint or lawsuit ensues. Nevertheless, we recommend actively seeking whatever such guidelines or standards apply to one’s work, and becoming familiar with them, is a best practice for ensuring professional competence and reducing liability risks (Knapp, Younggren, VandeCreek, Harris, & Martin, 2013). Professional liability and malpractice from the perspective of professional negligence is discussed in Chapter 13.

One illustration of confusion regarding determination of competence involves controversy about what constitutes a specialty, subspecialty, proficiency, or particular area of expertise in the practice of psychology. Clinical, counseling, industrial/organizational, and school psychology have traditionally been recognized as specialties within psychology, but there are certainly many special areas of expertise within each of these headings. For example, an industrial psychologist competent in human factors engineering may not be qualified to consult on personnel selection. A marriage and family therapist may not have special skill in sex therapy. A social worker with years of experience in child protective services may not have the requisite skills to work with geriatric patients. A clinical psychologist well trained in psychotherapy and assessment may lack the forensic knowledge to evaluate a defendant’s competence to stand trial. And, a counseling psychologist with many years experience as a psychotherapist to adults may be untrained in work with children. The professions have developed specialty standards (e.g., American Association of Sexuality Educators, Counselors and Therapists; American Board of Professional Psychology; National Organization of Forensic Social Work; and National Association of Forensic Counselors), but most of the mental health professions use ethics codes rather than practice labels from the front line of defining competent ethical practice

(APA: 2; AAMFT [American Association for Marriage and Family Therapy]: 3, 4.4; ACA [American Counseling Association]: A.11.a, C2, C4, E2, F; NASW [National Association of Social Workers]: 2.05.b), 2.10, 3.01–3.02, 4). In this context, all proscribe misrepresentation, but across colleagues, disagreements about the finer details will remain. What constitutes the basic qualification needed to practice personnel consultation, forensic evaluations, or child psychotherapy? Are these specialties or subspecialties or simply special types of competence, proficiencies, or skills? Consider the following examples:

Case 2–1: Charlotte Hasty, M.S.W., had practiced individual psychoanalytically oriented psychotherapy with adult clients for 10 years. After attending a half-day continuing education (CE) workshop on family therapy, Ms. Hasty began to conduct family therapy sessions for some of her clients while reading books in the field during her spare time.

Case 2–2: Carl Klutzkind, Ph.D., treated a woman with many adjustment problems in the wake of a separation and impending divorce. After Dr. Klutzkind had worked with the client for 6 months, her attorney asked whether he would testify in support of her having custody of her 7-year-old child. Despite having no forensic training or experience, Dr. Klutzkind agreed and from the witness stand offered many opinions about the adjustment of the woman and her child. The client's husband filed an ethical complaint against Klutzkind, noting that he lacked any training in child work, that he never actually interviewed the child, and that he was therefore negligent in offering an opinion. It seems that the child had been in treatment with another psychologist, and Klutzkind never sought information from that colleague or the child's father.

Case 2–3: Sarah Bellum, Psy.D., completed her graduate training in the 1980s, before clinical neuropsychology evolved as a distinct specialty. She was trained to “assess organicity” using the first edition of the Wechsler Adult Intelligence Scale (WAIS), House-Tree-Person drawings, and the Bender Motor Gestalt Test. She has never studied

neuroanatomy and has no knowledge of newer assessment tools designed for use in neuropsychological assessment. Her current practice focuses chiefly on psychotherapy. An attorney contacted Dr. Bellum about assessing a client who had suffered a closed head injury and was experiencing language, memory, and perceptual sequella. She accepted the referral and tested the client using the “tried-and-true” techniques she learned decades earlier.

In these three cases, the practitioners failed to recognize the boundaries of their respective formal training. While we acknowledge that no uniform professional standards now exist to define expertise in family therapy or forensic practice across professions and jurisdictions, Dr. Klutzkind and Ms. Hasty lacked even the minimum levels of competence one should reasonably possess. Dr. Klutzkind's lack of knowledge about forensic practice and failure to recognize the deficiency led him ethically astray. Perhaps his concern for his client, his desire to expound his views in court, or simple ignorance led him into trouble. His behavior clearly had a potentially hurtful impact on all the parties in the case and clearly violated both the APA's ethics code (APA: 9.01) and other extant professional guidelines of which he seems unaware. In Hasty's case, we cannot say for certain whether she actually hurt or helped anyone. No one would necessarily discover her lack of training under normal circumstances (i.e., unless a formal complaint were filed). Ms. Hasty did not see anything wrong with applying this new (for her) technique because she regarded herself as an “experienced psychotherapist.”

Dr. Bellum, who trained in an era that pre-dated most of what we now consider evidence-based neuropsychological assessment science, made no effort to keep current with that part of her training. She made no ethical errors until she agreed to take on a case for which her skills were no longer current or even adequate to contemporary professional standards. We cannot tell whether Dr. Bellum even had a clue regarding the evolution in the field since completing her doctoral training some

40 years ago. Both Drs. Bellum and Klutzkind also appeared ignorant of ethical constraints on psychologists' functioning as expert witnesses. (See Chapter 13 for a fuller discussion.)

When no formal standards exist for many specific types of practice or techniques, therapists must exercise prudence and take a conservative stance in assessing whether they require additional education or training prior to beginning the work. In such circumstances, we recommend seeking guidance from colleagues widely regarded as experts on the particular matters at hand. These colleagues can offer wise guidance regarding adequacy of training or of current practice standards.

An important trend in professional education involves focusing standards on development of particular competencies. For mental health practice, these have been conceptualized across six cluster areas: science, professionalism, interpersonal, application, education, and systems (Fouad et al., 2009; Palermo et al., 2014), each associated with measurable benchmarks or behavioral anchors. With the obsessiveness typical of psychologists, these clusters may also require modification to address subspecialty knowledge and career development modifiers. For example, psychotherapists planning to work with children may require a subset of additional skills not needed by those limiting their practice to adults. In addition, the skills needed to function successfully in a graduate student, intern, or postdoctoral training placement differ from the skills needed for entry-level independent practice, to qualify for board certification, to qualify as a supervisor or clinical manager, or to maintain one's competence as a senior practitioner decades beyond graduate school (Barnett & Molzon, 2014; Steele, Borner, & Roberts, 2014; Verma et al., 2009).

Such skills develop most strongly as a function of close and continually ongoing interaction with mentors and peers over time. This approach generalizes across the mental health professions and carries implications for both training and lifelong practices of therapists. Many clinical educators worry that distance learning or external degree programs, as

discussed further in this chapter, do not teach such skills effectively. A related recommendation involves training for ethics competency by using integrity checks in all course work (e.g., for plagiarism, data falsification, and misrepresentation), professionalism (e.g., for confidentiality, boundary violations, client welfare, procedural breaches), 360° evaluations in which everyone in the training environment evaluates each other, and assessing responses to actual ethical dilemmas (de las Fuentes, Wilmuth, & Yarrow, 2005; Domenech Rodríguez et al., 2014). Such a model would teach professionalism by example, although, disturbingly, at least one study found that a third of the graduate students surveyed reported unethical faculty behavior (January, Meyerson, Reddy, Docherty, & Klonoff, 2014).

Detecting Incompetence

Ethics codes enjoin us to avoid practicing beyond our areas of competence; however, such codes necessarily will have a general nature and give too few specifics to permit us to easily identify incompetent practice. Detection of incompetence must rely on observation and, ultimately, complaints by someone. As discussed in Chapter 18, expulsion from a professional organization will not necessarily interrupt the practice of the offender. The individual may simply practice without joining a professional association. If a regulatory board revokes the practitioner's license, the individual may easily continue to practice under an unregulated title, such as "psychotherapist" or "counselor." Incompetence can become a basis for malpractice litigation; however, one must first establish that damages have occurred (as discussed in Chapter 13).

Can incompetence be detected early? A particularly interesting study by Peterson and Bry (1980) examined competence by reviewing appraisals of 126 doctor of psychology (Psy.D.) students by 102 faculty and field supervisors. After rating students with whom they had worked, faculty and supervisors were asked to describe the dominant characteristics of both "outstanding" and "incompetent" trainees. The quality most frequently mentioned for

outstanding students was “high intelligence,” while the most common characteristic for incompetent trainees was “lack of knowledge.” When supervisors used a rating scale composed of the 28 most commonly used terms to evaluate students the subsequent year, four factors emerged as central to the conceptualization of competence:

- professional responsibility,
- interpersonal warmth,
- intelligence, and
- experience.

The data also suggested that behaviorally oriented supervisors gave somewhat less weight to warmth in evaluating competence than did more eclectic or psychodynamic supervisors.

Providing high-quality clinical supervision across a broad range of topics (e.g., consent, competence, attention to issues of diversity and multicultural competence, boundaries and multiple relationships) is critically important in professional development (Barnett & Molzon, 2014). This includes considering the competence and ethical conduct of supervisors (Jacobs, 1991) and well as potential incompetence or dishonesty on the part of trainees (Jensen, 2003). Mandatory personal psychotherapy has at times been advocated as a means to address such issues, but this does not necessarily make sense (Gavin, 2014). While therapy can help with sensitivity to the client role and remediation of a trainee’s emotional problems, personal therapy does not enhance clinical skills and knowledge or address an otherwise-dishonest character. The best prevention against producing unskilled or risky graduates is solid education and training with appropriate mentoring and supervision (see also Chapter 10).

Another problem to keep in mind when considering the conceptualization and detection of incompetence involves understanding the range or variability of skill among mental health professionals, whether they work as practitioners, academics, or consultants to industry. Daniel Hogan made the point well

many years ago in his four-volume work on the regulation of psychotherapists; he noted the substantial discrepancy between *adequate* and *superior* competence. Within each pool of licensed mental health professionals, there will be some who just barely passed the admission criteria and are, it is hoped, unlikely to cause anyone harm. Many others will fall somewhere in the middle, and some will “top the pool” (Hogan, 1977). Except in Garrison Keillor’s fictional Lake Woebegone (Altman, 2006), not everyone can be “above average.” While exceptional competence is certainly desirable, it is not unethical to practice in an area in which one’s competence is simply “adequate” or “good enough,” assuming we know what such ratings mean and have correctly established that threshold.

TRAINING ISSUES

A variety of controversies surround the training of mental health practitioners. These controversies involve questions about just how they ought to be educated and how behavioral scientists, physicians, or other professionals not trained as mental health practitioners ought to undertake retraining or acquire new skills should they wish to become human service providers.

A variety of training models have been proposed. Rather than arguing whether a “scientist-practitioner,” “scholar-professional,” or anything short of a “clinical science” model is ethically acceptable, we focus our concern about ethical issues in the conduct of training. Are practitioners adequately trained for the jobs they intend to perform? Are the techniques used to train them ethically defensible? Are students evaluated in an ethically appropriate manner? Is the institution providing the training competent to do so? These comprise the substantive ethical problems linked to the training across all mental health professions.

Competence by Degrees?

In the fields of law and medicine, the entry-level practice degrees in the United States are

recognizable (i.e., as the J.D., M.D., or D.O., respectively). Using psychology as our example, we find more historical diversity. In addition to Ph.D., Ed.D., Psy.D., M.A., and M.S. degrees, psychologists have historically listed a number of other earned degrees in reporting their qualifications for recognition as psychological health service providers (Wellner, 1978): These include C.A.G.S. (certificate of advanced graduate study), D.Sc. (doctor of science), Ed.S. (educational specialist), D.M.H. (doctor of mental health), Th.D. (doctor of theology), D.Min. (doctor of ministry), M.Ed. (master of education), and M.S.S.S. (master of science in social services). Not only have the degree designations varied historically, but also, in addition to departments of psychology, the following academic departments were listed by applicants as granting “closely related degrees” as they sought recognition as psychologists (Wellner, 1978): American civilization, anthropology, child study, divinity, education, educational research and measurement, general studies, guidance counseling, health and physical education, home and family life, law, philosophy, political science, rehabilitation, religion, social and human relations, special education, and speech pathology.

In social work, one may qualify for varying levels of licenses with a B.S.W., M.S.W., D.S.W., or Ph.D. Some programs also grant an M.S.S.S. Counselor education programs may offer M.A., M.D., M.Ed., Ed.D., or Ph.D. degrees. Marriage and family therapy programs may also offer M.A., M.S., or Ph.D. degrees. The alphabet soup becomes more complex when one looks at state licensing. Some states’ psychology licenses use only the word *psychologist*, while others designate those prepared to provide therapy or assessment as “health care providers” or as “clinical psychologists,” even if their degrees were issued in school or counseling psychology. Other states license school psychologists or educational psychologists under separate agencies from those granting health care practice credentials. Social workers might qualify for a license to practice under supervision or with full professional autonomy and might use their practice title, such as

licensed clinical social worker (L.C.S.W.) or licensed independent clinical social worker (L.I.C.S.W.). Other psychotherapists may hold credentials such as licensed professional counselor (L.P.C.), licensed mental health counselor (L.M.H.C.), or licensed marriage and family therapist (L.M.F.T.).

To complicate matters even further, the major fields within which degrees were granted are even more diverse. In part, this variety sprang from the fact that many state laws at one time recognized degrees in psychology “or a closely related field” as a qualification for psychology licensing. Similarly, in quest of licensing status, many mental health professions made compromises in their ideal licensing criteria to blunt opposition from practitioners who claimed that they were already qualified and practicing. Such regulations are often termed *grandparenting provisions*. By definition, these professional “grandparents” can retain their licenses to practice. Many will likely have died or stand on the verge of retirement as you read this chapter. However, that may not be the case for some jurisdictions with newly created license categories.

Medicine also has some interesting distinctions in degrees and training subtleties that raise competence issues. For example, most people will recognize the doctor of medicine (M.D.), but not know that many licensed physicians hold doctor of osteopathy (D.O.) degrees. In the United Kingdom, students typically begin medical studies at the age of 18 or 19, in contrast with the U.S. system, where medical schools require a bachelor’s degree. British medical courses typically last 5 years and lead to a bachelor of medicine and surgery, usually abbreviated as M.B.Ch.B. (from the Latin *chirurgia*, referring to surgery) or sometimes as B.M. for bachelor of medicine. The full range of medical degrees, however, seldom involves significant training in psychopathology or psychotherapy.

The relationship between a medical degree and competence to perform counseling and psychotherapy services has become increasingly challenging. State laws do not

typically regulate the practice of “counseling” by physicians in general. A former president of the American Psychiatric Association estimated that general physicians, not psychiatrists, write more than 75% of all prescriptions for psychiatric medications in the United States (Sharfstein, 2006). In addition, typical medical students have had only 6 to 8 weeks of training in psychiatry at graduation and essentially get on-the-job training when they enter a psychiatric residency. Because of economic factors, such as a low insurance reimbursement rates for 50-minute verbal psychotherapy sessions in contrast to fees received for much briefer medication visits, fewer psychiatrists find steady employment or fill their practices by conducting traditional psychotherapy. Instead, many focus on a more remunerative psychopharmacology practice, and psychiatric residency training programs are placing less emphasis on teaching verbal psychotherapy (Harris, 2011; Koocher, 2007). These factors may well contribute to the well-documented decline in United States medical school graduates entering psychiatric residencies (Moran, 2006).

The Doctoral Versus Master's Degrees

The doctoral degree has been well established as the entry-level practice credential in psychology (Fox, 1994; Robiner, Arbisi, & Edwall, 1994). According to the latest data from APA's Center for Workforce Studies (2014), approximately 6,000 doctorates in psychology are awarded annually in the United States, and about half of those are in specialties that qualify for licensing as a psychologist (i.e., clinical or counseling, as opposed to general or experimental). The number of master's degrees that are awarded each year in psychology is harder to track unless one focuses only on psychology departments. That number also becomes misleading because some of those degrees are awarded to students on the way to a doctorate and others are terminal. Because APA has consistently pegged licensing at the doctoral level, most master's degrees in psychology become irrelevant from a practice perspective. Unlike

doctoral programs, the APA does not accredit master's programs. An examination of course content, curriculum, and duration also substantiates that master's and doctoral training in psychology are not equivalent (Robiner et al., 1994). In states where master's-level psychologists may sit for the national licensing exam administered under the auspices of the Association of State and Provincial Psychology Boards (ASPPB; i.e., the Examination for the Professional Practice in Psychology, EPPP), doctoral-level licensing candidates have consistently outscored them (ASPPB, 2012; Robiner et al., 1994).

Does all this mean that holders of doctoral degrees are always more competent at specific professional tasks than holders of master's degrees? Of course, it does not. Rather, the data suggest that, on the whole, a person trained at the doctoral level in psychology will often have acquired a more substantial foundation in terms of both required course work and supervised experience. In addition, for psychologists, the profession will not generally grant a practice license below the doctoral level.

But, wait—many other mental health professions credential people for practice at levels below the doctorate. As noted previously, all of the states in the United States license social workers and nurses at various levels (i.e., from career entry to advanced practice), and many states also license mental health, rehabilitation, or marriage and family therapists or counselors. A number of professions do recognize a master's degree as the entry-level credential for independent (i.e., unsupervised) professional practice, including mental health counseling, marriage and family therapy, social work, and advance practice nursing (master of science in nursing or clinical specialist or doctor of nursing practice).

From an ethical perspective, three key issues independent of professional degree or training program apply:

- accurately representing one's training and credentials,
- practicing within the scope of such training and licensing, and

- adhering to the ethics, laws, and regulations applicable to similarly licensed professionals in one's practice jurisdiction (e.g., not holding oneself out as a psychologist, social worker, licensed counselor, or physician in a state where one's degree and experience do not qualify for use of that title).

Psy.D. Versus Ph.D.

The Psy.D. degree first began in response to a perceived need to offer specialized doctoral training for practitioners not seeking research careers (Peterson, 1976). Some psychologists subsequently argued that a Ph.D. degree was too generic a scholarly credential for determination of who ought to be recognized as a health service provider in psychology (Shapiro & Wiggins, 1994). They suggested that a doctor of psychology (or Psy.D.) degree should identify the doctoral-level health service provider in psychology and went so far as to recommend that Psy.D. degrees be awarded retroactively, in much the same manner as the J.D. degree was awarded to attorneys who had earned LL.B. degrees prior to the mid-1960s. The APA Council of Representatives was not receptive to such arguments, leading to abandonment of the effort in 1996.

Many professions that once considered the master's degree as the top clinical practice credential in their field have begun to imitate the Psy.D. degree. Physical therapy has encouraged a move from the master's degree to the doctor of physical therapy (D.P.T.) degree by 2020. Graduate nursing programs have begun to establish the doctor of nursing practice (D.N.P.) degree. Such credentials recognize advanced practice skills, without the heavy research career training components typically part of Ph.D. curricula. Pharmacists now typically have the Pharm.D., audiologists have the Aud.D., some engineers have the Eng.D., and some business school grads obtain a D.B.A. Can a D.C.A. (doctor of culinary arts) or D.C.R. (doctor of computer repair) be far behind?

In psychology, a large number of professional schools have evolved, some offering both Psy.D. and Ph.D. options. While some

professional schools of psychology exist within university systems, others are freestanding entities, and some are proprietary (e.g., owned by investors, as opposed to standing as non-profit educational institutions). Information on schools offering the Psy.D. degree can be found at the website for the National Council of Schools and Programs of Professional Psychology (<http://www.ncspp.info/>). The key to identifying a quality program in psychology or any other mental health field lies in checking sites of respected accrediting bodies for each profession that have earned recognition by the U.S. Department of Education through its Council for Higher Education Accreditation (CHEA; <http://www.chea.org>). For psychology, this would be the APA's Office of Program Consultation and Accreditation (<http://www.apa.org/ed/accreditation/>). Other useful data sites for psychology include those to seek internship placement rates (<http://www.appic.org>) and licensing examination scores (<http://www.asppb.org>).

Other professions have associations that created accrediting commissions and have attained CHEA recognition, such as the AAMFT Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE); the Council on Social Work Education (CSWE) Office of Social Work Accreditation; and the Psychological Clinical Science Accreditation System (PCSAS), a competitor to APA's system focused on clinical science.

Any professional degree program in any of the mental health fields should readily advise applicants of important data relevant to accreditation, graduation rates, internship and job placement rates, licensing exam pass rates for first-time attempters, and similar data. While no single piece of data affords an absolute assurance of competence, the types of information noted here do offer an indication of the degree to which any given program produces graduates who succeed in the early stages of their careers.

Ingredients of the Psychology Human Services Graduate Program

Psychology provides a useful example of how a training program is configured at the doctoral level. Recognizing that psychologists who act as human service practitioners take on great responsibilities, the APA has developed a thoughtful and detailed accreditation system (<http://www.apa.org/ed/accreditation/>) that provides a means for evaluating academic and internship programs purporting to train psychological practitioners. Curricula *must* address the following:

- biological, cognitive-affective, and social bases of behavior;
- history and systems of psychology;
- psychological measurement;
- research methods;
- techniques of data analysis;
- scientific foundations of practice;
- assessment and diagnosis; and
- cultural and individual diversity.

Considerable latitude is permitted within categories, however. For example, a student can graduate from a fully approved clinical psychology doctoral program without ever treating a child, working with a geriatric client, or learning to administer projective personality tests. Some programs graduate students following experience in several practicum placements and with dozens of client assessments behind them. Other program faculty believe that students who may have seen fewer than a dozen assessment and treatment cases are “good to go” on their internship.

Different professions will similarly have differing treatment models and a range of accrediting bodies. Although we use psychology as our primary illustrative model, other professions encounter similar variability. In social work, as noted previously, people with bachelor’s degrees (i.e., B.S.W.) may qualify for some jobs and credentials, while an M.S.W. plus years of experience may stand as the prerequisite for an independent practice license. In addition, some social workers may train primarily for

administration, community organization, or child protective services work and not as psychotherapists, while others may focus heavily on psychotherapeutic practice techniques or specialize in treating particular populations or disorders.

Variability in educational program emphasis across different programs within any profession is not necessarily bad as long as graduates remain aware of their competence and limitations. The recent graduate of a doctoral program who recognizes a training inadequacy for a particular career goal can remedy it in many ways, including postgraduate fellowships or certificate programs, CE programs, and proficiency development programs. More substantial difficulties face the psychologist who wishes to change specialties, such as a social, experimental, or developmental psychology graduate who wishes to become a health services provider. Such shifts are occasionally permitted by generic state licensing laws, as discussed in the following section.

Online Degrees

The rapidly increasing interest in online education over the past decade reached into the ranks of graduate mental health programs with highly mixed results. Some programs use fully online or blended models (e.g., some brief periods on campus with most classes completed online). Some such programs are offered by regionally or state-accredited institutions, meaning that the institution has the authority to issue a degree. However, the ability to offer a degree is unrelated to professional association or licensing board recognition. Some universities are more direct than others in warning potential students that they may not qualify for professional practice. One such school includes language on its website cautioning that it “cannot guarantee licensure, endorsement, certification, authorization, other professional credential or salary advancement. State regulations and professional credential standards vary. It is the learner’s responsibility to understand and comply with requirements for their states and professional associations” (Capella Education, 2015).

Many professional accrediting bodies have expressed concern that the level of rigor, supervision, and professionalism training that occurs in traditional programs cannot be duplicated in fully online programs; however, that perspective may be changing. Some for-profit companies have allied with highly respected universities to offer high-quality academic programming with robust immersive technologies in partnership (e.g., see <http://2u.com/about/partners/>). The NASW accrediting commission has granted full approval to a number of fully online B.S.W. and M.S.W. programs (see <http://www.cswe.org/Accreditation/Information/DistanceEducation.aspx>), and the American Bar Association has granted accreditation to a low-residency J.D. program at the William Mitchell College of Law in St. Paul, Minnesota. The hybrid option students will spend only a week or two on campus each semester and take the rest of their classes online (Lerner, 2013).

The track record of graduates from such programs in terms of comparative competence and licensing board complaints has yet to be studied. However, for those considering a career as a psychotherapist with their learning based chiefly on existing online degree and distance learning programs, we can only say *caveat discipulus* ("let the student beware").

Postgraduate Transformations

It is not all that uncommon for individuals who have already completed an advanced or entry-level degree in one program (or even already possessing licenses to practice in one mental health profession) to want to either switch to another program or add a new profession. The APA policy adopted by its Council of Representatives holds that simply completing internship or applied training as such is insufficient for the professional "retread," as those who wish to convert to clinical work are sometimes called. The policy holds that such individuals must also complete course work that would be equivalent to the desired degree but is missing from their academic records. It is preferable that this course work be taken in a programmatic,

sequential, and carefully monitored program, as opposed to a loose collection of casually collected courses. Some universities offer special 1- or 2-year programs aimed at retraining such individuals. Psychologists sometimes choose a "backdoor" route, seeking internships or training in applied settings without accompanying course work. Licensing or credentialing bodies do not look kindly at such candidates. Consider these examples that describe specialized services to children:

Case 2–4: George Grownup, Ph.D., completed a degree in clinical psychology from a program fully accredited by the APA. He took all of his practica, field work, and internship training at settings treating adults (i.e., a college counseling center and Veterans Affairs Hospital). Although he has not taken courses in child development or child psychopathology and has had no supervised clinical work with children, he now wants to start practicing with children. He begins to add child clients to his practice after reading a half dozen books about developmental psychology and child treatment.

Dr. Grownup may be a well-trained adult clinician, but his attempt to prepare himself to work with children is glaringly superficial. His clinical reach certainly exceeds his trained competencies, although he does not seem to grasp this fact. Although a regulatory board may never catch him unless someone files a complaint, his conduct remains ethically inappropriate.

Case 2–5: Dee Vella Pmental, Ph.D., completed her degree in human development within a psychology department. She then worked for 2 years as a researcher interviewing victims of family violence and assessing the cognitive development of infants with Down syndrome. She decided that she would like to be able to do more clinical forms of work, including personality assessment and psychotherapy, with the types of patients she has been studying. Dr. Pmental volunteered more than a dozen hours per week for 3 years at a local teaching hospital with an APA-approved internship program. She sees patients under close supervision, while also attending didactic seminars and

taking courses in personality assessment at a local university.

Dr. Pmental has better training to work with children than does Dr. Grownup, but technically she has not sought formal retreading. She has gone further and seems considerably more cautious than Dr. Grownup in attempting to ensure her competence in the activities she hopes to practice. Although her behavior may technically violate an APA policy or professional standard, it is not necessarily unethical. As long as she limits her practice to the areas in which she is well trained, her behavior might qualify as considered ethically appropriate from a competence perspective. However, she would have to satisfy her state licensing board that she qualifies as a health service provider, and many regulatory boards require a more formal sequence of training.

The following case illustrates similar issues in the context of a master's prepared licensed clinician from another profession.

Case 2–6: Meta Morphosis, M.S.W., completed her field placements as a medical social worker at a large general hospital. She became experienced in assisting families to cope with serious mental illness, locating community resources, and discharge planning. A few years following her graduation, Ms. Morphosis developed an interest in practicing psychotherapy, so she sought out a social work fellowship program offering clinical supervision in psychotherapeutic practice from well-credentialed senior colleagues as part of the training program.

Ms. Morphosis recognized that her education and training had not prepared her for a new area of practice she hoped to enter. She sought out an appropriate training opportunity that will allow her to develop the skills she seeks within a pathway recognized by her profession and licensing authority.

In some cases, the barriers to entry into licensed professions may flow more from guild issues than any objective measures of competence. Consider the following case:

Case 2–7: Nocan Doit completed a Ph.D. in social psychology with a specialization in the study of family dynamics. When Dr. Doit sought state licensing as an L.M.F.T., he was told that he would need to complete more than 30 credits of additional course work taught by individuals with L.M.F.T. credentials in addition to the usual number of supervised hours of experience. Interestingly, one of the courses Dr. Doit would need to take as a student was a course of professional ethics, the same course he had been teaching for several years for M.F.T.s. He would not receive any credit or waiver for a course he designed and taught.

Certainly, a licensing board would not want to waive criteria frivolously; however, many mental health professions establish barriers or hurdles to overcome that have little to do with actual competence and more to do with controlling access to the professional license.

The Student in Transition

At times, some advanced students seeking a shift in professional identity find themselves caught in a perplexing bind as they attempt a professional transition. Consider the following case example:

Case 2–8: Karen Quandary, M.S.W., has 4 years of experience as a clinical social worker and is licensed as an “independent clinical social worker” in her state. She decides to enter a fully accredited and approved program in clinical psychology offered by the Applied Institute of Professional Psychology. Ms. Quandary acknowledges that she does not hold a psychology license, although she is a “psychology graduate student,” and has identified with the profession by becoming a student member of APA. While she does not qualify for licensing as a psychologist, and thus cannot practice as a psychologist (e.g., undertake psychodiagnostic testing without supervision), one must presume she can competently practice within the scope of her license as a social worker.

A person with two valid professional identities has no obligation to surrender one while

developing the second. As long as Ms. Quandary continues to identify herself as a social worker and as long as she practices competently within her areas of expertise, she has not behaved unethically. Technically, Ms. Quandary cannot consider herself to be a psychologist or announce herself as one to the public until she meets appropriate professional and statutory standards for that profession. One must, however, discriminate between professional titles and professional functions for which one has appropriate training. To the extent that social work ethics and psychology ethics differ in specificity, Ms. Quandary should always hold herself to the more stringent standard across both codes. In addition, she would be wise to check with her faculty about any special rules imposed on her as a student in her particular degree program. Some programs place practice limitations on their students more stringent than the requirements of the ethics code.

Student Evaluations

Faculty members in all health service delivery programs have the responsibility to assess the progress of each student and to keep the student advised of these assessments. (See, for example, APA's *Guidelines and Principles for Accreditation of Programs in Professional Psychology*; APA Office of Program Consultation and Accreditation, 2013) Students who exhibit long-term serious behavior or competence problems or who do not function effectively in academic or interpersonal spheres should be counseled out of the program early. If necessary, they should be made aware of career alternatives or, after appropriate due process procedures, dropped from the program. Each program should have specific uniform procedures to routinely assess the progress and competence of students, advise them of the outcome, and delineate appropriate sequences of action and alternative outcomes. These procedures should be explicit, written, and available to all students and faculty. Graduate students terminated from degree programs represent an occasional

source of ethics complaints against faculty, which raises other competence issues.

Case 2-9: Michael Mello left his urban West Coast home to attend graduate school at a rural Midwestern university. At the end of his third semester, he received a written notice that he faced termination as "personally unsuited" to continue in the school's counseling program. Mello filed ethics complaints against the director of training and department chair. He complained that he had never previously been advised of problems. Furthermore, his grades were excellent, and he had been denied due process.

Case 2-10: Carla Confident also traveled across the country to attend graduate school in psychology. After 3 years in the program with satisfactory grades, she took her comprehensive examinations and failed. In a hurry to take an internship for which she had been accepted, Ms. Confident again attempted the exams and failed. As a result of failing twice, she was terminated as a degree candidate in accordance with department regulations. Ms. Confident filed an ethics complaint against several faculty members, noting that the grading of the exams she failed was highly subjective, and other psychologists to whom she had shown her answers thought they were well done. She went on to claim that her strong feminist views and ethnic heritage had been a source of friction between herself and some faculty for her 3 years at the school. She attributed her failures to contamination by these factors in the subjective grading of her exams.

These two cases had several elements in common when they came before an ethics committee at approximately the same time. They involved students with cultural values different from the majority of the faculty and community within which they were training. On inquiry by the ethics committee, it became clear that both schools lacked formal procedures for student grievances and that both students were "surprised" by the efforts to dismiss them. Mr. Mello claimed to have had no warning that the program deemed him to have serious problems prior to the written notice. Although he

received a variety of ambiguous messages, he had never had clear counseling or warning that dismissal loomed within the realm of possibility. Ms. Confident had sensed friction with some faculty members but had received good evaluations from her field placement supervisors and satisfactory or better grades in all courses. While she had known about the rule that two failures terminated candidacy, she had expected to pass and felt, in any case, entitled to an appeal.

While the universities and students involved each had valid reasons for criticizing the other's behavior, the students clearly were the more vulnerable parties and had been, at the very least, subjected to poor communications. Mediation by a professional association's ethics committee led to Mr. Mello's being awarded a master's degree for work completed, and he transferred to another university. Ms. Confident's university agreed to ask a panel of psychologists, suggested by the ethics committee, from universities in neighboring states to evaluate her exam answers independently and to take guidance from their judgment. In the end, her university restored her status, and she successfully completed her degree. Much of the acrimony generated in these episodes might have been prevented had the programs involved developed more specific procedures for monitoring the progress of students and given them timely feedback about their perceived competence problems.

We address the problem of the impaired psychotherapist or "sick doctor" at the end of this chapter. Many of the issues discussed under that heading can also apply to students (Gizara & Forrest, 2004; Jensen, 2003; Vacha-Haase, Davenport, & Kerewsky, 2004), and it seems appropriate to highlight the impaired student at this point. The students mentioned in Cases 2–8 and 2–9 did not have clear signs of any medical or psychological impairment. Consider the following cases from psychology and medical graduate schools:

Case 2–11: In 1975, Jane Doe entered New York University's Medical School. Prior to her admission, she had a long history of emotional problems,

including numerous involuntary hospitalizations, which she never revealed to the school. During her first year, the emotional problems "flared up" again, and she began behaving in a "bizarre and self-destructive manner," including at least one alleged suicide attempt in the anatomy laboratory on campus. The school encouraged her to take a leave of absence; she sought voluntary hospitalization and was released with a "guarded" prognosis. The medical school later denied her readmission after an examining psychiatrist deemed her emotionally "unfit to resume her medical education" (*Doe v. New York University*, 1981).

As the citations indicate, the Jane Doe case is drawn directly from case law. A federal court in New York issued a preliminary injunction ordering the medical school to readmit Ms. Doe as an "otherwise-qualified" person under federal antidiscrimination legislation. The court found that she would "more likely than not" be able to complete her education, despite her psychiatric history, based in part on the fact that she had earned a master's degree in public health at Harvard and had held down a stressful job without deterioration during the years of litigation.

Case 2–12: Irwin Flame was enrolled as a graduate student in social work at Middle State University. After a series of 12 arson fires in the psychology building, Flame was discovered as the culprit and sentenced to a term in prison. Following his parole, he reapplied to complete his degree. He had earned "straight A" grades and nearly completed a master's degree prior to his arrest.

Case 2–13: Emma Petous had enrolled as a graduate student at the Manhattan School of Professional Psychology, where she earned respectable, but not outstanding, grades. Some of the practica supervisors noted that she tended to be "impulsive and somewhat emotionally immature," although she seemed able to function quite well in a number of professional circumstances. After receiving an unsatisfactory C grade in her statistics course, Ms. Petous prepared a batch of handbills characterizing the instructor as "pompous and weird, with an anal personality and a

perverse intellectual style" and a variety of other unflattering terms. She placed the handbills on bulletin boards around the school building and inserted them in student and faculty mailboxes.

Case 2-14: Sam Smutty had completed a master's degree and all of the course work for his doctorate while completing his dissertation. He held a job teaching undergraduate courses to support himself. At the end of the semester, Smutty sent anonymous e-mail messages to several female students who been in his class describing in lurid detail the sex acts he fantasized engaging in with them. A number of the students independently contacted the campus security office, where officers quickly tracked the IP (Internet Protocol) address to its source and identified Smutty as the sender. When confronted, he admitted sending the messages.

Mr. Flame, Ms. Petuous, and Mr. Smutty represent disguised cases of variable pathology. They presented focal symptoms that demand consideration in light of the emotional context, their other behavior, and their professional goals. One cannot say without more information whether each subset of behavior cited constitutes grounds for termination from (or reentry into, as in Flame's case) the program, as opposed to some less-drastic and more rehabilitative approach. Smutty also faces the prospect of sexual harassment prosecution. The most difficult cases involve students who seem personally unsuited to the field in which they are seeking a degree or credential but whose problems are more diffuse and less easily documented.

Case 2-15: Arrogant Obnoxia performed well in class but earned the disdain of his educators and fellow students alike. He seemed to enjoy showing off with what he self-assuredly assumed to be his superior knowledge. He often provoked arguments and then seemed to relish in the ensuing verbal skirmish. The faculty worried that Mr. Obnoxia not only would become a risky mental health professional but also would reflect poorly on the department and institution.

Mr. Obnoxia presents a particularly difficult case because his annoying personality style, rather than his academic ability, leads to the problematic behavior. Readers may also want to review issues related to writing reference letters for this sort of person or dealing with such individuals as colleagues (see Chapter 10). The ability to engage in and maintain good collegial relationships can form the basis of a valid performance criterion and reason for dismissing a person from the workplace, described by a Stanford Business School professor in *The No Asshole Rule* (Sutton, 2007). However, educational and professional training programs have the obligation to tie dismissal to bona fide criteria, objectively applied, with appropriate warning, and efforts at remediation, when appropriate. Student handbooks or codes of conduct that delineate expectations and potential penalties provide good approaches to dealing with these problems.

The key point is that mental health professionals who operate training programs hold a dual responsibility, one focused on the public and potential clients and the other on the student. Considerable time and careful due process are required to advise students of any perceived difficulties, suggest remedies, monitor their progress, and possibly assist them in exploring other alternatives. Nonetheless, these responsibilities must be assumed by mental health professionals who direct academic and field training programs. The consequences for programs and faculty who default on their ethical obligations can be both serious and expensive, as illustrated in the following case:

Case 2-16: In 1992, Susan A. Stepakoff was expelled from the clinical-community doctoral psychology program at the University of Maryland. Stepakoff had complained within the psychology department about racist and sexist remarks made by faculty members and about other alleged faculty misconduct. In one of many examples provided to the court, Stepakoff alleged that during one class, when students watched a group therapy session through a one-way window, a professor remarked that he was "imagining the clients naked." He reportedly added that

he found the thought of viewing one large woman naked “really disgusting” (Shen, 1996). Stepakoff also complained that some professors were having sex with students. Department and university officials failed to respond to her requests for action. Instead, some faculty made a variety of allegations about Ms. Stepakoff and succeeded in having her expelled after she had been admitted to doctoral candidacy. These were not, however, sufficient allegations to convince a court of law. In June 1996, a Prince Georges County jury found that Stepakoff’s free speech rights had been violated and awarded her \$600,000 in compensatory and punitive damages. In November 1996, the state settled with Stepakoff for \$550,000 rather than appeal the case (Shen, 1996; “State Agrees,” 1996; *Susan A. Stepakoff v. University of Maryland at College Park et al.*, 1996).

One of us (G.P.K.) served as an expert witness for Ms. Stepakoff. All facts reported here, however, are drawn solely from public sources, as cited.

The Incompetent Institution

While many people are aware that it is possible to purchase phony diplomas by mail or online, few realize that the diploma mill industry flourishes in this country and abroad. Certificates or transcripts based on flimsy correspondence courses or no course work at all can easily be used to mislead and defraud the uninformed consumer. Often, such incompetent institutions provide larger and more impressively decorated diplomas than those from accredited schools. Some institutions attempt to cover any liability by describing the diplomas as “novelty items” in their advertisements. But, in recent years, those running these useless degree programs have become much bolder by omitting any disclaimers and even promising that these degrees are legitimate and fully accredited and will benefit one’s career status. Most of these so-called degrees are advertised over the Internet, and the “educational institution” is a post office box in a foreign country.

The names of these diploma mills—and they go in and out of business regularly—can

sound impressive (e.g., Lawford State University, the Royal Academy of Science and Art, Sussex College of Technology, Atlantic Southern University, Oxford Institute for Applied Research, the Carnegie Institute of Engineering, and Brownell University). Sometimes, the names of legitimate institutions of higher learning, or close approximations (e.g., Stamford University, Dartmouth College), are used as well.

Many of these bogus outfits attempt to give the illusion of a criterion to “earn” the degree, namely “life experience.” The definition is broad, generally amounting to the fact that you have remained alive and can come up with price of the product. A number of these enterprises offer services that will further assist the “grantee” in perpetuating an intentional fraud. For an extra payment, one can purchase transcripts (some charge extra for all As), and so-called verification services in case an employer wants to make sure that the degree was actually earned. Back when these degrees were mere novelty items (and marketed as such), the cost was low, less than \$100. Today, the charge can reach into thousands of dollars depending on how many extras are purchased.

Case 2-17: The outgoing and superficially charming Shammy Fake opened up a practice sporting five advanced degrees from fancy-sounding institutions, none of which involved any academic work or supervised experience. He called himself a “personal counselor,” running splashy advertisements in the local media bragging about his vast experience and educational accomplishments. His practice always had a waiting list until one client complained to her psychologist friend that for \$200 an hour she should be doing better. The friend became suspicious and took a closer look. She attempted to complain about Mr. Fake to a licensing board, but because he had no license and did not belong to any legitimate professional organizations, there was no way to proceed against him.

Such individuals abound and cause legitimate mental health professionals concern for the public welfare. Mr. Fake will be difficult to stop unless a regulatory authority in his state has

a clause that allows intervention if a complaining client was reasonably led to believe that the individual was a genuine mental health care provider. Typically, the most severe sanction in such circumstances would be a cease-and-desist order, but Mr. Faké could simply recast himself with an unregulated title, such as personal, life, or relationship coach or set up a new practice in another state.

The rules and regulations relative to awarding degrees vary from state to state, and there are few regulations with any impact on the sale of such “credentials” via the Internet. Thus, many opportunities for deception exist, and consumers can be misled at best and harmed at worst. No uniform national standards exist for accreditation of degrees in general, and a school that may hold state accreditation in California might not be recognized in New York. The watchword in determining a degree’s professional validity is regional accreditation by a U.S. Department of Education CHEA-recognized entity.

The following commonly used terms do *not* equal accreditation: licensed, recognized, authorized, approved, or chartered. These terms may differ in legal meaning from state to state and may have no relevant meaning at all. Many poor-quality schools or bogus degree programs will claim accreditation, but often by a spurious or unrecognized body. We identified over 70 so-called accreditation agencies that sham outfits claim in an attempt to substantiate legitimacy. One such outfit is so audacious that it compares itself favorably to “those phony diploma mills.” CHEA is the only government body charged with recognizing accrediting associations; for colleges or universities, there are only six regional accrediting associations: the Middle States, North Central, Northwest, Southeastern, Western, and New England Association of Schools and Colleges. CHEA posts considerable helpful information and articles about degree mills and accreditation mills on its website (see, e.g., <http://www.chea.org/degreemills/frmPaper.htm>).

Do universities have a liability for producing unskilled practitioners? Consider the following case:

Case 2-18: Diana Stett, who had already successfully sued her former therapist, Linda Watts, L.P.C., and the clinic employing Ms. Watts for \$1.7 million, attempted to take legal action against Louisiana Tech University, the institution where Ms. Watts had trained. Stett’s attorney proposed the novel, but ultimately unsuccessful, argument the university should be held liable for failing to ensure the competence of its graduates (Custer, 1994).

In this case, a well-regarded accredited institution seemed blamed for having a wayward graduate. Such cases, regardless of their merit, pose special concerns for institutions given that ensuring competence of a graduate is virtually impossible. Were such suits prevalent and successful, institutions may have to consider closing down certain training programs.

One must also take care to differentiate between diploma-granting certification boards and bogus or so-called vanity boards. For example, the member boards of the American Board of Medical Specialties (<http://www.abms.org/>), the American Board of Professional Psychology (<http://www.abpp.org/>), and the Academy of Certified Social Workers (<http://www.naswdc.org/credentials/credentials/acsw.asp>) require careful documenting of primary credentials and passing a rigorous examination process before awarding “board certification.” On the other hand, a number of other organizations, including one run out of a private home (M. Hansen, 2000), appear to offer “sheepskins for sale” (Golding, 1999). When in doubt, consumers and professionals alike should look to their professional associations for guidance and eschew credentials that require no solid documentation of clinical competence. Still other groups offer board certification in practice areas that have no meaningful clinical efficacy. For example, the International Board for Regression Therapy issues certificates purporting to document expertise in past-life regression therapy (<http://www.ibrt.org/>), a technique for which no substantive efficacy research exists.

Most professional associations limit citation of degrees in representing oneself to those earned at regionally accredited institutions

or those institutions relied on by state licensing authorities (APA: 5.01c; AAMFT: 9.4–9.5; ACA: C.2 and C.4.). The NASW does not address this directly but demands accuracy in representing one's credentials (4.06.c). While not intrinsically unethical to purchase or hold a phony degree, any misleading or deceptive use of such a degree as to imply competence would clearly qualify as unethical. This includes hanging or posting the degree in a location where a client or member of the public might be mistakenly influenced by it.

CREDENTIALING ISSUES

Credentials presumably exist as a tangible indicator of accomplishment in a given field, with implications for gauging the competence of the holder. In psychology, there are at least three levels of credentials, distinguished by their intrinsic characteristics and the data on the basis of which they are awarded. These have been referred to as primary, secondary, and tertiary credentials (Koocher, 1979). As one moves from the primary toward the tertiary level, one moves further and further away from the data most relevant for predicting potential competence. The need to develop valid measures of entry-level and continued professional competence is widely acknowledged, but the predictive validity of current levels of credentials is highly variable.

Primary Credentials

Primary credentials are those earned over time by direct contact with trained instructors. They are based on longitudinal samples of the practitioner's behavior, with person-to-person supervision and direct observation by senior colleagues. Objective and subjective evaluations of progress are made by multiple evaluators as training progresses in a stepwise fashion. Examples of such credentials include course work, graduate training programs, supervised practica, internships, and specialized postdoctoral training. Such credentials are not generic but rather reflect expertise in the particular matters and activities studied. The outcome measures may include

transcripts of grades, degrees, certificates of completion, or evaluative letters from supervisors or instructors. Typically, the costs of a primary credential (i.e., tuition and time spent in training) are paid before the credential is awarded, and no charges are assessed after completion.

Secondary Credentials

Secondary credentials not only use primary credentials as prerequisites but also incorporate other elements in determining qualifications. Such credentials include statutory licensing and certification, as well as recognition by reputable specialized certification boards (e.g., Academy of Certified Social Workers, the National Board for Certified Counselors, or the American Boards of Professional Psychology). One must first complete the appropriate training and degree programs (i.e., have the appropriate primary credentials) to be considered for a secondary-level credential. Next, some sample of the practitioner's professional behavior is sought. The sample is usually cross-sectional in nature and may consist of a multiple-choice, essay, or oral examination; submission of a work sample; direct observation of a session with a client; or a combination of these. Secondary credentials typically require payment of an application fee, followed by regular renewal charges. Some secondary credentials (e.g., practice licenses in some states) require periodic completion and documentation of continuing professional education or recertification at renewal intervals, but many do not.

Some of the examination models used may be extensive and well representative of the practice domain the practitioner intends to enter, but others have historically demonstrated notorious inappropriateness (Carsten, 1978; Greenberg, 1978). An example of the inappropriate type would include using a multiple-choice pencil-and-paper instrument to predict competence in delivery of psychotherapy, even though no validity data exist to justify such predictions. Another example involved an attempt by the ASPPB to ignore errors in the EPPP and then to block public revelation of

their behavior (Koocher, 1989a, 1989b). The ASPPB now provides substantial information on the development of the instrument (see, e.g., <http://www.asppb.org/publications/pdf/IFC.pdf>), but like most owners of credentialing tests allows no independent oversight. Most early career psychologists have come to view the process of passing the test as a kind of traumatic rite of passage, although data increasingly suggest that pass rates are correlated with degree program quality (Chamberlin, 2014; Ryan & Chan, 1999; Sharpless & Barber, 2013), a phenomenon most likely shared in other mental health fields.

In the absence of detailed knowledge of the candidate's background and behavior over time, the grantors of secondary credentials usually require the approval or endorsement by colleagues chosen by the candidate. In general, secondary credentials place heavy reliance on the honor system, and the credential granted is often generic in nature. This principle holds true across nearly all regulated professions because routine attempts to evaluate and reevaluate professional competence would prove time consuming and costly. Mental health professionals are supposed to recognize, acknowledge, and abide by their limitations (APA: 2; AAMFT: 3, 4; ACA: A.11.a, C2, C4, E2, F; NASW: 2.05.b, 2.10, 3.01–3.02, 4) and should not inadvertently perpetuate images of competence in undeserving individuals.

Tertiary Credentials

Tertiary credentials are distinguished from the other two types by virtue of requiring no behavioral sample, first-person contact, or substantial individual scrutiny intrinsic to the credential itself. Rather, they are based solely on evidence that primary and secondary credentials have been obtained. In a sense, they simply attest to the fact that the professional holds primary and secondary credentials. Membership in certain professional organizations such as APA divisions, state or local professional associations, or listing in the National Register of Health Service Providers in Psychology are examples of tertiary credentials.

In Chapter 11, we discuss the listing of various credentials in advertising or presentations of oneself in a professional manner to the public. We also suggest that the public may not necessarily understand the meaning or underpinnings of certain credentials, and that these credentials may sound more impressive than is justified. Certainly, in terms of content validity, criterion-related validity, or predictive validity for which professional competence is at issue, tertiary credentials are relatively worthless, and secondary credentials may be suspect for reasons discussed in the following pages. Primary credentials are the most likely to provide predictive validity regarding a practitioner's competence, as long as they are accurately represented and understood by the holder. How does this become an ethics issue? Consider the following case:

Case 2–19: Narcissa Script, Ph.D., served as a field placement supervisor for the Central States School of Professional Psychology and, as such, held the title of adjunct assistant professor at the school. Her role consisted of volunteering 2 hours per week of supervision. She was also listed in the National Register of Health Service Providers in Psychology by virtue of her degree, state license, and 2 years experience working in a health care setting. Next to her diplomas and licenses in her waiting room were framed copies of a letter confirming her "faculty" status and a "certificate of inclusion" in the register. She also chose to list those credentials in a published announcement of her practice and on her office letterhead.

Dr. Script's behavior falls in that gray area between the unethical and the acceptable in professional behavior. The uninformed member of the general public has no idea what the register listing signifies and could misinterpret it as constituting some incremental credential or testimony to Dr. Script's competence. The reference to faculty status could also be misleading and represent a deceptive attempt to boost her prestige by implication of a university affiliation that has little or no bearing on her practice. Depending on how she presents these affiliations, Script could be unethically representing

these documents as endorsements or indications of special skills. It would be best not to present these accomplishments and affiliations as practice credentials because they are not.

Licensing

In most states, the mental health practice license is a generic one. In Massachusetts, one can be designated as a “licensed psychologist” or as a “licensed psychologist—health services provider.” In Illinois, one can become a “licensed clinical psychologist.” However, in most states only the title of “psychologist” is licensed. In the application, the candidate may have been asked to specify and document areas of expertise (e.g., clinical psychology, school psychology, industrial consultation, etc.), but there is seldom any monitoring of this specialization after licensing unless a complaint is filed or suspicions are aroused. Some states designate some psychologists as health service providers during the licensing process as a way of identifying those who may bill third parties for mental health services. Similarly, social workers and counselors who hold state licenses will typically have no special qualifications listed, although subcategories may exist as independent practice requirements. Psychiatrists hold licenses to practice medicine as physicians in general, but no special license in mental health practice per se. The range of professions engaged in mental health care, along with the range of degrees and generic licensure, creates a public information problem because many people do not fully grasp the educational or practice differences in the mental health professions. All of the professions expect their members to recognize their own limitations and refer clients they lack the competence to treat to better-qualified colleagues. Clearly, this does not always happen.

Licensing of the professions has rarely originated as a result of public outcry. More often, licensing professionals have sought licensing as a legal means to obtain official recognition by the state, although protection of the public has historically been cited as the paramount rationale. The relationship between licensing and

the competence of practitioners is at best speculative and is based on unverified assumptions. In fact, some commentators have attempted to refute the claim that licensing protects the public and suggests it may even have some potential adverse effects by limiting access to therapists with nontraditional credentials (Danish & Smyer, 1981; Gross, 1978; Hogan, 1977).

Aside from questions of the validity of the examinations on which licensure is based, as noted, Hogan’s (1977) classic treatise demonstrating how, in the case of psychotherapy, licensure has failed to protect the public adequately has gone effectively unchallenged. Except for the most populous states, licensing boards are often so overworked and underfunded that disciplinary enforcement is nearly impossible except in the most flagrant cases of abuse or misconduct, as we discuss in Chapter 18.

Given the time-consuming task of investigating complaints with due process for the accused while also screening applications, conducting examinations, drafting regulations, and attending to the other duties of the board, little time remains to worry about such idealistic matters as checking the competence of practitioners about whom no complaints have been received. One study examined applications for psychology licensing from all 50 states and the District of Columbia in an effort to determine how boards approached screening applicants and found marked heterogeneity with respect to explicit screening for character and fitness indicators (Johnson, Porter, Campbell, & Kupko, 2005). The investigators found little consensus on what characteristics of applicants should be scrutinized prior to licensure. They recommended a national application for licensing with agreed-on screening questions aimed at differentiating among character and fitness (foundational characteristics) as distinct from impairment and competence, but in the ensuing decade their ideas gained no traction. Such questions would typically involve asking about an applicant’s current or previous licensure, criminal history, prior complaints or investigations, history of mental health problems, and concerns related to education

and training. (See more about licensing in Chapter 18.)

Mobility

Perhaps the greatest single problem with licensing statutes for psychology and some other mental health professions is their variability from state to state (DeLeon & Hinnefeld, 2006; Herman & Sharer, 2013; Kim & VandeCreek, 2003; Rehm & DeMers, 2006; Schaffer & Rodolfa, 2011; Vaughn, 2006). Even states that use the same examination procedure may employ different cutoff scores or have special educational requirements. An individual who is deemed qualified to sit for the licensing examination in one state may be denied entry to the examination in a neighboring state (Herman & Sharer, 2013; Vaughn, 2006). In general, physicians and nurses can move across state lines more easily, although states do vary in the functions allowed to advance practice nurses. The privileges afforded psychologists, social workers, and other master's-level practitioners will vary widely from state to state with respect to qualifications, titles, access to insurance reimbursement, and level of independent practice. The ASPPB has taken steps to improve the situation for psychologists by creating the certificate of professional qualification or CPQ (see DeMers & Jonason, 2006; Jonason, DeMers, Vaughn, & Reaves, 2003; <http://www.asppb.org/mobility/cpq/intro.aspx>). The CPQ serves as a tertiary credential that documents other credentials held and makes it easier for psychologists who qualify to obtain licensing in new jurisdictions.

The importance of understanding mobility as an ethics issue relates to the legality of performing services in a jurisdiction not covered by one's license. Although a licensed practitioner may have the competence necessary to perform a particular service, differing licensing criteria and statutes may preclude performing that service in a different jurisdiction. This set of circumstances illustrates a classic "law-versus-ethics" dilemma. Ethically, you may have the education and skill necessary to

competently perform clinical duties or render a professional service. Yet, if you lack a valid license (i.e., legal authorization) to provide such services in a given jurisdiction, doing so violates law. This presents significant issues for those who plan to practice using telemetry that crosses state lines, as discussed in Chapter 4.

MAINTAINING PERSONAL COMPETENCE

Using the analogy of radioactive decay, one psychologist estimated the half-life of the knowledge acquired by earning a doctoral degree in psychology at about 10–12 years (Dubin, 1972). Current perceived half-lives as assessed in Delphi polls of experts varied from a high of 18.4 years (for psychoanalysis) to a low of 7.6 years (for clinical health psychology), with an overall durability of knowledge estimate across all specialties of 8.7 years (Neimeyer, Taylor, Rozensky, & Cox, 2014; Neimeyer, Taylor, Wear, & Linder-Crow, 2012). That is, after a decade or so, half of what was learned in graduate school has become outdated. Mental health professionals function in the worlds of behavioral science, medicine, and law. As science advances and case law evolves, the pressure builds for us to keep up. In some fields, one must not only keep pace with the march of new knowledge, but also actually strive to stay several steps ahead. For example, one estimate put the half-life of an undergraduate engineering degree at 4 to 5 years (Eriksen, 1998). Even if we agree on a decade-long half-life for mental health practice, how can one retain any modicum of professional competence over a career that spans more than 30 years (Jensen, 1979; Neimeyer et al., 2014)?

A variety of strategies have been advanced to ensure that professionals strive to maintain competence. These include mandated CE, recertification requirements, and professional development models. Most states now require practitioners to complete certain amounts and types of CE course work to maintain a professional license, but many do not. No states and few certifying bodies, however, have yet deemed

it appropriate to require formal reexamination or recertification of license holders or diploma holders. Even those that have done so often allow extensive latitude for delays using grandparent clauses to exempt senior practitioners.

Part of the difficulty in implementing plans to monitor practitioner competence over time originates with a definitional problem. What constitutes a meritorious step toward maintaining one's competence? Is attending a workshop commensurate with teaching one? Is writing an article for a refereed journal a sign of continuing competence? Will taking or retaking a multiple-choice examination prove anything? Before we can address a means of maintaining professional capabilities, we must arrive at criteria that are linked to continuing competence (Jensen, 1979). Professional skills, competently executed on a daily basis, will certainly enhance competence. But, experience *per se* does not immunize one against error. It seems unlikely that a comprehensive solution to the problem of maintaining competence over time will be found in the near term. The most appropriate course of action for mental health professionals is to strive for a constant awareness of their limitations, recognize that these can increase over time after formal training has ended, and seek constructive remedies by both formal and informal means to keep skills current.

Case 2-20: Nardell Slo, Psy.D., conducted a cognitive evaluation of an adult client using the third edition of the WAIS (WAIS-III) a full 4 years after the revised form (WAIS-IV) had been published. When questioned on this point, he noted, "They're about the same, and the new kit priced at \$1,200 is far too expensive."

Case 2-21: I. P. Freely, L.M.H.C., continued to recommend long-term individual psychotherapy for child clients with secondary reactive enuresis, despite substantial evidence that certain behavioral treatments for this problem can be highly effective in a relatively brief time. When this was called to his attention, he seemed surprised and sought information in the professional literature.

Dr. Slo and Mr. Freely are in the same category as the college professor who has not bothered to update course notes in several years (see Chapter 14 for additional material on this topic). Both are delivering substandard service to their clients. Dr. Slo does so with some disturbing and inaccurate rationalizations, while Mr. Freely simply seems ignorant of treatments proven more effective. At least Freely seemed willing to attempt to find out about his area of ignorance, although the apparent apathy (implied by the fact that he did not do so sooner) is worrisome. Dr. Slo's resistance suggests a more serious problem, blending ignorance with arrogance. Clients who rely on the expertise of these practitioners will not receive the most efficient and effective treatments. Even if some new technique (e.g., the behavioral treatment for enuresis) presents problems from Freely's professional and theoretical perspective, he has a responsibility to remain aware of the development and to advise clients of alternative treatments and choices when discussing his recommendations with them.

Continuing Professional Education

As noted previously, many (but not all) professional organizations and licensing require clinicians to participate in CE, both as a means of keeping up to date and as a means of focusing attention on important issues. For example, some states have required all licensees to complete course work related to ethics, domestic violence, multicultural competence, or other important public interest topics. Most CE focuses on helping practitioners keep pace with emerging issues and technologies. Other goals include helping to maintain, develop, and increase professional competencies as a means to improve services (Golding & Gray, 2006). Evaluation usually involves an immediate assessment of participants' degree of satisfaction that the program met the stated goals, chiefly in terms of content (Jameson, Stadler, & Poulton, 2007).

One survey, limited to psychologists in Pennsylvania, found that although 75% of respondents favored mandatory CE, far fewer

would participate if CE credits were not mandatory. Forty-five percent of respondents believed that attendance at CE programs often increases their clinical effectiveness, while 41% reported this as occurring sometimes, and 11% as only rarely (Sharkin & Plageman, 2003). Some might challenge the effectiveness beliefs expressed in the survey, noting that a wide gap can occur between mostly brief didactic presentations and clinical implementation.

Accreditation of CE has raised many concerns, as the different mental health professions vary widely with respect to the rigor imposed on CE sponsors. The APA, as one example, has established standards (APA, 2009) that have been applied to reject awarding credit for some proposed sponsors and on some topics deemed insufficiently rigorous or unrelated to professional competencies in the field. Other standards and best practices exist (e.g., see Golding & Gray, 2006), but not all those offering approved CE across professions do a good job. Many opportunities exist to do “CE lite,” as with online courses that end with a perfunctory open-book quiz on the content.

The bottom line seems to tell us that CE is probably better than doing nothing as a way to encourage maintaining professional competence. At the same time, no research has reported on the effects of CE on the participants’ understanding of the content or their application of it (Jameson et al., 2007).

NEW PRACTICE DOMAINS

Beyond Competence

At times, it may seem reasonable for mental health professionals to stretch in extending their areas of competence, even if doing so demands special arrangements and breaking down old taboos. One such occasion might be termed the “compassionate exemption,” a term occasionally used in drug trials when treatment with an experimental protocol is authorized for a patient in extreme or unique need. Clinicians in rural areas know this problem well (Hargrove, 1986).

Case 2-22: Frederick Focus, Ph.D., was trained primarily in short-term behavioral treatment models. When he and his family moved to a small town in a mountain community, one they found very much suited to their ideal lifestyle, Dr. Focus was not prepared for the severity or chronicity of problems that a few of his clients presented. Some of these people could clearly benefit from longer-term psychotherapy, but the nearest practitioners trained in such models lived almost 200 miles away.

Will counseling from a therapist who lacks sufficient background in treating certain problems prove better than no treatment at all? No single correct answer covers all such possible cases, but the undisputed facts are that not all people are helped by therapy, and that some may actually experience harm as a result. Dr. Focus must strive to ensure that he causes no harm. One strategy might involve engaging in a three-step process. First, Dr. Focus must ensure that he fully understands every possible referral resource available in his community. If no appropriate resources exist, Dr. Focus might consider a second step: treating particular clients with ongoing, supportive consultation from a distance with a colleague who does have the proper competencies. We would quickly underscore that mental health professionals should not stretch too far using this second step, and the consulting colleague can help determine the reasonableness of the approach. Finally, if the discrepancy between the client’s needs and the therapist’s competence is too disparate, then the therapist risks causing more harm than good and should not undertake treatment. In the most recent iteration of its ethics code, the APA recognized this problem and offered specific guidance for practitioners who feel inclined to stretch their competence in emergency or other challenging situations (APA 02: 2.01–2.02; not addressed by AAMFT, ACA, or NASW codes).

Prescription Privileges: Psychology Versus Psychiatry

Perhaps no single issue has stirred more controversy among psychologists and psychiatrists

since the 1990s than the notion of granting some psychologists prescription privileges. Similar controversies have focused on what the American Medical Association has termed nonphysician prescribers (e.g., nurses, pharmacists, and physicians' assistants); however, the arguments reported in favor of the practice among psychologists include the following:

- The majority of psychiatric drug prescribing already originates with nonpsychiatrist providers, such as primary care physicians (Sharfstein, 2006).
- Psychologists practice in many communities lacking psychiatrists.
- Improved care of elderly overmedicated patients in nursing homes would become possible.
- Psychologists already have much of the knowledge and skills necessary to assess behavioral and cognitive changes in a scientific manner.
- Some other categories of nonphysician providers, such as optometrists, podiatrists, nurse practitioners, and even pharmacists, already have prescription privileges.
- Psychologists typically have better training in human psychopathology and psychotherapy at initial licensing than do most psychiatry residents.

Social necessity has proved the most compelling argument in favor of psychologists' entry into this new practice domain (e.g., Riding-Malon & Werth, 2014), followed by effective demonstration projects conducted under military auspices (DeLeon, Sammons, & Sexton, 1995; Sammons, 2013; Sammons, Paige, & Levant, 2003). On the basis of these arguments, the prescription privileges movement by psychologists has advanced significantly. The U.S. territory of Guam legalized prescription privileges for psychologists (under the supervision of physicians), and many programs now exist to train civilian-sector psychologists (Fagan et al., 2004). In March 2002, New Mexico became the first state to provide statutory recognition of prescriptive authority for psychologists, followed by Louisiana in May 2004 and Illinois in 2014.

Opponents of prescription authority within the profession of psychology have asserted that granting prescriptive authority to psychologists would medicalize the discipline at the expense of the more traditional psychotherapies that target the social causes of mental disorders (Albee, 2002). In addition, they have pointed to the need for more science-based course work than is currently taught to psychology students if they are to gain competence in psychopharmacology and have suggested that adding this training to current graduate programs would require dramatic changes in the training model currently in use (Sechrest & Coan, 2002; Tumlin & Klepac, 2014). Finally, added training time and costs have been raised and used as an argument against prescription privileges (Fagan et al., 2004; Olvey, Hogg, & Counts, 2002; Wagner, 2002). Those who oppose prescription privileges have also expressed concern that psychologists who prescribe may experience atrophy of their psychotherapy skills or experience incidences of prescription drug abuse similar to physicians and nurses (Koocher, 2007).

The American Psychiatric Association has argued that psychiatrists use all their training to function as a physician for the whole patient, and psychologists would need full medical school training to do so, adding that the non-physician providers who currently do prescribe at least have medical backgrounds. Such assertions seem hollow considering two facts: First, declining numbers of young American physicians choose psychiatric residencies; second, those who do enter psychiatry focus on psychopharmacology to the relative exclusion of psychotherapy training (Gabbard, 2005; Koocher, 2007; Sharfstein, 2006). Very real concerns exist about the potential economic collapse of psychiatry as a medical specialty.

As with any area of practice, mental health professionals with established competence based on education and training can ethically practice any techniques or treatments legally authorized under their licenses (McGrath, 2012; Riding-Malon & Werth, 2014). As new areas of practice emerge, the ethical practitioner will want to move forward with caution,

informed by and avoiding the errors of others who have previously entered the domain.

THE IMPAIRED PRACTITIONER

When personal problems begin to interfere with professional activities, mental health professionals become a serious danger to clients and sometimes to themselves. Much more has been written about the impaired physician than the impaired psychotherapist, but perhaps that is because physicians' access to drugs makes them a more visible foci of concern. There are many facets to the problem of the impaired practitioner, including consideration of some types of psychological practice as "high-risk" or "burnout-prone" occupations (Freudenberger & Robbins, 1979; Koocher, 1980; Leiter, Bakker, & Maslach, 2014; Maslach, 2001; Schoener, 2013). Another facet is a therapist's failure to recognize when a client is not improving or is deteriorating while in the therapist's care. Most dramatic, however, are the instances when the therapist, by virtue of addiction, emotional disturbance, or other problem-induced inadequacy, begins to harm clients and presents a danger to the public.

While physicians have long had programs to assist and monitor impaired colleagues (Green, Carroll, & Buxton, 1978; Katsavdakis, Gabbard, & Athey, 2004), formal rehabilitation programs for impaired psychologists and other mental health professionals are rare, although not unheard of (Barnett & Hillard, 2001; Igartua, 2000; Laliotis & Grayson, 1985; Larson, 1981). However, increasing attention is being devoted to this problem across the professions (Enochs & Etzbach, 2004; Farber et al., 2005; Hurst et al., 2007; Mearns & Allen, 1991; Sadoff & Sadoff, 1994; Schoener, 2013). Annas (1978) did an excellent job of summarizing the difficulty in handling impaired practitioners. He noted that a conference of physicians agreed that an emotionally impaired airline pilot should be grounded immediately and, before being permitted to fly again, required to submit to carefully monitored treatment until beneficial results are documented. Not surprisingly, a

group of pilots believed that impaired physicians should immediately cease practicing and abstain from practicing permanently unless successfully treated and rehabilitated. Some pilots argued that at least they have copilots present in the cockpit. Given the sad circumstances involving Andreas Lubitz, the mentally impaired copilot who intentionally crashed Germanwings Flight 9525 after locking the pilot out of the cockpit 37 years after Annas's article, it seems that having a copilot is not an unmitigated protection.

Burnout

Burnout is described as a kind of emotional exhaustion resulting from excessive demands on energy, strength, and personal resources in the work setting (Baker, 2003; Maslach, Schaufeli, & Leiter, 2001; Shirom, 2006). Job-related burnout has long been recognized as a factor in the work of mental health professionals (Freudenberger, 1975). Neglecting self-care can result in corrosive consequences for therapists, such as making poor decisions and disrespecting one's clients (Pope & Vasquez, 2005; Schoener, 2013). It may involve a loss of concern for the people one works alongside, as well as a loss of positive feelings, sympathy, and respect for one's clients (Maslach, 2001; Maslach et al., 2001). Important client factors related to staff burnout include the client's prognosis, the degree of personal relevance the client's problems have for the therapist, and the client's reactions to the therapist (Maslach, 2001). Burnout is also especially likely when therapists have little control over work activities, are working too many hours, and are overburdened with administrative tasks (Rupert & Morgan, 2005).

Feelings of powerlessness and emotional loss have long been recognized as causal components of depression (Seligman, 1975) and as powerful components of countertransference stress (Adler & Buie, 1972; Maltsberger & Buie, 1974). These stresses can arouse substantial anger in the therapist. The anger appears to have two distinct components: *aversion* and *malice*. Societal and professional values mediate against direct expressions of malice or sadism

toward one's clients. The aversion component of countertransference stress may prove more subtle and, as a result, more insidious. The therapist may experience aversion in relation to the client both directly and unconsciously. A schedule suddenly becomes "too crowded for an appointment this week." A troubled client who gripes, "I don't need any help," is permitted to withdraw emotionally instead of being engaged in dialogue.

Expressions of burnout are especially likely when the therapist feels helpless with guilt because the client has not made satisfactory progress or continues to manifest signs of difficulty (e.g., suicidal ideation, addiction problems, or coping emotionally with a life-threatening illness). If a therapist's efforts to assert control over his or her own emotional issues and a client's distress fail, perceived helplessness may result (Baker, 2003; Seligman, 1975). Therapists experiencing this reaction no longer believe their actions will have any effect on the outcomes. Both client and therapist may come to feel that they will suffer regardless of their behavior. In such circumstances, a therapist may defend against experiencing strong emotion by becoming detached (Barnett, 2008; Maslach, 2001; Maslach et al., 2001). While some in medicine have traditionally suggested that a style of "detached concern" constitutes an appropriate means of relating to clients (Lief & Fox, 1963), clear dangers are inherent in this type of response. Clients may experience such detachment as a lack of caring or unresponsiveness with resulting failure to adhere to treatment (Baker, 2003; Barnett, 2008; Koocher, McGrath, & Gudas, 1990; Wolf, Goldfried, & Muran, 2012).

Case 2-23: George Sarcoma, M.S.W., worked as a social worker and psychotherapist at a cancer treatment facility. He had worked at this full-time job for several years and, as a caring and sensitive clinician, made himself available "on call" for extended service hours. Following both the death of a client with whom he felt particularly close and a disruption in his marriage, Mr. Sarcoma's performance began to fall off. He failed to respond to messages from colleagues

and clients, occasionally missed appointments without notice, and became somewhat distanced from his clients. Ultimately, he was fired from his job but went on to perform well at another setting.

Case 2-24: Susan Skipper, Psy.D., worked as an educational psychologist in a large urban public school system. She felt overworked and unappreciated by clients and administrators, who often made unreasonable demands on her time. Dr. Skipper could not set limits on her work situation and began to dread going to work each day. She applied for and got a job in another part of the country and resigned her current position, giving less-than-adequate notice and leaving behind several uncompleted student evaluations.

Mr. Sarcoma and Dr. Skipper both experienced burnout. This occurred as a result of an interaction of their jobs, personal life events, the stressful client problems they dealt with regularly, and a variety of other factors. Any mental health professional who spends most of his or her day listening to the problems of others is a potential victim. Both Sarcoma and Skipper dealt with learned helplessness and depression, and both hurt their clients as a result. Sarcoma's avoidance and detachment may not have yielded identifiable injury to clients; however, it is likely that some suffered as a result. While Dr. Skipper's abrupt departure has elements of vengeful retaliation against her ungrateful employer, it also doubtlessly disadvantaged a number of students.

As with many potential ethical problems, the best way to deal with burnout is through prevention (Leiter & Maslach, 2005). Employers need to remain aware of impending problems among their employees, and mental health professionals who begin to see symptoms of burnout in colleagues or sense it in themselves should take steps toward early intervention (Koocher, 1980). Warning signs of burnout include

- uncharacteristic angry outbursts,
- apathy,
- chronic frustration,
- a sense of depersonalization,
- depression,

- emotional and physical exhaustion,
- hostility,
- feelings of malice or aversion toward patients, and
- reduced productivity or lowered effectiveness at work.

A substantial body of research (Koocher, 1980; Leiter et al., 2014; Leiter & Maslach, 2005; Maslach, 2001; Maslach et al., 2001; Shirom, 2006) has identified many factors that can predispose a person to professional burnout, including

- role ambiguity at work, including vague or inconsistent demands and expectations;
- conflict and tension in the workplace;
- a high level of discrepancy between ideal and real job functions;
- unrealistic preemployment expectations;
- lack of social support at work;
- a perfectionist personality with a strong sense of being externally controlled;
- losses through death or divorce in the family;
- chronic helplessness;
- permeable emotional boundaries;
- substance abuse; and
- overly high expectations for oneself, such as a “savior complex.”

Conversely, factors that can help insulate a person from burnout include

- role clarity,
- positive feedback,
- an enhanced sense of autonomy at work,
- opportunities for rehabilitation from stress at work,
- social support in the workplace,
- personal accomplishment,
- realistic criteria for client outcome, and
- an accurate awareness of personal strengths and weaknesses along with a good sense of internal control.

The Wounded Healer

Cases 2–23 and 2–24 illustrate some of the problems that can occur when therapists begin

to suffer burnout. However, mental health professionals are not immune from more serious emotional problems (Barnett, 2008; Gizara & Forrest, 2004; Guy, Poelstra, & Stark, 1989; Johnson & Barnett, 2012; Keith-Spiegel, 2014), and many do not actively seek assistance (O'Connor, 2001) or recognize the resulting impact on their professional services (Zeddis, 1999; Zerubavel & Wright, 2012). Decision making and other elements of competence may be compromised, thereby putting emotionally distressed professionals at greater risk for engaging in unethical behavior (Good, Khairallah, & Mintz, 2009; Hendricks, Bradley, Brogan, & Brogan, 2009). Almost 70% of the sample in the classic survey conducted by the APA Task Force on Distressed Psychologists reported personal knowledge of therapists experiencing serious emotional difficulties (in VandenBos & Duthie, 1986). In another large-scale survey, almost three quarters of the respondents divulged dealing with personal distress during the previous 3 years, and many of these admitted delivering declining care to clients (Guy et al., 1989).

The concept of self-destructive emotional healers seems paradoxical. However, an elevated risk of suicide for health care professionals is well established (e.g., Agerbo, Gunnell, Bonde, Mortenses, & Nordentoft, 2007; Schernhammer, 2005). Psychologists were not included in these data, but some surveys, despite methodological shortcomings, suggested that suicide rates and suicidal ideation are higher among psychologists than for the general public (Kleespies et al., 2011). Pope and Tabachnick (1994) found that 29% of their national sample of 800 psychologists reported suicidal ideation, and 4% reported having actually attempted suicide. Possible risks include social isolation, depression, impulsivity, underemployment, and access to lethal means (Kleespies et al., 2011; O'Connor, 2001).

While the variety of resulting ethical infractions seems endless, many people, including the mental health professional involved, are harmed in the end. Consider these examples:

Case 2–25: An ethics complaint charged Martha Ottenbee, L.M.F.T., with overbilling clients.

She proved to be an extremely disorganized, absent-minded mental health counselor whose case notes and financial records were often incomprehensible. She appeared totally inept at managing her practice, although she seemed basically good hearted. She responded in a slightly frantic and easily distracted manner when asked to explain her behavior to the ethics committee.

Case 2-26: Kurt Mores, M.S.W., was convicted in state court of “fornication” after a female client complained that she had been emotionally harmed as a result of having sex with him. At an ethics committee hearing, Mr. Mores admitted having had sexual intercourse with a dozen of his female clients over the past few years. He added that extreme pressure within his marriage had caused considerable anxiety, loss of self-esteem, and feelings of sexual inadequacy. He told the committee, referring to his sexual activity with clients, “It was good for them, it was good for me, and I didn’t charge them for that part of the session.” He also expressed the belief that, “It’s okay to ignore the ethical code as long as you think about it carefully first and talk it over with clients.”

Case 2-27: Paul Pious, Ph.D., internationally known as an author in the field of moral development, had developed a major teaching program for application in public schools when his life began to come unglued. He was involved in a stressful divorce and publicly listed in a newspaper as a “tax delinquent.” He found himself becoming increasingly suspicious about the motives of people with which he worked. When a schoolteacher raised objections to his teaching program, Dr. Pious called the school superintendent and reported that the teacher, an openly gay man, had engaged in sexual relationships with high school students. An investigation revealed no support for the allegations, and Dr. Pious acknowledged lying to protect his project. He subsequently sought admission to a mental hospital for treatment.

Case 2-28: Lester Lapse, Ph.D., came before an ethics committee following a complaint that he had plagiarized an entire article from a professional journal and submitted it to another journal, listing himself as the sole author. At the committee hearing, Dr. Lapse appeared despondent. He

described many pressures in his life and admitted that he must have plagiarized the article, although he had no conscious memory of having done so. He actually believed that he had conducted the study himself, even though there was no evidence that he had done so, and the article he submitted was identical, down to two decimal places in the tabular data reported, to the prior publication by another researcher.

Ms. Ottenby’s incompetence in the business end of her practice causes one to wonder what she is like as a therapist. Mr. Mores seemed to have a unique moral outlook, with minimum insight into problems caused by his conduct and few, if any, regrets. Dr. Pious found himself in a desperate situation and adopted a distorted moral standard that permitted him to lie and nearly ruin the career of an innocent party. Dr. Lapse, like Dr. Pious, seems to have had a mental illness defense for his admittedly unethical conduct. Will Mr. Mores’ arrogant attitude justify a harsher sanction than dealt to Drs. Lapse and Pious, who each acknowledged their weaknesses? Should the committee investigating Ms. Ottenby’s slipshod business practices seek to investigate her clinical skills, even though they have not been specifically addressed in the complaint? We address these questions in Chapter 18.

Case 2-29: Two clients nearly died while in treatment with Flip Grando, Ph.D. At an ethics hearing looking into the case, Dr. Grando explained these unfortunate occurrences as the result of “insufficient faith” on the part of the clients. Dr. Grando’s therapy technique involved locking the client in an airtight box for an extended period of time because, Grando explained, he had been given the special power to convert the client’s own carbon dioxide into a healing force for all emotional and physical ailments. Dr. Grando’s whole demeanor suggested a serious emotional disorder.

Case 2-30: Willis C. Driscoll, Ph.D., worked as a well-regarded psychologist in central Ohio. One day in 1991, he left Columbus in a hurry, never returning from lunch to retrieve files or say good-bye. He left behind two daughters and three

sons, relocating to his mother's home in North Carolina. In May 1996, his sister telephoned local North Carolina police from her home in Florida. She was concerned that Dr. Driscoll would not allow her to talk to her mother on the telephone. After obtaining a search warrant, police located the skeletal remains of 96-year-old Mrs. Driscoll behind her locked bedroom door, on the floor, surrounded by trash and rodent droppings. Dr. Driscoll was sent to the Dorothea Dix Hospital in Raleigh for evaluation (Stephens & Somerson, 1996).

Case 2-31: Holli L. Bodner, Ph.D., who had performed competency exams for the court system in two Florida counties, lied about neighbor Jean Pierre Villar's mental health in court documents to convince a judge to commit him to a mental health facility for evaluation. Bodner and Villar had allegedly feuded for a year over issues, including dog droppings and streetlights. Local police were well aware of the dispute. Bodner allegedly told an officer that Villar "was missing the frontal lobes of his brain, had a low IQ, was mixing alcohol with his pain medication . . . (and) was abusing his wife and daughter."

Two deputies armed with a judge's order to take Villar into custody arrived at his home. Villar, rehabilitating from spinal surgery following an injury suffered while doing construction work and wearing a back brace, answered the door. He allegedly suffered injuries when the deputies grabbed his arms and bent him over after he refused to get in the car while screaming and crying.

Bodner pleaded no contest to perjury for lying on the commitment papers. She was sentenced to 10 weekends in jail and 6 months probation. The Florida Board of Psychology disciplined Bodner, leaving her license active on probationary status. She paid a \$150,000 settlement to Villar as compensation for pain, mental anguish, and humiliation (Scarella, 2006).

As too often proves the case among troubled professionals, Dr. Bodner continued to run afoul of professional ethics. In January 2012, she was arrested for allegedly smuggling oxycodone and lorazepam in her bra and passing the drugs

to an inmate while visiting the Sarasota County Jail (Schelle, 2012). According to state records available online, she voluntarily relinquished her psychology license in August 2012, noting problems of marijuana and opiate dependence, major depressive disorder, attention deficit disorder, and chronic pain.

Will Dr. Grando eventually cause a person's death? If Dr. Driscoll ever resumes practice, will clients who know his history feel comfortable with him? Have we heard the end of Dr. Bodner's adventures? Certainly, no single remedy or rehabilitation plan will apply across all of these cases. Ask yourself: Should one even bother to try to rehabilitate the professionals mentioned? Is mental illness a proper defense against a charge of ethical misconduct?

These complex questions demand additional data before we can frame an adequate answer, but such complexities lie at the very nature of these complaints. In general, we would agree that rehabilitation ought to be the paramount goal, except when the behavior itself is sufficiently objectionable to warrant more strictly punitive action. Mental illness is certainly an issue that mental health ethics experts will want to consider, but it does not justify ethical misconduct. Many mental health professionals with serious emotional problems are able to seek treatment without committing ethical misconduct. An interesting paper on the claim of mental illness as a defense by lawyers, brought before the bar association on charges of misconduct, suggested similar reasoning (Skoler & Klein, 1979). We conclude that while bar association discipline committees and courts will consider mental illness as a mitigating factor, it will seldom be a fully adequate protection (Barnett, 2008; Katsavdakis et al., 2004; Skoler & Klein, 1979).

We observed that the impaired mental health practitioner is most typically a professionally isolated individual. This fact suggests that those therapists who strive to maintain regular professional interactions with colleagues may prove less susceptible to burnout and decompensation or may simply have such problems called to their attention constructively

prior to committing serious ethical infractions. Of course, it is also possible that some therapists become marginalized or rejected by their colleagues because they are emotionally impaired, thus forcing them into professional isolation. (See Chapter 8 for more on the risks attending professional isolation.)

Mental health professionals who recognize problems with their behavior and who seem committed to addressing them constructively certainly will be more likely to successfully rehabilitate than those who do not. At the same time, one must exercise caution when broadening an ethics inquiry to include aspects of therapists' lives not in question.

Case 2-32: A licensing board received a complaint against Knotty C. Kret, M.D., from a former client, who accused Dr. Kret of improper billing practices. In the complaint document, the client added a comment that he had witnessed Dr. Kret from a distance cavorting at a local club where like-minded people gather for anonymous sexual encounters.

In this instance, the licensing board investigated the billing complaint while appropriately ignoring the allegation regarding aspects of Dr. Kret's life unrelated to any complaint of professional misconduct. However, if an ethics inquiry uncovers signs of personal impairment or mental illness, a broadened inquiry may prove necessary in the public interest. This becomes particularly important if the therapist asserts emotional problems as a defense. Such a claim might imply the presence of impairments that could adversely affect other clients.

The ethics codes of most mental health professional organizations mandate the limitation or suspension of services when emotional or physical problems diminish competency. Although judging impairment is a subjective and imperfect process (Williams, Pomerantz, Segrist, & Pettibone, 2010), ethics codes also encourage collegial intervention when a colleague is suspected of incompetence due to mental illness (APA: 2.06; AAMFT: 3.3; ACA: C.2.d, C2g; NASW: 2.10, 4.05).

Yet, the question remains: How impaired is too impaired? Such a decision may involve a subjective and imperfect process (Williams et al., 2010). Furthermore, it is unclear whether therapists experiencing personal difficulties are capable of being forthcoming when assessing their own competence (Zeddes, 1999; Zerubavel & Wright, 2012).

It is not often that therapists will spontaneously recognize the fact that personal distresses are impaired in ways that affect their professional competence (Zeddes, 1999; Zerubavel & Wright, 2012). It is even more infrequent that therapists will be willing to make these judgment errors public. A rare and sensitive paper by Kovacs (1974) traced such events and their consequences for him and one particular client. It is certainly worth reading to better understand the subtle encroachments of poor judgment in eroding a therapeutic relationship. Here is a brief selection from Kovacs's introductory statement:

The central notion which I choose to affirm and which shall illuminate these remarks is that the style of the calling of a psychotherapist cannot be separated from the great themes of his own existence. We delude ourselves often that our task consists of our merely executing a set of well learned techniques in the service of our patients' needs. I now know that this formulation is nonsense. What we do with our patients—whether we do so deviously and cunningly or overtly and brashly—is to affirm our own identities in the struggle with their struggles. We use them, for better or worse, to secure precious nourishments, to preserve our sanity, to make our lives possible, and to reassure ourselves in the face of that inefable dread that lurks always beyond the margins of our awareness and can be heard as a very quiet electric hum emanating from the depths of our souls when everything is silent. (p. 376)

An important potential remedy for the troubled colleague might involve the formation of support networks through professional associations at the state and local levels. Such groups might offer consultation and referral to colleagues willing to treat disturbed peers. Mutual

support groups for mental health professionals working in particularly stressful settings are another possibility, as are the checklists or guides to the warning signs of professional burnout presented previously. (See also an extended list of “red flags” in Chapter 17.)

THE CLIENT WHO DOES NOT IMPROVE

The APA ethical code clearly indicates that a psychologist should seek to terminate a relationship with a client when it is evident that the client no longer needs services or has ceased to benefit (APA: 10.10a; ACA: A.11.c; NASW: 1.16.a). This may involve transferring the client to another practitioner who may be able to treat the client more effectively, or it may mean simply advising the client that services are no longer needed. Consider the following cases:

Case 2–33: Ida Demeanor had been in psychotherapy with Manny Continua, Psy.D., every week for 6 years. Ida had successfully dealt with the issues that first brought her to treatment but had become dependent on her sessions with Dr. Continua. While there had been no real change in Ms. Demeanor’s emotional status for at least 4 years (aside from the increasing attachment to him), Dr. Continua made little effort to move toward termination. His philosophy was, “If the client thinks she needs to see me, then she does.”

Dr. Continua had a conceptualization of treatment that suggests the potential for endless psychotherapy. While it is not possible to state categorically that diminishing returns begin at a certain point or that all treatment beyond X sessions is useless, Continua may well be mistreating his client. He may have fostered her dependency and actually perpetuated her “need” for treatment. Ideally, he should evaluate his work with her critically from time to time and refer her for a consultation with another therapist if he has doubts about the necessity for continued treatment. This assumes that he does not have an emotional (or financial) blind spot that prevents him from recognizing her situation.

Case 2–34: Nemo Creep initially entered psychotherapy with Harold Narrow, L.M.H.C., for treatment of his growing anger at his employer. It became evident to Mr. Narrow that Mr. Creep was becoming increasingly paranoid and troubled. Narrow tried to suggest hospitalization to Creep several times, but each time Creep refused to consider the idea. Narrow continued to treat him and ultimately became the object of Creep’s paranoid anger.

Mr. Narrow failed to recognize that a case was beyond his capability to treat. When it became clear that Mr. Creep needed more intensive (i.e., inpatient) treatment but was refusing to consider it, Mr. Narrow could have taken a number of steps to help Creep. One such step would have been to decline to further treat Creep unless he would seek appropriate care for himself. If Creep’s behavior presented a danger or warranted a commitment for involuntary hospitalization, Mr. Narrow would be responsible for considering those options.

Case 2–35: Ivan Snidely, Ph.D., is an industrial/organizational psychologist hired to assist a major corporation improve employee morale and reduce product defects in a large factory. According to effectiveness data Snidely collected himself, it was evident that his efforts were not meeting with success. Nonetheless, he chose to ignore the data, tell the company that a longer trial period was needed, and continue to supply the ineffective services at a high fee for several additional months before the company canceled its contract with him.

Dr. Snidely may be greedy or simply blind to his own inadequacy for the task at hand, but there is no excuse for his ignoring the data. If he had no alternative plan, he should not have continued to provide services that he knew to be ineffective. The failure to reassess treatment plans in the face of continued client problems and the failure of the intervention are inexcusable (Knapp & Gavazzi, 2011).

WHAT TO DO

- Heed standards of practice or guidelines issued by professional associations to guide competent practice behaviors.
- All mental health practitioners should base their practices on conservatively assessed indicia of competence and legally authorized practice domains.
- Those administering training programs should recognize and balance dual sets of responsibilities, one set of duties to their students and another set to the public that will be studied, counseled, or otherwise served by their graduates.
- Provide students with timely evaluations of their developing competence and status.
- Develop a formal evaluation system for trainees with routine means of feedback, progress assessment, and appeal.
- Remain mindful of the potential for burnout or exhaustion in certain types of job settings and seek help when needed.

WHAT TO WATCH FOR

- Many specialty practice areas or unusual techniques require expertise for which no generally accepted practice criteria exist. In those situations, consult with experienced practitioners familiar with the specialty or technique to assess appropriate levels of training before using such interventions.
- No comprehensive consensus exists on course work or training ingredients for all types of degrees in psychology and other mental health disciplines. The holders of many types of degrees may have the skills and qualifications needed by clients. Ultimately, however, it is each mental health professional's personal responsibility to ensure that she or he is practicing within the range of activity appropriate to her or his training.
- Remain alert and counsel colleagues who are distressed as needed to avoid causing difficulty, inconvenience, or harm to the clients they serve.

- If personal distress, illness, or other impairments arise and bear on your ability to perform work with competence and responsibility, refrain from practicing. If in doubt, consult with colleagues.

WHAT NOT TO DO

- Many institutions or organizations exist that grant degrees of a questionable or totally bogus nature. Ethical professionals should not associate themselves with such institutions and should not behave in any way that implies that the credentials granted by such programs suggest competence in the field.
- Generic licensing laws and the variety of valid earned degrees held by people licensed as mental health practitioners in various states present the potential for considerable ambiguity. Ethical professionals should not behave in ways that their credentials and experience have not prepared them for and should answer consumer questions frankly, honestly, and with appropriate factual information.
- Students or practitioners with limited licenses may well have the competence to perform a number of sophisticated professional functions, but they should not seek to skirt or avoid statutes and professional standards.
- Do not simply continue to treat clients who do not show progress or seem to be worsening despite your best interventions. Seek consultation or appropriate means to terminate the ineffective relationship.

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3

Psychotherapy I

Ethical Obligations of Psychotherapists

Neurotic means he is not as sensible as I am, and psychotic means that he is even worse than my brother-in-law.

Karl Menninger

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WHAT IS PSYCHOTHERAPY AND HOW DOES IT WORK?

Ask any mental health professional about the ethics of their work, and they tend to become philosophers. Writing on the ethics of their craft, psychotherapists have referred to the practice of therapy as a science (Karasu, 1980); an art (Bugenthal, 1987); a source of honest and nonjudgmental feedback (Kaschak, 1978);

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the systematic use of a human relationship for therapeutic purposes (Bugenthal, 1987); and a means of exploring one's "ultimate values" (Kanoti, 1971). Less-flattering descriptions from within the profession include "a house of cards" (Dawes, 1994); the purchase of friendship (Schofield, 1964); a means of social control (Hook, 2003; Hurvitz, 1973); tradecraft (Blau, 1987); and even "a potentially difficult, embarrassing, and overall risky enterprise ... [that

can] induce fear and avoidance in some individuals" (Kushner & Sher, 1989, p. 256). Our personal favorite definition of psychotherapy came from the secretary for the proceedings of the historic Boulder conference on the training of psychologists, who satirically noted (Lehner, 1952): "We have left therapy as an undefined technique which is applied to unspecified problems with a nonpredictable outcome. For this technique we recommend rigorous training" (p. 547).

Debate about the worth of psychotherapy or the need to use trained experts to provide it has spanned more than seven decades in the scientific literature (Eysenck, 1952; Freedheim, 1992; Garfield, 1981; Marshall, 1980; Norcross, Beutler, & Levant, 2005; Wampold & Imel, 2015). Challenges to the objective assessment of the worth of psychotherapy began with Freud's assertion that psychoanalysis ought to be exempt from systematic study (Strupp, 1992). As Garfield (1992) noted in reviewing 100 years of development, "Carrying out research on psychotherapy is a complex, difficult, and even controversial activity" (p. 354). Despite some controversy, however, the majority of clients apparently benefit from psychotherapy (Seligman, 1995; Wampold & Imel, 2015).

Public perceptions of the effectiveness of psychotherapy vary widely. One national poll (Goode & Wagner, 1993) revealed that 81% of Americans think that therapy for personal problems would be helpful "sometimes" or "all of the time." The same article suggested that more than 16 million Americans sought mental health treatment that year. However, a national poll in Australia (Jorm et al., 1997) reflected a belief that general medical practitioners (83%) would likely prove more helpful in addressing concerns such as depression than psychiatrists (51%) or psychologists (49%). Respondents to that same study believed many standard psychiatric treatments (e.g., antidepressant and antipsychotic medications, electroconvulsive therapy, admission to a psychiatric ward) could prove more often harmful than helpful, while also believing that some nonstandard treatments (e.g., increased physical or social activity, relaxation and stress management, vitamins,

and special diets) would prove more helpful than medication. A poll of *Consumer Reports* readers confirmed the benefits of psychotherapy in the eyes of the public and ascribed increased benefits to a longer duration of treatment and greater experience of the therapist (Seligman, 1995). More recent polls suggested that nearly 20% of Americans have seen a psychotherapist for treatment, and an equal number have taken medication for depression (Adler, 2006).

Research has also taught us that a powerful placebo effect exists with respect to psychotherapy, meaning that good evidence demonstrates that seemingly inert "agents" or "treatments" may prove to have psychotherapeutic effects (Baskin, Tierney, Minami, & Wampold, 2003; Geers, Weiland, Kosbab, Landry, & Helfer, 2005; O'Leary & Borkovec, 1978; Shapiro & Struening, 1973). Aside from the general practice of psychotherapy, we must also consider placebo effects when considering child therapy (Weisz, McCarty, & Valeri, 2006) and so-called positive psychology interventions (Robitschek & Sperling, 2012; Seligman, Steen, Park, & Peterson, 2005). In addition to a general placebo effect, expectations, anticipated outcomes, and fears related to self-disclosure also play a powerful role in predicting results (Vogel, Wester, Wei, & Boysen, 2005).

From the client's viewpoint, it may matter little whether positive changes or perceived improvements result from newly acquired insights, a caring relationship, restructured cognitions, modified behaviors, abandoned irrational beliefs, expectancies, or a placebo effect. From the ethical standpoint, the central issue remains *client benefit*. If the client improves as a result of the therapist's placebo value, so much the better. If, however, the client fails to improve or his or her condition worsens while under care, the therapist has an ethical obligation to take corrective action (American Psychological Association [APA]: 10.10a; American Association for Marriage and Family Therapy [AAMFT]: 1.9; American Counseling Association [ACA]: A.11.c; National Association of Social Workers [NASW]: 2.06 and 3.06). When the client seems to be deteriorating clinically, consultation with more experienced

colleagues in an effort to find alternative treatment approaches becomes more urgent. Should a client fail to or cease to benefit from treatment, termination of the relationship and an offer to help the client locate alternative sources of assistance would likely be the best course of action.

Considering the therapist's ethical obligations, recognition of a problem in the therapeutic relationship can prove difficult. Once detected, dealing with a sensitive problem can pose many difficulties. *Recognizing, preventing, and remediating problems in the client-therapist relationship form the crux of ethical concern for client welfare in psychotherapy.*

ETHICAL OBLIGATIONS OF PSYCHOTHERAPISTS

In this chapter, we discuss the nature of the treatment contract and the special obligations of the psychotherapist. In Chapter 4, we discuss technique-oriented ethical problems, such as the special difficulties of multiple-client treatment (i.e., group, marital, and family therapy), sex therapy, hypnosis, behavioral approaches, and unproven or fringe therapies.

In a rather angry and overly one-sided volume about the practice of psychotherapy, which even the most favorable reviewers described as showing questionable scholarship "owing to lack of completeness" (Miller, 1995, p. 132) and "occasionally offering firmer negative conclusions than the data warrant" (p. 131), the late Robin Dawes (1994) claimed that we have viewed the psychologist-client relationship as analogous to that of parent and child. Dawes contended that this results in adhering to a "paternalistic ethic" that allegedly "not only resolves problems raised by the professionals' ambivalent feelings toward their clients but advances the profession" (p. 256).

Our actual view of the ethical obligations of mental health professionals does not arise from any sense of paternalism. Rather, it flows from premises of trust and knowledge of intimate secrets. We do not, as Dawes apparently concluded, espouse the view that psychotherapists

position themselves "one up" on their clients as a matter of course. Rather, we believe that clients invest us with a significant degree of confidence when they come seeking help with their most personal concerns. This reliance demands particular safeguards. An airline pilot who takes people where they want to fly, an architect who designs a safe and attractive new home, and the plumber who installs a new toilet in conformity with sanitary codes all exercise a degree of professional expertise to take care of our needs. We rely on these people and trust them to work on our behalf as professionals with special skills. Because the competent psychotherapist has special knowledge and expertise related to understanding human distress, psychopathology, and intervention strategies, a degree of authority accrues, and we must exercise it thoughtfully and collaboratively with the client. We assert that therapists have an *exceptional* responsibility to respect the rights of all clients and to advance their well-being as professional consultants or advisors in partnership with them. This stance should become enabling in every respect, not paternalistic.

The Therapeutic Contract

If a client and therapist expect to form a therapeutic alliance, they must share some basic goals and understandings about their work together. Strupp (1975) noted: "Clients have a right to know what they are buying, and therapists have a responsibility to address this issue explicitly" (p. 39). In warning psychotherapists about how not to fail their clients, Strupp noted three enduring functions of the psychotherapist:

1. The healing function or the alleviation of emotional suffering through understanding, support, and reassurance;
2. An educational function, including promoting growth, insight, and maturation; and
3. A technological function, by which we may apply various techniques to change or modify behavior.

The notion of a client-therapist contract is not new, although attempts to define the parameters

of such contracts did not begin until the late 1970s (Everstine et al., 1980; Hare-Mustin, Marecek, Kaplan, & Liss-Levenson, 1979; Harris & Bennett, 2005; Liss-Levenson, Hare-Mustin, Marecek, & Kaplan, 1980; Sills, 2006). The ethics codes of professional associations and a number of state and federal laws now make it clear that the therapist must inform clients of a number of aspects of the professional relationship at the outset of their work together by addressing informed consent (APA: 3.10; AAMFT: 1.2, 1.12, and 5.2; ACA: A.2 and B.5; NASW: 1.03 and 1.13); the limits of confidentiality (APA: 4.02; AAMFT: 2.2; ACA: B.1.d; NASW: 1.07; Health Insurance Portability and Accountability Act [HIPAA], 1996), relationships with third parties (APA: 3.07; AAMFT: 1.13; ACA: B.2.c, B.3, B.5.c, B.6.g, C.6.b, and E.6.b; NASW: 1.03), and the like.

In general, the notion of contracting dictates that the therapist should assume responsibility to provide clients with the information they need to make their own decisions about therapy. The therapist should be willing to treat the client as any consumer of services has a right to expect. This may include responding to clients' questions about training and experience, attempting to resolve clients' complaints, and even using formal written contracts when indicated (Knapp, Younggren, VandeCreek, Harris, & Martin, 2013). Although many therapists do not use written contracts, some therapists and clients do agree to highly structured written documents outlining their relationship in great detail, particularly in certain legal (e.g., court-ordered therapy) or treatment (e.g., work with substance-abusing or suicidal clients) contexts. We summarize the essential elements of any client–therapist treatment agreement in Box 3–1 from the perspective of the questions clients may have in mind.

Some state laws have mandated various types of consent-to-treatment procedures as part of a therapeutic contract. In one attempt to assess the impact of such a law, Handelsman and his colleagues (Handelsman, Martinez, Geisendorfer, & Jordan, 1995) found that psychotherapists in Colorado obeyed the law but did not necessarily provide ethically desirable

information in a form that clients could readily use. For example, the average readability of the consent forms they reviewed fell at a grade level of 15.7 (i.e., upper-level college), whereas 64% of the forms reached a readability grade of 17 plus. Some states have also placed limits on some psychotherapeutic techniques. For example, on April 17, 2001, then-governor of Colorado Bill Owens signed a bill into law that specifically prohibits the use of "rebirthing" techniques by mental health professionals (Colorado Revised Statutes Section 2, 12-43-222). This action occurred 1 year after a 10-year-old girl died while undergoing such therapy. (A more detailed discussion of such unorthodox techniques appears in Chapter 4.)

The Client's Frame of Reference and the Quest for Empiricism

The key assumption implicit in the contracting process requires the therapist to take account of the client's unique frame of reference and personal psychosocial ecology when deciding whether and how to organize treatment. Therapists unfamiliar with the social, economic, and cultural pressures confronting women, minority group members, and the poor may fail to recognize the contribution of such stresses in creating or exacerbating psychological problems. Conventional psychotherapy training historically emphasizes clients' contributions to their problems, at times neglecting to adequately consider the external forces that help to shape the client's behavior.

Beginning in the late 1990s, a *zeitgeist* focusing on the use of empirical data to validate psychotherapeutic approaches became increasingly prominent. Advocates of this perspective demanded basing clinical practice on robust, primarily research-based evidence. This movement has used various terminology, such as empirically supported treatments (ESTs), empirically supported relationships (ESRs), evidence-based practices (EBPs), and called for the approval of assorted practice guidelines that are focused on diagnostic categories or behavioral symptoms. As several fine collected

Box 3–1 Key Elements of a Therapeutic Contract

Describe the goals of treatment by specifying

- Who is my client (e.g., an individual, a family, a group)?
- What will we be working toward?
- How will the process of therapy go forward?
- How will we work together?
- When and how often will we meet?
- How can we remain in contact between sessions, when necessary?
- How do I relate to clients (or not) via social media?
- What are the client's rights and responsibilities?
- What are the therapist's rights and responsibilities?
- How does the client's legal status bear on the work (e.g., minor status, mandated treatment, etc.)?

Explain what client(s) and therapist can expect regarding

- The process of therapy.
- What risks may accompany treatment.
- Fees, methods of payment, and services covered by third-party payments (or not).
- Treatment techniques to be used.
- Therapist availability and communication modes (e.g., access by telephone or Internet, emergencies, etc.).
- What are the limits of confidentiality?
- What professional records do I keep?
- What state or federal laws govern access to my records?
- What are my personal policies within the statutory options?
- How does this bear on minors or incompetent clients?

works have noted (e.g., Castonguay & Beutler, 2006; Forte, Timmer, & Urquiza, 2014; Norcross, 2011; Norcross et al., 2005; Spirito & Kazak, 2006), some well-researched treatment approaches have proven highly effective in the treatment of some conditions, but many questions remain open, and many challenges continue. Such questions include the following:

- What qualifies as an EBP (e.g., clinical expertise, scientific research, or patient values and preferences)?
- What qualifies as research on which to judge effective practice (e.g., case studies, single-participant design research, qualitative research, effectiveness research, or only randomized clinical trials)?
- Which treatment goals or outcome measures should we use to establish EBP (e.g.,

self-report measures, objective behavioral indices, therapist judgment, external society-driven decisions)?

- Does the use of treatment manuals improve therapy outcomes, and if so, how often (i.e., rarely, sometimes, frequently)?
- How often do research participants and clinical trials adequately represent actual real-world practice?
- What should we actually attempt to validate (e.g., treatment methods, therapists' behavior, therapy relationships, or other variables)?
- Which factors should influence publication, thereby qualifying it as published evidence (e.g., theoretical allegiance, funding source, conventional wisdom, pure-form therapies)?
- Do EBPs produce outcomes superior to non-EBP therapies, and if so, how often?

- How well do EBPs address various dimensions of diversity (e.g., ethnic minority, gender, sexual orientation, disability status)?
- Do efficacious lab-validated treatments readily generalize to clinical practice, and if so, how often?

Consider the following cases:

Case 3-1: Sammy Soggy, age 6, completed toilet training at age 2 but still has occasional bed-wetting “accidents” at night. This nocturnal enuresis seems to have increased in frequency since the birth of a sibling a few months ago. Sammy’s parents have consulted child psychiatrist Seymour Toodoo, M.D. Dr. Toodoo has many years’ experience as a child psychoanalyst and advises the parents that the enuresis most likely represents displaced aggression tied to sibling rivalry. He recommends psychodynamic therapy three times a week to assist Sammy in addressing his tensions related to the new baby.

Dr. Toodoo seems woefully unaware of the significant body of literature documenting the highly beneficial results in treating nocturnal enuresis with brief behavioral interventions (e.g., Friman, 2011; Mellon & McGrath, 2000). Alternatively, he may have theoretical blinders that preclude his recognizing the viability of interventions outside his primary frame of reference. Whatever the reason, failure to attempt state-of-the-art intervention with well-proven efficacy or, at the very least, failure to acknowledge it as a viable alternative to his proposed course of action creates a serious ethical problem.

Case 3-2: Troubled by residual anxiety, sexual assault victim Connie Sensus sought treatment at the Comprehensive Rape Anxiety Program. A newspaper advertisement described the program as having “well-established high success rates.” The counselor told Connie about their special 10-session program with “guaranteed results” and explained that the program’s founder had developed a validated manual-based treatment approach. Connie agreed to try the program. At the end of each session, the counselor asked her

to rate her PLD (personal level of distress) on a 10-point scale of intensity, explaining that she could remain in the treatment program as long as necessary after the 10 sessions ended, free of charge, until her PLD declined to zero as the program’s guarantee. Connie did not find the sessions helpful but felt too unassertive to tell this to the enthusiastic, confidence-exuding counselor. After three sessions with no change and no sense of emotional connection to the counselor, Connie lied. She reported that her PLD had fallen to zero, and that she was done with the treatment.

Connie Sensus had a very unsatisfying treatment experience at the hands of a clinician who seemed bent on applying a formulaic approach to her problems. The difficulty may lie in an attempt to apply a manualized treatment by rote without first investigating the specific needs, desires, and inclinations of the client. Interestingly, Connie’s response to the demand characteristics of the situation led her to exit nonconfrontationally by saying she had improved. The counselor probably chalked her response up as yet another successful outcome.

Another element of ethical practice relative to clients’ frames of reference involves counseling clients from diverse backgrounds by therapists not trained to work with such groups. Factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status all have significant implications for psychotherapeutic work. Many subgroups of society, including women, children, the elderly, people living in institutional care, and some racial or ethnic groups, experience social forces in a manner that may accustom them to having their individual rights to self-determination denied (Liss-Levinson et al., 1980). We discuss cross-cultural issues in more detail in Chapter 5, but consider just one illustration of the degree to which society inculcates troubling and enduring prejudices. The Sue brothers (Sue, 1998, 2003) invited us to consider “Who owns history?” Noting that traditional instruction in American history and even some IQ tests have suggested that “Columbus discovered America,” when the simple fact is

that Columbus was lost when he reached the “New World,” thinking at first that he had found India.

Another concrete example of the critical need for cultural competence in psychotherapy involves the clinical problem posed by suicidal clients. A series of articles in *Science* (Miller, 2006a, 2006b, 2006c; Zonana, 2003) documented the very different ways that depression and suicide risk become manifest in non-Western populations. For example, some Asian and South American groups may express depressive symptoms more frequently as somatic than emotional. In the Chinese language, for example, the tendency to express emotion in terms of physical distress is clearly demonstrated by use of the word for heart in describing symptoms of depression. These commonly include *xinhuang* (“heart panic”), *xinfan* (“heart vexed”), and *xintong* (“heart pain”). Miller also noted that some Asian populations have no religious or moral taboo against suicide, with the net result that it becomes entertained more frequently as a legitimate option. In Western societies, women attempt suicide more often than men, but men succeed more often. In China, successful suicides by women (particularly in rural areas) outnumber those by men. One study reported data suggesting that for 45% of suicides in China, the contemplation time prior to a suicide attempt was 10 minutes or less (Miller, 2006a).

Therapists must remain sensitive to cultural competence issues and to the general reluctance that an emotionally troubled client may have in asking important questions or raising certain needs or concerns. In such cases, the therapist must assess the client’s circumstances carefully and elicit basic information needed to forge a meaningful treatment contract.

Brown (1994) introduced the notion of “empowered consent” as a means of framing what would constitute a genuine and competent informed consent process essential to a therapeutic contract. To provide empowered consent (as opposed to simply informed consent), the therapist considers the quality of information and the manner in which it is presented to maximize the client’s optimal

capacity to consent freely and knowingly to all aspects of the therapy relationship without feeling in any way coerced. The goal of such a process is to reduce the risk that a therapist might unilaterally impose a risky or unwanted intervention on an unwitting client. Consider these illustrations:

Case 3–3: Marsha Young, a recent business school graduate, won a job at a prestigious advertising agency. The office was highly competitive, and she soon developed anxiety attacks and insomnia. At times, she felt as though she were the “token woman” in the organization, and she feared that her work was being scrutinized far more critically than that of recently hired males. She sought a consultation with Jack Chauvinist, Ph.D. Dr. Chauvinist soon concluded that Ms. Young suffered from “penis envy” and was afraid of heterosexual intimacy. He advised her that it was critical for her to address these matters in therapy if she ever hoped to be able to be married and bear a child, thus fulfilling herself as a woman.

Case 3–4: Yochi Tanaka was the eldest son of a proud Japanese family; he was sent off to attend college in the United States at age 17. He had some difficulty adjusting at the large state university and failed midterm exams in three subjects. Mr. Tanaka sought help at the college counseling center and was seen by Hasty Focus, M.A., an intern. Mr. Focus became misled by Tanaka’s excellent command of English, Western-style fashion consciousness, and tendency to nod in seeming assent whenever Focus offered a suggestion or interpretation. Focus failed to recognize the subtle, but stressful, acculturation problems or to detect the growing sense of depression and failure Tanaka was experiencing. Tanaka was apparently unwilling to assert his concerns over the interpretations of the “expert” in an impolite or unseemly fashion. After five sessions and 6 weeks, fearing failure on his final exams and disgrace in the eyes of his family, Tanaka committed suicide.

Case 3–5: Inda Closet had always felt attracted to other women but had dated men from time to time because it was what her parents and society seemed to expect of her. Concerned about sexuality, fearful of social rejection, and wondering

about how to explore her sexual feelings, Ms. Closet built up the courage to consult a psychotherapist and made an appointment with Heda Knowsitall, Ph.D. After taking a brief history, Dr. Knowsitall informed Ms. Closet that she was "definitely heterosexual" because "she had a history of dating men and therefore had instinctual drives toward heterosexuality." Closet was advised to enter behavior therapy to "unlearn" her attraction to women.

All three of these cases suggest degrees of incompetence on the part of the therapist, but our intent here is to show that a more central problem was the ultimate failure to adequately detect and incorporate the client's psychosocial needs into the treatment plan. Dr. Chauvinist seems to have ignored some very real life stresses in Ms. Young's psychological and social ecology. He had little sense of her possible career goals, professional interests, or the pressures she might be feeling. Instead, Chauvinist seemed to be relying on a stereotypic interpretation of her complaint, which may have little relevance to her immediate needs or symptoms. Likewise, Mr. Focus was unaware of the cultural pressures his client felt and the impact of these with respect to the current problem. Focus was deceived in part by Tanaka's head nodding, a cultural response intended as a common courtesy, interpreted by Focus as license to pursue irrelevant goals. Dr. Knowsitall manifested little understanding of lesbian sexuality and was far too glib in offering her unfounded opinions as the primary basis for directing therapy. None of these therapists showed much interest in eliciting specific goals or therapeutic direction from the client, although all would probably claim to have done so.

Another sort of dilemma tied to the client's frame of reference and goals involves a tactic described as the "bait and switch" in psychotherapy (Williams, 1985). This term refers to the unethical tactic sometimes used in retail sales. A department store may advertise a product at substantial savings to lure customers into the store. Once on the scene, a salesperson will attempt to make the specific item on sale seem inferior and encourage the client to purchase

a more expensive model. Williams drew the analogy between this practice and certain types of long-term psychotherapy. He presented the following comments from one of his clients, describing a previous therapist:

My physician was concerned that there might be a psychological cause for my high blood pressure, so he sent me to see a psychotherapist. I was eager to go because I had become desperate for some kind of relief, and the medicine I took had too many bad side effects. Psychotherapy was an approach I hadn't even considered. I walked into the therapist's office for my first session. He greeted me and asked me to sit down, and we sat there looking at each other for a while. Finally, he asked me about my sex life, which I said was fine. We looked at each other some more, then he told me that the time was up. He expected to see me the following week, but I never went back. (p. 112)

In this case, the client had consulted a therapist for help in managing hypertension. The next thing he knew, the topic of discussion was his sex life. In the client's view, the therapist had a certain agenda different from his own and expected the client to buy it without serious questions. If the client explicitly chose to discuss his sex life or any other issues on his own, or if the therapist indicated some connection might exist between the topic and the presenting symptom, there would have been no "switch" and therefore no ethical problem. If the client decided to seek personal growth and exploration through treatment, there would also be no ethical problem. Instead, however, the story implies that the pursuit of this other issue was a unilateral and never-discussed decision of the therapist, possibly intended to extend the duration of contact with the client. Perhaps this particular approach was therapeutically indicated and perhaps not. Regardless, the rationale should have been discussed openly with the client.

Williams (1985) noted that diverse psychotherapy systems, including psychoanalysis and Gestalt therapy, incorporate rationales for such bait-and-switch tactics (e.g., "the problem is really unconscious, and the patient is unaware

of the real meanings,” or “anybody who goes to a therapist has something up his sleeve”). However, a theoretical rationale does not make use of the technique ethical. It is clearly possible to retain one’s theoretical integrity in any psychotherapy system and still call on the client for active participation in setting goals and doing the work of treatment.

Case 3–6: Mary Slick, Psy.D., advertised a special “assessment package” and “short-term treatment option” at a relatively inexpensive rate for children with behavior problems. One consumer complained that when she took her child for the appointment, she was encouraged to purchase the more expensive “complete assessment battery” rather than the less-costly one advertised.

Dr. Slick’s behavior in this case seems more obviously unethical than the situation described by Williams (1985). Dr. Slick advertised an attractive price and then attempted to switch the client to a more expensive arrangement after she arrived at the office. Slick’s inclusion of a treatment option as part of an assessment package also sounds suspiciously as though she has preordained the existence of a problem requiring such intervention.

Conflicting Values in Psychotherapy

What about the situation in which the goals and values of the client and therapist are at variance or the result of treatment may be more than the client bargained for? One of the most fundamental dilemmas related to therapy goals is whether to encourage a client to rebel against a repressive environment or attempt to adjust to it (Emiliussen & Wagoner, 2013; Karasu, 1980; Kocet & Herlihy, 2014; Proctor, 2014). Issues related to abortion choice, sexual preference, religion, and family values are among the potential conflict areas. The therapist must assume responsibility for avoiding the imposition of personal values on the client.

Case 3–7: Arnold Polite, age 14, is referred to Frank Facilit, Psy.D., out of concern that he is becoming increasingly depressed and socially

withdrawn. Dr. Facilit finds Arnold to be somewhat inhibited by the close, and at times intrusive, ministrations of his parents while Arnold struggles to develop a sense of adolescent autonomy. Over several months, Facilit sees good progress in his work with Arnold, but then he begins to receive telephone calls from Mr. and Mrs. Polite, who express concern that Arnold is becoming too assertive and too interested in people and activities apart from the family. They express the fear that Facilit’s work with Arnold will alienate him from the family.

In this instance, the progress of the client toward more developmentally appropriate behavior alters his relationship with his parents, and they may not care for the new behavior. As we discuss in this section, the best interests of one client may well be antithetical to the best interests of a coclient or close family members. Perhaps Dr. Facilit can work toward some accommodation by means of a family conference or similar approach, but the possibility exists that this will not prove satisfactory.

Case 3–8: Sam Escape, age 23, moved from Boston to Chicago and entered psychotherapy with Sidney Silento, Ph.D. Shortly thereafter, Mr. Escape terminated contact with his family in Boston. His parents and an uncle, a psychiatrist, contacted an ethics committee to complain that Dr. Silento would not respond to inquiries about the location or welfare of the young man. Because Mr. Escape was an adult, the committee was reluctant to become involved; however, it seemed to the committee members that the family was at least entitled to a response to their unanswered letters and phone calls. Dr. Silento ignored three letters from the committee and was then sent a letter from the committee’s legal counsel threatening him with sanctions for failure to respond to a duly constituted ethics panel. At that point, Dr. Silento replied apologetically, noting that he was preoccupied with his day-to-day therapeutic efforts and had a poor correspondence filing system. He reported that Mr. Escape sought to establish himself as an autonomous adult in Chicago and did not wish to contact his family or to authorize contacts by Dr. Silento.

In this situation, Dr. Silento had not behaved unethically for failing to give information to the family, although he certainly could have responded to them with that fact rather than simply ignoring their calls and letters. His excuse for failing to respond to the ethics committee over several months constituted another matter. His procrastination only dragged out the case and exacerbated the family's considerable anxiety, while costing the professional association a substantial sum in staff time and legal fees needed to evoke a simple explanation. The extent to which treatment with Dr. Silento contributed to Escape's decision to avoid family contacts remained unclear, although Escape stood well within his rights to do so. Dr. Silento did have a legitimate obligation to respect that decision, even if he felt sympathy for the family.

Case 3–9: Helena Sistine, M.D., a psychiatrist and a conservative Christian, holds deep traditional values. She works in the counseling center of a state university. Carl Quandary came in for an initial appointment and wanted to discuss the anxiety he has experienced over several homosexual contacts he had during the prior 6 months. Mr. Quandary reported, “I don’t know what I’m supposed to be. I want to try and figure it out.” Dr. Sistine realized that her own feelings of opposition to homosexuality would make it difficult for her to work with Quandary objectively, especially if he should decide to continue having sexual relationships with other men. She listened carefully to his concerns and explained that she planned to refer him to a colleague at the counseling service who had particular experience helping clients with similar issues.

Dr. Sistine recognized her potential value conflict with Quandary’s need to make important life decisions according to his own values. In addition, she realized that she lacked familiarity with the life experiences and issues with which he struggled. She also recognized Quandary’s highly vulnerable emotional state, so she did not expose her value system to him and did not attempt to engage him in a therapeutic dialogue. Instead, she collected the information

needed to make an appropriate referral and presented the referral to the client in a positive manner to minimize the risk of his feeling rejected or abandoned. (In Chapter 4, we address controversies associated with so-called reparative psychotherapies as these might apply in Cases 3–5 and 3–9.)

The key to an ethical response in any treatment involving matters laden with social, political, or religious significance includes conducting a careful assessment and offering an intervention that has proven efficacy and meets the preferences and needs of the client, apart from any preordained biases of the therapist.

Consent for Treatment

We discuss matters of informed consent and the right to refuse participation at many points in this book, especially in relation to confidentiality (Chapter 6) and participation in research (Chapter 16). From the client’s frame of reference, however, consent issues in the context of psychotherapy may feel quite different. Psychotherapy unavoidably affects important belief systems and social relationships. Consider, for example, the case study of Mary, a Christian Scientist with a socially reinforced obsessive disorder (Cohen & Smith, 1976). In a discussion of the ethics of informed consent in this case, Mary clearly experienced some sense of divided loyalties about her religious practices as a result of psychotherapy. Coyne (1976) noted “even the simplest intervention may have important repercussions for the client’s belief system and social relationships” (p. 1015).

The consent-getting process for mental health professionals should generally involve a discussion with clients of goals, expectations, procedures, and potential risks (Barnett, Zimmerman, & Walfish, 2014; Becker-Blease & Freyd, 2006; Everstine et al., 1980; Hare-Mustin et al., 1979; Knapp et al., 2013; Vogel & Wester, 2003). (The need to disclose the limits of confidentiality in particular is discussed in Chapter 6.) Clients might also reasonably expect warning about other foreseeable as well as unforeseen effects of treatment. Obviously, no therapist can anticipate every potential

indirect effect, but a client who presents with marital complaints, for example, might change behavior or make decisions that could drastically alter the dynamics of the relationship for better or worse. Likewise, a client who presents with job-related complaints might choose to change employment as a result of therapy. Such cautions seem particularly warranted when the client has many inadequately addressed issues and the therapist suspects that uncovering these concerns (e.g., long-repressed anger) might lead to distressing feelings.

Consider the married adult who enters individual psychotherapy hoping to overcome individual and interpersonal problems and to enhance the marriage. What if the result leads to a decision by one partner to dissolve the marriage?

Case 3–10: Tanya Wifely enters psychotherapy with Nina Peutic, L.M.F.T., complaining of depression, feelings of inadequacy, and an unsatisfactory sexual relationship with her spouse. As treatment progresses, Ms. Wifely becomes more self-assured, less depressed, and more active in initiating sexual activity at home. Her husband feels ambivalent regarding the changes and the increased sense of autonomy he sees in his wife. He begins to believe that she is observing and evaluating him during sexual relations, which leads him to become uncomfortable and increasingly frustrated. He begins to pressure his wife to terminate therapy and complains to an ethics committee when she instead decides to separate from him.

We certainly do not have sufficient information to comprehend all of the psychodynamics operating in this couple's relationship, but treatment did change it. Perhaps Ms. Wifely experiences the change as one for the better. She certainly has the right to choose to separate from her spouse and continue in treatment. On the basis of these facts, we cannot conclude that Ms. Peutic did anything unethical. However, we do not know whether Ms. Peutic ever informed Ms. Wifely that her obligation as a therapist was to Wifely's mental and emotional health, not to the marriage. We must wonder whether the outcome might have been different had Ms. Peutic warned Ms. Wifely that changes

could occur in the marriage as a result of her individual therapy.

The Right to Refuse Treatment

A client who does not like the specifications and risk–benefit statement offered by the therapist can generally decide not to seek treatment or to seek alternative care. Some clients do not have such a choice. These clients may include patients confined in mental hospitals and minors brought for treatment by their parents or guardians. We discuss some ethical issues related to special work settings (e.g., schools, the military, and correctional institutions) in Chapter 15. However, therapists should take pains to recognize and respect the rights and preferences of clients regarding the conduct and goals of psychotherapy, particularly when the client has noteworthy vulnerabilities (e.g., those associated with institutional confinement).

In the landmark case *O'Connor v. Donaldson* (1975), the U.S. Supreme Court recognized for the first time a constitutional basis for a “right to treatment” for the nondangerous mentally ill patient. Mr. Donaldson suffered from schizophrenia, and his father sought to have him committed for psychiatric care. Once in the hospital, Mr. Donaldson declined somatic treatments based on his Christian Science religious beliefs. He remained confined for refusing medication, despite the fact that he posed no danger to himself or others. No verbal or behavioral therapies were offered. The court ruling essentially held that the state could not confine such patients without providing treatment. Yet, what if the patient does not want the treatment? A host of lawsuits asserting the right of mental patients to refuse treatment, especially those that involve physical interventions (e.g., drugs, psychosurgery, and electroconvulsive shock therapy), have highlighted special ethical problems (Appelbaum & Gutheil, 1980; Lewis, 2014; White & White, 1981; Winick, 1997). In particular, the right of the patient to refuse medication has been described ironically as the “psychiatrist's double bind” (Ford, 1980) and dramatically as the “right to rot” (Appelbaum & Gutheil, 1980).

Until recently, nonphysician psychotherapists have not had legal authorization to employ somatic psychotherapeutic tools (e.g., medication, psychosurgery, and shock therapies) and have therefore not yet become the object of such suits. Nurse practitioners practicing psychotherapy and psychopharmacology and psychologists authorized to prescribe (as discussed in Chapter 4) may soon find themselves the focus of litigation by clients wishing to refuse medications, as happened to Dr. O'Connor, the psychiatrist in *O'Connor v. Donaldson*. However, a pair of more recent federal court cases provides an intricately complex set of legal and ethical issues.

Case 3-11: Charles Sell, D.D.S., practiced as a dentist in Missouri and had a troubled emotional history. In September 1982, after telling doctors that the gold he used for fillings had been contaminated by communists, Sell was hospitalized, treated with antipsychotic medication, and discharged.

In June 1984, he called the police to report a leopard was outside his office boarding a bus, and he then asked the police to shoot him (i.e., Dr. Sell). On other occasions, he complained that public officials, a state governor and the police chief, were trying to kill him.

In April 1997, he told law enforcement personnel that he "spoke to God last night," and that "God told me every person I kill, a soul will be saved."

In May 1997, the U.S. government charged Sell with Medicaid, insurance, and mail fraud, alleging he had submitted multiple false claims. A judge ordered a psychiatric examination and found Sell "currently competent" but noted that Sell might experience "a psychotic episode" in the future. The judge released Sell on bail. A grand jury later indicted Sell and his wife on numerous counts of mail fraud, Medicaid fraud, and money laundering.

In early 1998, the government claimed that Sell had sought to intimidate a witness. During a bail revocation hearing, Sell's behavior at his initial appearance was, in the judge's words, "totally out of control," involving "screaming and shouting," the use of "personal insults" and

"racial epithets," and spitting "in the judge's face." The judge revoked Sell's bail.

In April 1998, the grand jury issued a new indictment charging Sell with attempting to murder the agent from the Federal Bureau of Investigation who had arrested him and a former employee who planned to testify against him in the fraud case.

In early 1999, the court sent Sell to the U.S. Medical Center for Federal Prisoners at Springfield, Missouri, for examination. Subsequently, the judge found that Sell was "mentally incompetent to stand trial." He ordered Sell "hospitalized for treatment" at the medical center for up to 4 months "to determine whether there was a substantial probability that [Sell] would attain the capacity to allow his trial to proceed."

Two months later, medical center staff recommended that Sell take antipsychotic medication. Sell refused to do so. The staff sought permission to administer the medication against Sell's will.

The U.S. Supreme Court ruled by a 6–3 majority that the government may involuntarily administer antipsychotic medications to a mentally ill criminal defendant to render the defendant competent to stand trial, "but only if the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the fairness of the trial and, taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests." The court clarified that (a) in determining whether the government has an important interest in bringing a defendant to trial, a trial court must consider whether the defendant will be civilly committed or has already been detained for a lengthy period; (b) the government must show that the medication is substantially likely to render the defendant competent to stand trial; (c) the court must find that no alternative, less-intrusive approach is likely to achieve substantially the same result of restoring a defendant to competency; and (d) the particular medication must be in the patient's best interest, taking into account both efficacy and side effects (*Sell v. United States*, 2003). Based on this ruling, mental

health professionals will want to give careful consideration to the role that forced medication may play in the lives of very troubled clients who become involved with the legal system (Heilbrun & Kramer, 2005).

Case 3-12: Nancy Hargrave had a long history of paranoid schizophrenia and multiple admissions to the Vermont State Hospital. During a period of emotional stability, when not hospitalized, Ms. Hargrave completed an advance directive in the form of a durable power of attorney (DPOA) for health care. The document designated a substitute decision maker in case she again became incompetent by reason of psychosis. The DPOA specified that she wished to refuse "any and all anti-psychotic, neuroleptic, psychotropic, or psychoactive medications" should she ever again be involuntarily committed.

The state legislature subsequently passed Act 114, a 1998 Vermont statute that attempted to address a dilemma inherent in such psychiatric advance directives. Although intended to facilitate patients' participation in treatment decisions, such DPOAs have the potential to prevent all treatment, even of patients who are ill enough to qualify for civil commitment under dangerousness standards. The statute allowed hospital (or prison) personnel to seek court permission to treat incompetent involuntarily committed patients, notwithstanding any advance directives to the contrary. Ms. Hargrave believed that the new law violated her rights under the Americans With Disabilities Act.

The U.S. District Court and the Second Circuit Court of Appeals agreed, failing to find any of these state's contentions persuasive. With regard to claims that Hargrave and other involuntarily committed patients constitute a direct threat, the three-judge panel noted that not all committed patients would pose a threat to others, as required under the Americans With Disabilities Act, because many became hospitalized only for danger to themselves. Even people found to be dangerous to others at the time of commitment, the court held, could not still be presumed dangerous when seeking to override their advance directives. Hence, the

court concluded that the statute violated the Americans With Disabilities Act and enjoined its enforcement (Appelbaum, 2004).

One predictable development on the basis of cases finding a right to refuse medication and other somatic treatments is an increased demand for nonmedical approaches to the treatment of psychological disorders. There are instances in which institutionalized clients have asserted a right to refuse psychological treatment not involving somatic approaches, but these have generally been technique related (e.g., behavior modification and aversive therapies) and are discussed in Chapter 4.

Obtaining consent for treatment from a minor presents another set of issues (Fried & Fisher, 2014; Koocher & Keith-Spiegel, 1990; Melton, Koocher, & Saks, 1983; Molin & Palmer, 2005; Parekh, 2007; Pinnock & Crosthwaite, 2005; Potter, 2004). Although a small number of states (e.g., the Commonwealth of Virginia) permit minors to consent to psychotherapy independently of their parents, such authority represents an exception to the norm. In some states, such services could conceivably be provided as adjuncts to a minor's right to seek, without parental consent, birth control or treatment for sexually transmitted diseases or substance abuse. Usually, however, a parent's permission would be needed to undertake psychotherapy with a minor client (Koocher, 1995, 2003). If a child wishes to refuse treatment authorized by a parent, there will most likely be no legal recourse, even if the proposed treatment involves inpatient confinement (Koocher, 2003; Melton et al., 1983; Weithorn, 1987, 2006). The courts have tended to assume that the mental health professional called on to hospitalize or treat the child at the parent's behest is an unbiased third party who can adequately assess what is best for the child (*J. L. v. Parham*, 1976; *Parham v. J. R.*, 1979). Some mental health professionals have argued that the best interests of parents are not necessarily those of children, and that mental health professionals are not always able to function in the idealized unbiased third-party role imagined by the court (Koocher, 1983; Melton et al., 1983; Weithorn, 1987, 2006).

Case 3–13: Jackie Fled, age 13, walked into the Downtown Mental Health Center and asked to talk to someone. Jackie was seen by Amos Goodheart, Ph.D., and told him of many personal and family problems, including severe physical abuse at home. Jackie asked Dr. Goodheart not to discuss the case with “anyone, especially my folks.” Dr. Goodheart discusses his options with Jackie, explaining that he cannot offer treatment to anyone under 18 years of age without parental consent. Goodheart also discusses his duty to report suspected child abuse to the state’s Department of Child Welfare. Jackie feels betrayed.

Some decisions are too difficult or complex for children to make independently (Fried & Fisher, 2014; Koocher, 2003). While some children under age 18 may be competent to consent to treatment in the intellectual and emotional sense, it is also evident that many are not (Grisso & Vierling, 1978). Dr. Goodheart recognized two important legal obligations and an additional ethical obligation. First, he recognized that he could not legally accept Jackie’s request as a competent informed consent for treatment with all that it implies (including responsibility to pay for services), although it did not occur to him to provide Jackie with a careful explanation about the limits of confidentiality from the start of their session, as required under HIPAA (Health Insurance Portability and Accountability Act, 1996). Second, he recognized his obligation to report the case to authorities duly constituted to handle child abuse complaints. This is a statutory obligation in all states, although it certainly would have been less than professionally responsible had he sent Jackie home to additional potential abuse and done nothing. Finally, he recognized Jackie’s rights as a person and a client, taking the time to discuss his intended course of action with Jackie, thereby showing considerable respect for the child.

SPECIAL OBLIGATIONS OF THE THERAPIST

At this point, it may seem that we have already discussed many obligations of mental health

professionals to their clients. However, there are three special types of obligation that deserve highlighting: respect for the client, even the difficult or obnoxious client; duties owed to clients who make threats; and the obligation to terminate a relationship when it is clear that the client is not benefiting. These are common factors related to ethical complaints. That is, few clients complain to ethics committees about a psychologist’s failure to obtain treatment consent or adequately consider their cultural value system. However, many complaints grow out of cases related to particularly difficult clients or the failure to terminate a nonbeneficial relationship or treatment that has “gone wrong” (APA: 10.10a; AAMFT: 1.9; ACA: A.11.c; NASW: 2.06 and 3.06).

The Exceptionally Difficult Client

The definition of the exceptionally difficult type of client, however, is a relative one because the client who may prove difficult for one therapist could be another’s forte. However, some types of clients would be considered difficult by virtually any therapist. These include the client who makes frequent suicidal threats, who is intimidating or dangerous, who fails to show for appointments or fails to pay bills, who is actively decompensating and acting out, who is overly dependent and telephones with urgent concerns at all hours of the day and night, or who harasses the therapist’s family.

Therapists may experience a range of uncomfortable feelings brought on by clients’ abrasive verbal comments or inappropriate behavior (Knapp & Gavazzi, 2011; Wolf, Goldfried, & Muran, 2012), and these are not necessarily countertransference artifacts (Bongar, Markey, & Peterson, 1991). Sometimes, the fit is mismatched; Personalities and deeply held values may clash (Baker, 2009), and if the therapist cannot manage his or her own responses, a sensitively formulated referral should be proposed to avoid possible harms all around. The next case, adapted from Keith-Spiegel (2014), reveals the possible peril when therapists try to stifle their feelings toward a difficult client.

Case 3-14: Sandy Bag, Ph.D., dreaded the appointments of his demanding and flamboyant client, who insulted him regularly for not understanding what she was trying to get across. He could feel himself tense up as her therapy hour approached and felt a strong feeling of relief when she left, usually spelling out his shortcomings as a therapist on her way out the door. By the ninth session, Dr. Bag could no longer control his own feelings. When the client said, "I think you need to go back to school to learn more about psychotherapy," he shouted, "I think you need to go to hell. Get out of my office!"

Despite Dr. Bag's efforts to excuse his behavior to an ethics committee, he was found guilty of incompetent management of this particular client. Just because a client is irritating does not absolve the responsibility to treat her with respect. In a survey by Pope and Tabachnick (1993), the majority of clinicians admitted feeling anger toward their clients for being verbally abusive, uncooperative, or overly demanding. A third of the respondents admitted feeling hatred toward a client, and almost half admitted responding in a way they later regretted (Pope & Tabachnick, 1993).

A client may be experienced as difficult only because the therapist is not sufficiently qualified to recognize or treat certain types of emotional disorders, as the next case illustrates.

Case 3-15: Robert Bumble, L.M.H.C., began treating a troubled young woman in an office at his home. Mr. Bumble failed to recognize signs of increasing paranoid decompensation in his client until she began to act out destructively in his office. At that point, he attempted to refer her elsewhere, but she reacted with increased paranoia and rage. Mr. Bumble terminated the relationship, or so he thought. The ex-client took an apartment across the street from his home to spy on him, telephoned him at all hours of the day and night with an assortment of complaints and explicit threats, and filed several ethical complaints against him.

Mr. Bumble failed to realize that his client was beyond his ability to treat until matters had seriously deteriorated. When he finally

recognized that the case had gone awry, there was little he could do. Although many of the client's bizarre accusations proved unfounded, it was evident to the committee that Bumble had been practicing beyond his level of competence and, as a result, had contributed to the client's problems. Bumble ultimately had to seek police protection and obtain a court restraining order in an effort to stop his ex-client's intrusive harassment. Bumble also learned a lesson about a potential downside to using an office in one's home.

Case 3-16: An ethics committee received a long, handwritten letter from Anna Crock, an anguished client of a public agency, complaining that Ira Brash, Ph.D., the supervisor of her therapist, had treated her in an unprofessional manner, creating considerable stress and depression. The therapist was a psychology intern who was apparently having severe difficulties with Ms. Crock and had asked her to attend a joint meeting with Dr. Brash. Crock had seen the intern for 14 sessions but had never met the supervisor. She complained that during the joint session that Dr. Brash was extremely confrontational. The committee wrote to Dr. Brash asking for his account of these events. Brash gave a clinical description of Ms. Crock's "negative transference" to the intern. Ms. Crock allegedly treated the intern in a hostile manner, calling him "stupid" and "a know-nothing." He indicated that the joint meeting was an attempt to "work through" the problem. He stated that the use of confrontational tactics was an effort to get Ms. Crock to release some feelings. He stated that he had to leave the joint meeting early and alleged that after his departure the intern berated Ms. Crock for her abusive behavior during the joint meeting and abruptly terminated her. Dr. Brash attempted to remedy this later in another meeting with Ms. Crock, in which, by her account, "He was a completely different person." However, she was still quite angry.

The case of Ms. Crock, Dr. Brash, and the intern has a number of troubling elements. To begin, Ms. Crock thought that treatment had gone well for 14 weeks, whereas the intern and his supervisor believed that treatment was

progressing poorly. Dr. Brash's attempt to handle a complicated clinical problem in a single session, which he had to leave prematurely, showed questionable judgment. His use of a confrontational style with Crock in the absence of a therapeutic contract, alliance, or even minimal rapport also seemed questionable in the ethics committee's view. The committee also chastised Dr. Brash for attempting to shift some of the responsibility for the premature termination to the intern. As the supervisor, Brash could not escape ultimate responsibility. Poor communication, a difficult client, an attempt to move too quickly in therapy, and a botched termination all combined in a manner that left the client feeling angry and hurt.

In working with challenging clients, it is essential that therapists remain cognizant of their professional and personal limitations as discussed in Chapter 2. This means knowing enough not to take on clients that one is not adequately prepared to treat or knowing enough to help clients in need of different services to find these services early in the relationship rather than waiting until problems develop. Some types of clients seem especially likely to evoke troubling feelings in therapists. The client who is verbally abusive or sarcastic or does not speak very much during the session can certainly generate a number of unpleasant feelings on the therapist's part. Also, remember that therapists have no obligation to take on all comers. Habitual substance abusers, pedophiles, individuals with borderline personality disorders, people involved with legal proceedings, and individuals with histories of violence can easily demand levels of special expertise that many therapists may not possess. When a therapist feels personally or professionally unprepared to take on a client, a prompt referral elsewhere will usually prove the best course of action.

There is nothing unethical about refusing to treat a client who stirs up troubling feelings or anger in the therapist. In fact, it is probably more appropriate to refer such clients than to try to treat them while struggling with strong countertransference. On the other hand, it is important to minimize the risk and discomfort to all clients. One should therefore learn

to identify those sorts of clients one cannot or should not work with and refer them appropriately and quickly without causing them personal uneasiness or stress.

Case 3-17: Jack Fury was an angry 15-year-old referred to Harold Packing, M.D., for displaying antisocial behavior, including school vandalism. After the fourth session, while Dr. Packing was in an appointment with the next client, they smelled smoke and discovered that a fire had been set in the waiting room. The fire was put out, and Dr. Packing called Jack and his parents in for a meeting. Jack acknowledged setting the fire. When Packing expressed concern that he could have been killed in the blaze, Jack replied, "Everybody's got to go some time."

Dr. Packing felt so angry at Jack Fury's fire setting and subsequent indifference that he was unwilling to continue treating him. Whereas some therapists might have agreed to continue working with Jack, Dr. Packing was not. Presumably, he would be willing to refer the family elsewhere, giving the new therapist an appropriate warning about Jack's behavior. Packing recognized these feelings and dealt with them promptly. Psychotherapists have no ethical obligation to continue treating clients when threatened or otherwise endangered by that client or another person with whom the client has a relationship (APA: 10.10b; AAMFT: 1.1-3, 3.3; ACA: A.11.c; NASW: 1.16). After all, one can hardly devote full professional attention to such clients with threats or danger looming.

Case 3-18: Serena Still contacted Patience McGraw, M.S.W., seeking psychotherapy as a means to overcome her shyness and difficulty in establishing new relationships. The sessions were characterized by long periods of silence. Ms. McGraw found herself unable to draw Ms. Still into conversation aside from the most superficial pleasantries. She tried several different approaches, including asking Ms. Still to write down her thoughts about events between sessions, but Ms. Still remained taciturn and uncommunicative. After four such sessions, Ms. McGraw

suggested that perhaps she should attempt to help Ms. Still find a therapist with whom she could communicate better, or that they should discontinue sessions until Ms. Still had some issues she wished to discuss.

Ms. McGraw had a somewhat different problem. Her client's stated problem was shyness, and this seems the manifest symptom the client did not feel able to address in treatment sessions. Ms. McGraw's best efforts to engage the client were fruitless, and she felt somewhat frustrated. Certainly, she should raise the problem directly with Ms. Still and explore alternatives (e.g., a different therapist or a break in the treatment program), but she should do this as gently as possible given the likelihood that this is a source of probable anxiety for the client. We address the matter of the client who is not benefiting from treatment in a separate section. We raise the problem of Ms. Still to underscore therapists' common tendency to become angry by a client's lack of participation, resulting in a failure to be fully sensitive to the client's fears.

Yet another type of difficult client is the one whose behavior or problems tend to interact with the psychological conflicts of the therapist to cause special countertransference situations.

Case 3–19: Buffie Storm sought a consultation from Van Helsing, Psy.D., shortly following her divorce. Dr. Helsing was also recently divorced, although he did not mention this to Ms. Storm. Her presenting complaint was that she had difficulty controlling her rage toward her ex-spouse. As Dr. Helsing listened to her vindictive attacks on her ex-husband, he found himself tensing considerably and continually biting his lip. Minutes later, Ms. Storm screamed and fled out of the office. She wrote to an ethics committee, complaining that Dr. Helsing was a vampire. The committee feared that they were dealing with a very disturbed complainant, but contacted Dr. Helsing, asking if he could provide any explanation for her perception.

Dr. Helsing recounted essentially the same story, noting he had unconsciously bitten his lip to the point that it began to bleed. He had not realized it until after Ms. Storm had left,

when he looked in a mirror and saw the trickle of blood that ran from his lip to his shirt collar.

Aside from the unfortunate stress the incident caused Ms. Storm, the scene might have been laughable. The point here is that therapists must strive for sufficient self-awareness to recognize their anger toward clients and make every effort to avoid acting out or otherwise harming the client unnecessarily. There are many appropriate ways to handle anger toward a client, ranging from direct overt expression (e.g., "I am annoyed that you kicked that hole in my office wall and am going to charge you the cost of repairing it") to silent self-exploration (e.g., the client who stirs up countertransference feelings because of similarities to some "significant other" in the therapist's life). The therapist should always consider the client vulnerable to harm and avoid using the power position inherent in the therapist role to the client's detriment. When such problems occur more than rarely in a therapist's career, it is likely that one is practicing beyond the scope of personal competence or has a personal problem that needs attention.

The most difficult sort of client a psychotherapist can encounter is one who not only presents a clinical challenge but also presents issues that resonate heavily with personal concerns of the therapist.

Case 3–20: Ralph Redneck, a 15-year-old high school sophomore, has sought treatment in response to feelings of inadequacy and embarrassment about his lack of athletic ability and late pubertal development. A good therapeutic alliance has formed, and Ralph is working effectively on these sensitive issues. As he has felt more comfortable in therapy, Ralph has begun to evidence a considerable amount of racial and ethnic prejudice. He often criticizes some of his classmates as "niggers" or "Jew bastards." Ralph is unaware that his "White" therapist is Jewish and married to a person of color.

The case of Ralph Redneck focuses clearly on the clash of client and therapist values. Should the therapist offer self-disclosure in an effort to provoke some enlightened attitude change on Ralph's part? After all, Ralph

clearly did not seek psychotherapy to improve his racial sensitivity. In such cases, the therapist should make every effort to maintain clear personal boundaries and focus treatment on the issues raised by the client. Should Ralph discover that his prejudices apply to the therapist, it would then be appropriate to discuss them as one would any aspect of the therapeutic relationship. Self-disclosure and initiation of such a discussion by the therapist, however, would constitute an inappropriate intrusion into Ralph's ongoing treatment because Ralph does not (at least initially) experience his biases as problems. Attempting to call his attention to these prejudices could place additional emotional stress on Ralph while not addressing the problems he presented in requesting help.

A more difficult question is whether Ralph's therapist can maintain an adequately empathic relationship or whether negative countertransference and conscious anger will begin to compromise treatment. This is a question that therapists must ask themselves frequently when clients present values conflicting with those of the therapist, but unrelated to the foci of treatment. In such circumstances, the most appropriate course of action for the therapist would involve seeking guidance or perhaps therapeutic consultation from a colleague to assess the legitimate therapeutic needs of the client as distinct from their own. The therapist's issues should never become the client's problems.

Case 3-21: Two weeks prior to his scheduled appearance before the state parole board, Mickey Malevolent telephoned Charlene Choice, M.S.W., from prison. Mr. Malevolent explained that he was in the eighth year of a 20-year criminal sentence for child rape and ritualized sexual abuse of children and was now eligible to apply for an early release from prison. He explained that his case before the parole board would be helped if he could line up a psychotherapist to work with him after release. Mr. Malevolent noted that he was innocent of all wrongdoing, despite his conviction, but had been "framed" and "railroaded" by the parents of several "oversexed kids" and a legal system biased against his satanic religious beliefs. He went on to say that he really did not need therapy but just

wanted to show the authorities that he knew "how to play their game." When Ms. Choice declined to take him as a client, Mr. Malevolent filed an ethics complaint, claiming that Ms. Choice had unreasonably discriminated against him by not accepting him as a potential client or offering him a referral to another practitioner.

Ms. Choice found herself confronted with a self-referral from an individual whose conduct and belief system she found despicable. She had no ethical obligation to take any particular new client who called for an appointment. She was free to turn down any such referral without giving a reason. In addition, she had ample reason to believe that Mr. Malevolent was not truly seeking treatment but rather was seeking to manipulate the parole system. By his own statements, Mr. Malevolent presented himself as an individual unlikely to make appropriate use of psychotherapy and who may be at high risk to offend again. In addition, she had no ethical or professional obligation to Mr. Malevolent and need not assist him locating another therapist. In fact, she might be doing a disservice to colleagues were she to pass their names on to Mr. Malevolent, who might mistakenly assume that her referral was a recommendation that they agree to work with him.

When a Client Threatens

The worst thing the therapist can do when a client becomes threatening is nothing. Do not assume that the threats will stop or go away spontaneously. All threats or acts of violence by clients should be taken seriously. Such threats should trigger a reassessment of the patient, the diagnosis, and the treatment plan. Violence may escalate over time, and verbal threats may progress to actions. Pay special attention to the client's history with respect to violence or acting out. But remember, although prior violence may be a predictor of future violence, there was always a first time. Make it clear to patients who verbally abuse or threaten that such behavior is unacceptable and could lead to termination of the relationship. Document all threats, your responses, and the rationales for your responses

in your clinical record (Bongar & Sullivan, 2013; VandeCreek, 2005; VandeCreek & Knapp, 2000). Duties to warn and protect third parties are discussed in Chapter 6, but the same action principles apply whether the threat is made to the therapist or to others.

Clients who threaten are often overwhelmed by personal or family distress. Many have serious mental illness in addition to difficulty with impulse control, problems with anger control, or a history of antisocial behavior (Bongar & Sullivan, 2013; Deffenbacher, 1994). Be mindful of the potential danger when taking on such clients and be certain you are reasonably qualified to handle what may come up (Blau, 1987; Botkin & Nietzel, 1987). When conducting intake interviews with new or prospective clients, be sure to ask about difficulties in these areas (Knapp et al., 2013). Consider asking, "What is the most violent or destructive thing you have ever done?"

When threats occur, obtain consultation on the case as soon as practical from your attorney and senior colleagues. Do not wait until an event occurs to hunt for such consultants. Draw up a list of names and telephone numbers of potential consultants and keep it available. State psychological associations will often prove especially helpful in referring colleagues to attorneys in their geographic area who are familiar with psychological practice issues. Review your treatment plan and revise it to take into account the new developments. Consider a hierarchy of responses from least intrusive to more confrontational, keeping the safety of yourself and others in mind. Be certain that you are not alone in the office area or at a remote location when meeting with the potentially violent client. If working in an institution, notify security personnel. When threats or actions occur outside the office, contact the police. If work with the client is to continue, set clear rules regarding threatening behavior and consider increasing the frequency of sessions with a focus on rage and fear themes (Blau, 1987; VandeCreek, 2005; Knapp et al., 2013). Clinical competence, good diagnostic skills, an understanding of the confidentiality issues involved (see Chapter 6), and careful advance planning are the best preventive measures.

Sometimes, there is simply not much that a therapist can do to avoid becoming the victim of an angry client:

Case 3-22: Bertha Blitz had intermittently failed to keep or cancel several appointments with her psychotherapist, Vic Tem, Psy.D. After several warnings, Dr. Tem informed Ms. Blitz that he would have to begin charging a fee for missed sessions not properly canceled in advance, as specified in the written billing policies she had received at the start of therapy. Blitz missed the next session without canceling, and during the subsequent kept appointment Dr. Tem reminded her that there would be a fee for the missed appointment. Ms. Blitz said that she had used the time to go to a smoking cessation group as Dr. Tem had urged her to do. Dr. Tem replied that he approved of her participation in the group but that did not make up for her failure to cancel their appointment. Ms. Blitz became angry, asked how much she owed for the missed session, wrote out a check, slammed it on the therapist's desk, and stormed out of the office. When Dr. Tem left the office 2 hours later, he found over 100 hammer dents in the hood and roof of his car. He had no proof that Ms. Blitz was responsible but was strongly suspicious.

In this instance, Dr. Tem can do nothing without evidence. At the same time, however, it appears that he may have missed an opportunity to deal with Ms. Blitz's anger in the office. We will never know whether direct efforts to engage her in conversation about her feelings of not being treated fairly might have prevented the mysterious automobile damage. (See also Chapter 17 for information on decision making in difficult circumstances.)

Failure to Terminate a Client Who Is Not Benefiting

Termination when treatment is no longer beneficial was discussed in Chapter 2 but warrants additional comment with respect to psychotherapy (APA: 10.10a; AAMFT: 1.9; ACA: A.11.c; NASW: 2.06 and 3.06). Ethical problems related to the duration of treatment fall in this category. In the previous case examples, we

discussed premature termination. But, what of the client who, by virtue of fostered dependency or other means, is encouraged to remain “in treatment” past the point of actual benefit? Such judgments are complicated by varying theoretical orientations. Some therapists would argue, “If you think you need therapy, then you probably do.” Others might argue, “If you are sure you don’t need it, then you definitely do.”

We recognize such biases in many of our colleagues and could choose two of them on opposite ends of the continuum for a test. A person might be selected at random and sent to each for a consultation. One would predictably find the person basically well adjusted, whereas the other would probably find the same person in need of treatment. A casual observer might presume that one or the other is unethical, either for suggesting treatment when none is needed or for dismissing a person prematurely who is in need of help, but neither situation is necessarily the case. If the therapist presents the client with the reasons why treatment is or is not needed and proposes a specific goal-directed plan (Hare-Mustin et al., 1979; Knapp et al., 2013), the client is in a position to make an informed choice. The therapist who sees emotional health may do so in the absence of symptoms, while the therapist recommending treatment may sense some unconscious issues or potential for improved functioning. These views can and ought to be shared with the client.

Ethical problems arise if the therapist attempts to play on the client’s fears, insecurities, or dependencies as a basis for initiating or continuing unnecessary treatment. Consider these examples:

Case 3–23: Solo Funk has been quarreling with his spouse about relationships with in-laws and decides to consult a psychotherapist, Tyrone Mull, L.M.H.C. A half-dozen sessions later, Mr. Funk believes that he has acquired some new insights into matters that upset him and some new ways of handling them. He is arguing less with his wife, thanks to Mr. Mull, and states his intent to terminate treatment. Mull acknowledges that progress has been made but reminds Funk of many sources of stress in his past that have “not been fully worked through,” hinting darkly that problems may recur.

Mr. Funk believes that he has gotten something out of psychotherapy, but Mr. Mull’s remark suddenly leaves him feeling somewhat anxious. Has he really made progress? Will he experience a “pathological regression” if he drops treatment now? Will his marriage deteriorate? Mr. Mull seems to be using his powerful position (i.e., as an expert) to hint that additional treatment is needed. This seems at variance with Funk’s desires, but instead of outlining the basis of his impression and suggesting an alternative contract, Mull stirs Funk’s insecurities in a diffuse and unethical manner.

Case 3–24: Brenda Schmooze has been in psychotherapy with Vivian Vain, Psy.D., for nearly 5 years. At the beginning of treatment, Ms. Schmooze was very unhappy with the hostile-dependent relationship she had developed with her intrusive mother. Schmooze had long since resolved those problems and was living independently, working in an office, and coping well in a general sense, although she remained an emotionally needy and lonely person. Her therapy sessions with Dr. Vain have generally entailed discussions of her activities, mixed with praise for Dr. Vain’s help. There has been little change in Schmooze’s social or emotional status for nearly 2 years.

Ms. Schmooze and Dr. Vain seem to have established a symbiotic relationship. Schmooze has acquired an attentive ear and Vain an admiring client. Some might say, “What’s wrong with that if it’s what Schmooze wants? She’s an adult and free to make her own choice.” Unfortunately, it seems that Dr. Vain may have replaced Ms. Schmooze’s mother as a dependency object. Schmooze may not be able to recognize this, but Dr. Vain ought to recognize what is going on. It might be that the intense relationship with Dr. Vain is preventing Ms. Schmooze from forming more adaptive friendships outside treatment, for which she would not be paying a fee. If Vain does not find treatment issues to raise and work on with Ms. Schmooze, she is ethically obligated to help the client work toward termination.

From time to time, legitimate doubts will arise regarding a client’s therapeutic needs. When this occurs, the client and therapist

should discuss the issues, and the client should probably be referred for a consultation with another mental health professional. This procedure is also often useful when a client and therapist disagree on other major treatment issues.

Case 3–25: Ernest Angst had been in treatment with Donald Duration, M.D., intermittently over a 3-year period. Angst had many long-standing neurotic conflicts with which he struggled ambivalently. He began to wonder aloud in his sessions with Dr. Duration if therapy was doing him any good at all. Angst acknowledged that he wanted to work on his conflicts but had mixed feelings about them. He expressed the thought that perhaps someone else could be of more help to him. Dr. Duration interpreted these comments as a means of avoiding other issues in treatment but suggested that Angst should get a second opinion. He provided Angst with the names of several well-trained professionals in the community. Angst selected one and saw him for two sessions. Both client and consultant decided that Angst should continue trying to address the difficult conflicts he felt with Dr. Duration, who knew him well and could help focus the work better than could a new therapist.

In this case, the client raised a legitimate issue, and the therapist had a contrary opinion. The therapist suggested a consultation in a nondefensive manner and assisted the client in obtaining it. In the end, the client returned to treatment with renewed motivation and reassured trust in his therapist. Just as with the other cases in this chapter, the focus rests on the ethical fundamentals of the therapeutic relationship and the role of the therapist. The next chapter explores how specific strategies and tactics interact with professional ethics.

WHAT TO DO

- From the start of the professional relationship, seek to reach explicit understandings with clients regarding the terms of the treatment contract, whether formal or informal. This includes some mutual discussion about the goals of treatment and the means to achieve these goals.

- Therapists should strive to recognize their feelings with respect to each client as well as the degree to which these feelings may interfere with therapy.
- Update treatment plans as circumstances change with the client's full participation.

WHAT TO WATCH FOR

- Carefully consider the unique needs and perspective of each client in formulating therapeutic plans. This includes special attention to issues of diversity, particularly race and social class issues relevant to the client.
- Therapists' personal beliefs, values, and attributes may limit their ability to treat certain types of clients. They should strive for awareness of such characteristics and limit their practices appropriately.
- In certain circumstances, clients have specific legal rights either to receive or to refuse treatment. Therapists should remain aware of these rights and respect the underlying principles, even when no specific laws are in force.

WHAT NOT TO DO

- Therapists have no obligation to treat any and all clients who walk through their doors. If you do not feel competent to treat the client, or have discomforts, biases, or concerns that might compromise care, refer the potential client elsewhere in a respectful professional manner.
- When the client does not seem to be benefiting or the client's behavior is threatening or provocative, do not simply continue treatment as usual. Obtain consultation or consider alternative courses of action promptly.

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4

Psychotherapy II

Ethical Issues in Psychotherapeutic Techniques and Related Controversies

Preliminary investigations further established that the group, like most of the dominant religions on the planet from the same time period, was monotheistic, confining worship to the deity “Talk.”

Miller and Hubble

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The quotation used to introduce this chapter comes from an article reporting the history of the field we know as “psychotherapy” from the perspective of an extraterrestrial archeological survey team (Miller & Hubble, 2004). At the time of the team’s visit to Earth in the distant future, a collision with a comet had long since

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wiped out Earth’s population. The group discovers, however, that the apparent religion known as “Therapy” died out long before the cataclysmic collision. The team posited that one of the primary reasons for the demise of Therapy was that therapists did not adhere to a single doctrine or liturgy. To the contrary, the

practitioners of the religion divided into a large number of sects (known at the time as schools of psychotherapy), each having a unique set of doctrines (referred to as models) and set of rites for worship (known as techniques). In the end, adherents of the mutually exclusive sects died off, maintaining their uniqueness to the end.

THE MOVEMENT TOWARD EVIDENCED-BASED TREATMENTS

Just as Chapter 3 focused on the basic obligations of psychotherapists to all clients, this chapter addresses technique-oriented issues in psychotherapeutic practice. In some sense, this moves us from a consideration of the definition of psychotherapy to a consideration of what sorts of relationships and activities may have psychotherapeutic effects. The strategies and tactics of therapists differ widely across a range of psychological problems and client populations. Some approaches to psychological treatment demand highly specialized training along with competencies and ethical considerations beyond the basic skills required for entry to practice. Certain special client circumstances may also require modification of a therapist's standard operating procedures. Thinking through the ethical dilemmas posed by such variations requires thoughtful planning, creativity, and ethical sensitivity.

As discussed in Chapter 3, the 1990s saw considerable interest in basing medical and mental health practice on a firm evidentiary footing (Institute of Medicine, 2001). As a result, so many different groups began work on assorted treatment guidelines that the American Psychological Association (APA) issued model criteria for evaluating them (APA, 2002). Research and scholarly debate led the APA Division of Clinical Psychology to sponsor a book on empirically supported treatments, *A Guide to Treatments That Work* (Nathan & Gorman, 1998, 2007). A burgeoning literature on so-called empirically supported or empirically based therapy and empirically supported relationships led to the creation of an APA Presidential Task Force and a multitude of

subsequent publications (e.g., Barlow, 2008; Bohart, 2005; Messer, 2004; Norcross, 2011; Norcross, Beutler, & Levant, 2005; Presidential Task Force on Evidence-Based Practice, 2006; Safren, 2005; Spirito & Kazak, 2006). As this book went to press, a search of the PsychInfo database of the professional literature registered more than 15,000 items under the key term "evidence based practice." APA's formal reports and policies appear online at <http://www.apa.org/practice/resources/evidence/index.aspx>.

Other therapists have responded to the search for evidence-based techniques by focusing attention on discredited or so-called psychoquackery (Jacobson, Foxx, & Mulick, 2005; Koocher, Norcross, McMann, & Stout, 2014; Norcross, Koocher, Fala, & Wexler, 2010; Norcross, Koocher, & Garofalo, 2006). Discredited or unproven therapies often appeal to people struggling with difficult-to-treat conditions, when the proposed treatment has some intuitive or face value appeal and the advocacy of charismatic proponents. Others have addressed the issues of therapy techniques based solely on myths and irrational beliefs and why ineffective therapies appear to work (Lilienfeld, Lynn, & Beyerstein, 2010; Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2014). Further in this chapter, we give some examples of untested or fringe therapies.

THERAPIES INVOLVING MULTIPLE CLIENTS

In marital, family, and group therapies, the therapist has more than one client in the session simultaneously. It seems most unlikely that the goals or best interests of every client in the treatment room will fully coincide with those of the others. Especially in marital and family work, the needs or wishes of one member will often prove quite different and at times in direct opposition to those of another (Knauss & Knauss, 2012; Lakin, 1994; Lebow, 2014; Snyder & Doss, 2005; Southern, 2006; Southern, Smith, & Oliver, 2005). Competence needed to conduct couples or group therapies successfully also requires

different techniques and training than that typically required for individual psychotherapies. Such multiple-client therapies raise a host of other ethical issues, including matters of confidentiality and social coercion (Knauss & Knauss, 2012; Lasky & Riva, 2006; Lebow, 2014). In this section, we attempt to highlight some of the most common ethical dilemmas associated with multiple-client therapies.

Marital and Family Therapy

Ethical guidelines dealing with a therapist's responsibility to clients, confidentiality, informed consent, and client rights are certainly ambiguous at times, even when considering the interaction between one therapist and one client (Bass & Quimby, 2006; Gladding & Coombs, 2005; Southern, 2006; Southern et al., 2005). When treatment involves a couple or multiple family members, matters become more complicated. Treatment will often involve a therapeutic obligation to several individuals with conflicting needs (Bass & Quimby, 2006; Gladding & Coombs, 2005; Hare-Mustin, 1979, 1980; Hines & Hare-Mustin, 1978, 1980). Margolin (1982) cited several illustrations of such conflicts. She described the mother who seeks treatment for her child so that he will behave better, which may ease pressure on the mother while not necessarily helping her child. Margolin also cited the case of the wife who seeks to surmount fears of terminating her marriage, whereas her husband's goal focuses on maintaining the status quo. A therapist in such situations must strive to ensure that improvement in the status of one family member does not occur at the expense of another. When such an outcome may be unavoidable (e.g., in the case of the couple whose treatment may result in the decision of one or both partners to seek a divorce), the therapist should advise the couple of that potential outcome early in the course of treatment as part of the consent process (discussed in Chapter 6). In this type of situation, the therapist's personal values and theoretical orientation become critically important (Hare-Mustin, 1979, 1980; Hines & Hare-Mustin, 1980).

Case 4-1: Hugo Home, Psy.D., likes to consider himself a "gentleman of the old school" who holds the door open for women, tips his hat when passing them on the street, and generally behaves quite genially to the "fair sex." In conducting family therapy, however, Dr. Home has a clear bias, favoring the view of women cast in the wife-mother role. He believes that mothers of children under 12 should not work outside the home and frequently asks his female clients who seem depressed or irritable whether it is their "time of the month again." Dr. Home does not recognize how these biases might adversely affect the female partner in marital counseling.

Case 4-2: Ramona Church, L.M.F.T., is a family therapist and devout member of a religious group that eschews divorce under any circumstances. She continues to encourage her clients in marital therapy to work with her, "grow up," and "cease acting-out immature fantasies," even when both partners express a serious consideration of divorce. She will often tell clients who have worked with her for several months that they will have failed in treatment and that she will have no more to do with them if they choose divorce.

Case 4-3: At the initial session of marital therapy, Sarah Wellingood, L.I.C.S.W., asked Ralph and Hope Anna Prayer about their goals in treatment. Both stated a wish to improve their relationship and make their marriage work. It soon became increasingly clear to Ms. Wellingood that the best outcome from Hope's perspective would be to remain in the relationship. While Ralph did not want to hurt Hope, he clearly felt an intense need to escape from the relationship to take his life in a preferred direction. Hope could not seem to read the signals and Ralph was not very direct in expressing his wish for a divorce.

Both Dr. Home and Ms. Church have clear biases and seem either oblivious to their impact or self-righteously assertive of them. They fail to recognize the power and influence they wield as psychotherapists and their accompanying responsibility to clients. Neither should treat couples in marital therapy, at least not without a clear warning from the outset about their biases. Ms. Church's threat to abandon any of

her clients who stray from the personal values she prescribes holds particular danger. The vulnerable and insecure client may experience harm at the hands of such therapists. In addition, Ms. Church's stance essentially threatens client abandonment. Hines and Hare-Mustin (1978) long ago highlighted the "myth of valueless thinking" and enjoined therapists to carefully assess the impact that their own values and stereotypes may have on their work.

Dr. Wellingood has found herself with two clients whose best interests (as the clients see them) diverge. There no way that she can meet the conflicting preferred outcomes. She can help the Prayers to each articulate their needs and wishes more clearly, but she will not likely bring about a change that satisfies both clients. Her inability to obtain a result that will please both is not an ethical issue, but rather a problem of not being able to resolve diametrically opposite goals.

Four decades ago, the APA Task Force on Sex Bias and Sex-Role Stereotyping (APA, 1975) noted that family therapists surveyed at that time had particular vulnerability to certain biases. These included the assumption that remaining in a marriage represents the better adjustment for a woman and a tendency to defer to the husband's needs over those of the wife. The same report noted the tendency to demonstrate less interest in or sensitivity to a woman's career as opposed to a man's and the perpetuation of the belief that child rearing and children's problems fall primarily in the woman's domain. The report also noted that therapists tended to hold a double standard in response to the extramarital affairs of a wife compared to those of a husband. Although we believe social changes and better training of therapists have significantly improved the situation, we must remain aware of the historical problem as an illustrative example and continually maintain sensitivity to such issues.

Several authors have noted a prevailing "therapeutic ideology" holds that all persons can and should benefit from therapy (Hines & Hare-Mustin, 1978). Some family therapists also insist that all members of the family must participate in treatment (Hare-Mustin, 1979,

1980; Margolin et al., 2005; Southern, 2006; Southern et al., 2005). What does this belief system do to a person's right to decline treatment? Must the reluctant adolescent or adult feel pressured into attending sessions at the behest of the psychotherapist? Data suggest children as young as 14 are as competent as adults in making decisions about treatment (Griss & Vierling, 1978; Koocher, 2003), yet it remains unclear how often young family members have a truly voluntary choice.

Case 4-4: Ronald McRigid, M.S.W., a family therapist, was consulted by the Partial family. The Partials have three children ranging in age from 12 to 18. The youngest child had engaged in considerable acting out, including a recent arrest for destroying school property. The juvenile court judge recommended family counseling. Peter Partial, the oldest child, had no interest in participating. However, both parents and the two younger children (including the identified client) did express a willingness to attend sessions. Mr. McRigid informed the Partials that he would not treat them unless everyone attended every session.

While Mr. McRigid may have good clinical or theoretical reasons for his stance, we cannot condone coercion of any reluctant family member to participate in treatment. This does not preclude a therapist's urging that the resistant family member attend at least one trial session or attempting to address the underlying reasons for the refusal. The therapist who strongly believes that the whole family must participate should not use coercion to drag in the reluctant member or permit that reluctant member's refusal to deny treatment to the rest of the family who wish to have it. In such cases, the therapist should at the very least provide the names of other professionals in the community who might willingly treat the subgroup desiring treatment. When the client in question is a minor child, the therapist has a special duty to consider that client's needs as distinct from those of the parents (Koocher, 1976, 2003; Koocher & Keith-Spiegel, 1990; Melton, Koocher, & Saks, 1983).

Confidentiality constitutes yet another issue that complicates marital and family therapy. Should a therapist tolerate secret keeping or participate in it? Should parents be able to sign away a child's right to confidentiality? The concept and conditions of confidentiality are somewhat different in the family context than as discussed in Chapter 6. Often, couples may have difficulty in establishing boundaries and privacy with respect to their own lives and those of their children (Bartlett, 1996; Dishion & Stormshak, 2007; Koocher & Keith-Spiegel, 1990). Adult clients can, and should, have the ability to assert privacy with respect to their marriage and to avoid burdening their children with information that may prove frightening, provocative, or simply beyond their ability to comprehend adequately. On the other hand, many attempts to maintain secrets have a manipulative purpose and do not serve the general goals of treatment.

The most reasonable way to handle this matter ethically would involve formulating a policy based on therapeutic goals and defining that policy to all concerned at the outset of treatment. Some therapists may state at the beginning of therapy that they will keep no secrets. Others may express some willingness to accept information shared in confidence to help the person offering it determine whether it is appropriate for discussion in the whole group. Still another option would involve discussing the resistance to sharing the information with the member in question. That approach might help the person to share the information with the family, if indicated. Secret keeping presents the added burden of recalling which secret came from whom, not to mention the need to recall what was supposed to be kept "secret" and what was not. The therapist who fails to consider and discuss these matters in advance with family clients may make accidental disclosures within a very short time that could have serious ethical fallout.

Group Therapy

Mental health professionals may treat unrelated clients in groups for a variety of reasons,

ranging from simple economy to specialized treatment plans. For example, a group may consist of people with similar problems, such as recently hospitalized mental patients, divorced males, cardiac rehabilitation patients, women with eating disorders, bereaved parents, or children with handicaps. In such groups, the identified clients gather to address similar emotional or social problems in a common supportive context. Other groups may focus on enhancing personal growth or self-awareness, as opposed to addressing personal psychodynamics or psychopathology (Coleman, 2005; Klontz, 2004; Nagy, 2005; Page, 2004; Tkachuk & Martin, 1999). In his classic book on the subject, Carl Rogers (1970) offered a sample listing of group types, including so-called T-groups, encounter groups, sensitivity groups, task-oriented groups, sensory awareness or body awareness groups, organizational development groups, team-building groups, victim groups, perpetrator groups, and Gestalt groups.

Group treatment has considerable potential for both good and harm. The influence and support of peers in the treatment process may facilitate gains that would be slow or unlikely in individual treatment. The group may also become a special therapeutic ecology within which special insights and awareness may develop. At the same time, significant hazards to group members exist when the group leader lacks proper training or the ability to adequately monitor the experience for all members (American Group Psychotherapy Association, 2002). Pressures toward cohesion and emotional expressiveness common in group therapy can be inappropriate for some clients (Lakin, 1994). The group therapist has much less control over the content and direction of the session than does an individual therapist. As a result, a greater potential exists for individuals in the group to have unfavorable or adverse experiences. Problems might include stresses resulting from confrontation, criticism, threats to confidentiality, or even development of dependency on the group (American Group Psychotherapy Association, 2002; Lasky & Riva, 2006). In many ways, then, the risk of harm to individual clients is

greater in group than in individual therapies (Corey, Williams, & Moline, 1995).

Our discussion here focuses on two sets of related issues, the first regarding groups intended as psychotherapy experiences and then on that subset of group programs intended as growth experiences. The term *growth experiences* refers to short-term group programs focusing on individual development or growth rather than psychotherapy or treatment of psychopathology. We use the term *group therapy* to generally discuss treatment for people seeking help in response to specific emotional or psychological symptoms; such treatment usually occurs over a period of months or years rather than days or weeks as in the growth experience programs.

In the 1960s, a plethora of growth-oriented interventions bloomed, and APA issued a one-page “Guidelines for Psychologists Conducting Growth Groups” (APA, 1973), making several important points as mandates for the clinician leader to provide informed consent, ensure that participation is fully voluntary, conduct proper screening of participants, and carefully differentiate roles based on whether the group is intended as therapeutic or educational. These guidelines make it evident that the responsibility for these obligations rests on the therapist leading the group. The more modern American Group Psychotherapy Association (2002) standards address similar responsibilities of the psychotherapist.

The following three cases suggest inadequacies in preparation, screening, orientation, and follow-through by the therapists in question:

Case 4–5: The president of a small manufacturing company became so excited about the insights he acquired in a weekend marathon therapy session conducted by Grover Grouper, Ph.D., that he hired Grouper to run such a session for his executive staff and ordered them all to participate.

Dr. Grouper, in agreeing to conduct the sessions, seems to have overlooked the coercion involved in the company president’s demand that the staff attend. Both the nature and the goals of the group remain unclear. If intended as therapy, the failure to screen

potential participants for appropriateness and the enforced participation (or even voluntary participation) of people who work together raises serious questions regarding individual privacy and therapeutic merit. If the goals of the group focus on growth or team building, it still behooved Grouper to screen participants carefully and ensure that no coercion, however subtle, played a role in their decisions.

Case 4–6: Lena Lonely was a socially isolated freshman at Large State College. She joined an 8-week “encounter group” run by intern Vivian Speedo, M.A., at the college counseling center. Ms. Lonely hoped that the group experience would help to remedy her social isolation. When the group sessions ended 8 weeks later, Lonely felt disillusioned by her lack of accomplishment and despaired over what she perceived as her inadequacies. She dropped out of school.

One must wonder whether Ms. Speedo adequately screened candidates for the group to assess the appropriateness of the program for Ms. Lonely. Even if the referral to the group seemed appropriate, Ms. Lonely clearly did not benefit from participating. Speedo should have monitored the status of participants sufficiently to identify any group members whose condition seemed to worsen or whose needs went beyond what the group offered. Had Ms. Speedo done so, she might have identified Ms. Lonely’s continuing problems and assisted with a fresh referral.

Case 4–7: Fernando Frank, L.M.H.C., describes himself as a strong proponent of the “get real and tell it like it is” school of psychotherapy. In the first meeting of a new group, Mr. Frank focused attention on Jack Small, encouraging Small to reveal some intimate detail of his life to the group. Mr. Small shared such a detail, only to have Frank and the other group members focus on it and highlight the personal inadequacies it implied. Small never returned to the group and 2 weeks later sought admission to a psychiatric hospital, experiencing severe depression.

As in the previous case, it appears that Mr. Frank may not have adequately screened

candidates for appropriateness. In addition, Mr. Frank apparently did not recognize the potential emotional damage to Mr. Small. Had he done so, Mr. Frank could have attempted to mitigate any emotional harm during the session or reached out to Mr. Small on an individual basis following the session.

During the 1960s and 1970s at the peak of the so-called human potential movement, some proponents of growth groups essentially argued that participants owned responsibility for whatever happened in the sessions. As one example, Parker (1976) reported the exuberantly radical views of Schultz (1971) that each person in the group is solely responsible for him- or herself. Parker quoted Schultz as writing, "You have your choice. If you want to bow to pressure or resist it, go crazy, get physically injured, stay or leave or whatever, it's up to you." Parker rightly recognized that philosophy as one that leads to high-risk groups and a dangerous laissez-faire leadership style. However trendy or attractive this may have seemed at the time, it is dangerous and presents the potential of serious harm to clients.

At the start of the 21st century, such groups continue to attract participants, although not on the same scale as the mid-20th century. Some groups do focus clearly on therapeutic goals (e.g., anger management, illness or bereavement support, and substance abuse), while others focus on personal growth, spiritual growth, marriage enhancement, or training as a group therapist (Kiweewa, Gilbride, Luke, & Seward, 2013). Even when the group does not have particular therapeutic or remedial goals, such as with experiential growth groups, similar ethical issues require attention (McCarthy, Falco, & Villalba, 2014). The participants may not qualify as therapy patients in the sense of seeking remediation of mental health problems, but the therapist stills owes them the usual professional ethical duties of care.

Yalom and his colleagues (Vinogradov & Yalom, 1994; Yalom, 1995) identified many participant vulnerability factors therapists should consider in constructing and conducting groups. These include the following:

- vulnerability to aggression
- fragile self-esteem
- excessive dependency needs
- intense fears of rejection
- history of withdrawal
- transference to the group leader
- internal conflicts aroused by group discussions
- unrealistic expectations
- guardedness

The matters of confidentiality and privileged communication in group psychotherapy also differ significantly from individual therapy in important ways. Although we generally discuss these in Chapter 6, the group context adds new variables to the equation since, by definition, more than two people stand in a position to disclose a confidence learned in the session (i.e., the therapist and at least one other client). After reviewing Chapter 6, readers will recognize the differences between privilege and confidentiality. In most jurisdictions, no statutory privilege extends to material disclosed in group sessions to client members of the group (Behr, 2006; Coleman, 2005; Hawkins & Schermer, 2005; Lasky & Riva, 2006). The therapist should therefore advise clients in two ways early in the group treatment process. First, the clients must be cautioned about the lack of legal protections (i.e., privilege) regarding information disclosed. Second, the therapist should encourage recognition of the importance to all group members of a mutually respectful duty of confidentiality regarding what each member says in the course of treatment.

Therapists tend to express far more concern about issues of confidentiality than members of groups (Slovenko, 1977). One wonders whether clients in group treatment should automatically recognize that gossip about sensitive material revealed in sessions may be communicated to others outside the group by their peers. As a result, clients might normally self-censor particularly sensitive revelations or material. Even so, not everyone has sound judgment, and the pressures toward self-disclosure in group therapy or even experiential growth programs may prove intense.

Therapists should have these issues in mind as the group sessions proceed.

SPECIAL TECHNIQUES AND ISSUES

Under the general practice of psychotherapy, a number of special issues or techniques have attracted sufficient numbers of ethics inquiries over time to warrant specific discussion. These include the issue of triage and intake procedures, as well as techniques associated with sex therapy, behavior modification, the use of psychological devices, so-called coercive treatment techniques, and electronic media. Some therapy techniques that attract special ethical concerns originate in part as a function of the sensational nature of the context within which they are applied and in part as a function of the special social concerns associated with the treatment issue. Examples include sexual practices and sex therapy and the civil rights issues associated with coercive treatment programs.

Triage and Intake

The concept of triage applies in medical emergency situations, referring to a priority assignment for certain patients waiting in a queue. For example, a patient who has stopped breathing or who is hemorrhaging will be seen immediately, even if other less-severely injured patients must wait for an extended period in pain and discomfort. Likewise, a clinic with a long psychotherapy waiting list might move a suicidal client to the head of the line for treatment because of the urgent nature of the problem. At times, however, clients remain uninformed of such priorities, even if reasonable, with the result that the client may suffer needless delay rather than seeking an alternative treatment. In some instances, the system of priorities and intake procedures themselves raise ethical questions.

Case 4-8: Midtown Psychotherapy Associates, Incorporated, is a private group practice consisting of several licensed therapists. To keep all available appointment times filled, the administrative assistant keeps a waiting list of at least 8

to 10 clients. She informs potential clients seeking an intake appointment that she has put them on a short waiting list and will call them for an appointment soon, even when the practice has no openings in the foreseeable future.

Case 4-9: The Capitol Mental Health Center (CMHC) had a 6-week backlog for intake assessments and a policy that only emergency cases could be taken out of order. Nicholas Bluster, the mayor of Capitol City, telephoned the therapist who directed the CMHC seeking an immediate appointment for his adolescent son, who had been “mouthing off at home.” The therapist in charge placed Junior Bluster at the head of the list.

Both of these cases demonstrate unethical priority setting in a manner that was detrimental to some clients. In the case of Midtown Psychotherapy Associates, the people waiting for appointments should more appropriately be advised of the potential duration of their wait and offered the opportunity for a referral elsewhere. An indefinite hold on the waiting list could be reasonable if the potential client, advised of the details, chooses to wait (i.e., based on convenience, cost, or perceived quality), but the situation described at Midtown misleads callers. The director of the CMHC was clearly responding to political expedience. Perhaps Junior Bluster does need services and qualifies to receive them at the center; however, moving him ahead of others on the list provides an unfair priority unless an emergency intervention is required. The director could have met the political social demands of the situation in many appropriate ways, such as offering a referral elsewhere or making time available personally to assist the Blusters, while not delaying services to others in need.

Sex Therapy

The very word *sex* immediately captures the attention of an adult audience, and when using the term *sex therapy*, most mental health professionals think only of the most common presenting symptoms, such as erectile dysfunction,

premature ejaculation, anorgasmia, dyspareunia, vaginismus, and loss of interest in sexual activity (Derogatis & Brotto, 2013a, 2013b). However, a variety of other problems might become the focus of sex therapy. These include hysterical conversion reactions with a sexual focus; paraphilic (e.g., exhibitionism, pedophilia, and voyeurism); gender dysphoria syndromes (e.g., transsexualism); physical developmental disorders (e.g., hypospadias); disease-related disorders; and problems resulting from medical side effects, surgery, or traumatic injury to the sex organs (Aloni & Katz, 2003; Binik & Hall, 2014; Leiblum, 2007, 2010; Southern, 1999). Significant numbers of clients may also present with varying degrees of concern about sexual functioning, gender preference, or homosexuality. Considerable guidance for treating such clients exists (APA, 2000, 2012; Drescher, 2002; Safren, 2005). In the next section, we discuss some of the ethical issues that accompany various sexually related therapies.

The American Association of Sexuality Educators, Counselors, and Therapists (2014) published a code of ethics and training guidelines for individuals practicing in this specialized field. These guides and other writings on sex therapies highlight the complexity of the social, psychological, anatomic, and physiological factors that may become involved in sexual problems (Binik & Hall, 2014). As these complexities illustrate, this field of practice demands special skills and ethical sensitivities. Often, the style and substance of clinically appropriate sex therapy will differ dramatically from other therapeutic activities and become laden with personal and societal values. For example, more than four decades ago, one set of authors (Lowery & Lowery, 1975) asserted that the most ethical sex therapy is that "which cures the symptom and improves the marital relationship in the briefest time and at the least cost" (p. 229). Evidence continues to show that neither insight-oriented treatment nor therapist-client sexual activity satisfy these criteria as evidence-based practice (Binik & Hall, 2014).

Emotional reactions linked to treating sexual problems (e.g., feelings associated with

personal insecurities, embarrassment, or compromised quality of life) are not limited to the general public. A fascinating debate began in the professional literature with the publication of a study describing highly specific behaviorally oriented masturbation procedures for anorgasmic women (Zeiss, Rosen, & Zeiss, 1977). This was followed by a critique, "Psychotherapy or Massage Parlor Technology?" (K. G. Bailey, 1978), which invoked ethical, moral, and philosophical (as well as social psychological) reasoning. This was followed by one comment describing Bailey's critique as "antiscientific" (Wagner, 1978), and another well-reasoned critique noting that value-free therapy does not exist and that the client should be fully engaged in goal setting while conducting the least intrusive treatment (Wilson, 1978).

Therapists may also find themselves caught between members of an intimate dyad with very different sexual preferences, goals, and expectations. For example, consider the therapists confronting the ethical problems that arose when a couple presented for sex therapy to address the wife's sexual reluctance, particularly in relation to conflicts over the husband's demands for anal sex (Wylie, Crowe, & Boddington, 1995). Should the therapeutic goal in such circumstances focus on helping the husband to respect and accept his wife's reluctance or on encouraging the wife to consider acceptance of her husband's wishes?

Sexual Surrogates

Perhaps the most dramatic focus of concern in the evolution of practice in sex therapy involves the use of sexual surrogates—sexual partners used by some mental health professionals to assist certain clients by engaging in a variety of social and sexual activities for a fee. Surrogate use, initially employed by Masters and Johnson (1976) with some single clients and discussed in the 1970s as more than a prescription for prostitution (Jacobs, Thompson, & Truxaw, 1975), is rarely reported in professional circles today, although a web search will quickly turn up many potential surrogates and even professional

associations purporting to certify them (<http://www.surrogatetherapy.org/>).

More attention is paid to a host of other issues and techniques, for example, biomedical treatments, cognitive and behavioral approaches, psychoeducational interventions, and approaches combining multiple techniques (Derogatis & Brotto, 2013a, 2013b; Leiblum, 2007, 2010). Still, some psychotherapists may find themselves tempted to use surrogates from time to time (i.e., with medically disabled clients), although this may lead to substantial ethical and legal complications as the legal status and liability issues can be quite complicated (Aloni & Katz, 2003; Aloni, Keren, & Katz, 2007; Balon, 2005; Freckelton, 2013; Gianotten, 1997; Poelzl, 2001; Rotem, 2014).

In some states, a mental health professional who refers a client to a sex surrogate may become liable for criminal prosecution. Some state laws could lead to prosecution under procurement, prostitution, and antifornication laws, or even rape charges, should some aspect of the relationship go wrong or come to the attention of a zealous district attorney. A variety of potential civil liabilities or tort actions are possible if one spouse objects to the other's use of a surrogate or if the client contracts a sexually transmitted disease from (or transmits one to) the surrogate. In the case of HIV or hepatitis viral transmission, the costs can prove especially high. In such cases, the referring therapist may have a vicarious liability and will generally find his or her liability insurer unwilling to cover a resulting claim (Freckelton, 2013).

These dramatic cases illustrate some of the complex problems, including the blurring of roles and values that often seem to occur when sexual surrogates come into play.

Case 4-10: Lorna Loose worked as a receptionist and secretary to Cecil Thud, Ph.D. Dr. Thud approached her about acting as a sexual surrogate for some of his male clients. Ms. Loose agreed and allegedly enjoyed the work sufficiently that she began to offer such services on a freelance basis in addition to her work with Thud's clients. Subsequently, her ex-spouse sued for custody of their two children, citing her work as "a prostitute"

in court. Loose allegedly sought emotional and documentary support from Thud and later claimed that he seduced her.

Dr. Thud denied ever having had sex with Ms. Loose, although he did acknowledge recruiting her as a sex surrogate and admitted that this role later caused her considerable personal difficulty. In the actual incident on which our case is based, the therapist was sued by his employee, who won a substantial financial damages award in a highly publicized trial.

Case 4-11: George Trotter, L.M.F.T., employed one male and three female assistants with master's degrees in counseling fields to work in his clinic specializing in sex therapy. He would occasionally refer some of his clients to one of the assistants, who would act as a sexual surrogate. Trotter reasoned that he was practicing appropriately since the surrogates had all obtained counseling training and were not the therapists of the specific clients in question. Ultimately, Dr. Trotter faced prosecution on prostitution and fraud charges filed by an insurance company, claiming that Trotter had billed the sex sessions with his assistants as psychotherapy.

Mr. Trotter was at best ethically insensitive and careless in his conclusion that the use of his assistants, however willing, did not create a conflict-ridden situation. His decision to bill these visits as insured services, when he had clear information that they were not covered by the insurance company, constituted strong evidence of fraud. Although the prostitution charges were ultimately dropped, a substantial amount of harmful publicity deeply troubled the more appropriate and conservative sex therapists in the community.

Case 4-12: Nova Gyna sought treatment by her therapist, Oopsie Daisy, M.S.W., for depression and marital dissatisfaction involving a number of life issues. One important issue to Ms. Gyna involved her ability to have orgasms when masturbating but never with her highly critical husband of 5 years. Her family physician had prescribed an antidepressant medication. Ms. Daisy

recommended couple's therapy, but Mr. Gyna refused. She attempted to refer the couple to a sex therapist, but again, Mr. Gyna declined to participate. Ms. Daisy suggested some self-help books that Ms. Gyna might use to encourage her spouse in varied approaches to lovemaking, but her client could not work up the courage to ask her husband to do anything differently from his routine. Feeling at the end of her ideas, Ms. Daisy suggested that Ms. Gyna pay a visit to an adult sex club in a neighboring city, where she might find an anonymous willing partner for "practice purposes, using safe sex," of course. Ms. Gyna ultimately contracted an HIV infection and passed the virus on to her spouse, who filed for divorce.

We do not know whether Ms. Daisy had any competence as a sex therapist, and we recognize that Mr. Gyna's refusal to participate complicated best practice approaches for treating his wife's sexual issues. If Ms. Daisy had sought consultation from a colleague more experienced with this condition, she might have come up with better and less-risky suggestions, including investigation of the influence of some antidepressant medication (Binik & Hall, 2014; Derogatis & Brotto, 2013a, 2013b; Leiblum, 2007, 2010; O'Mullan, Doherty, Coates, & Tilley, 2014).

Sexual behavior is an emotionally charged, value-laden aspect of human life, and therapists working actively at altering such behaviors must take appropriately cautious and sensitive approaches to both community and professional standards. Sexual practices also pose significant potential for transmission of a range of serious diseases. In such areas of practice, haphazard ethical practices and indiscretions will prove much more likely to lead to major problems for the client and practitioner than in almost any other realm.

Sexual Orientation Conversion or Reparative Therapy

Sexual orientation conversion therapies, once considered the treatment of choice in the era when homosexuality was considered an illness or form of psychopathology, raise a number of

ethical challenges. For over a century, medical, psychotherapeutic, and religious practitioners sought to reverse unwanted same-sex attraction or homosexual orientation through a variety of methods, including psychoanalysis, prayer, electric shock, nausea-inducing drugs, hormone therapy, surgery, and a variety of behavioral treatments, including masturbatory reconditioning, visits to prostitutes, and even excessive bicycle riding (Murphy, 1992). The American Psychiatric Association's 1973 decision to remove homosexuality from its *Diagnostic and Statistical Manual of Mental Disorders* marked the official passing of the illness model of homosexuality (Spiegel, 2002). Despite this now-complete official "depathologizing" of homosexuality, efforts by both mental health professionals and pastoral care providers to convert lesbians and gay men to heterosexuality have persisted (Greene, 2007; Haldeman, 1991, 1994; Schneider, Brown, & Glassgold, 2002; Super & Jacobson, 2011).

Such efforts, variously described as conversion therapy, reparative therapy, or therapy to eliminate same-sex attraction, span a variety of treatment modalities. So-called reparative therapy emerged in the early 1980s as a "new method of curing" homosexuals. Elizabeth Moberly, a conservative British Christian theologian with a Ph.D. degree in experimental psychology, became a key proponent of the approach in 1983 after publishing her theory "that the homosexual ... whether man or woman ... has suffered from some deficit in the relationship with the parent of the same sex; and that there is a corresponding drive to make good this deficit ... through the medium of same-sex, or 'homosexual,' relationships" (p. 2). Organizations currently promoting psychotherapeutic care for individuals with same-sex attraction often have moralistic or religious underpinnings and include the National Association for Research and Therapy of Homosexuality (NARTH) and Jews Offering New Alternatives to Homosexuality (JONAH).

As noted in Chapter 3, the concepts of taking guidance from clients and engaging clients in goal setting stand at the center of the psychotherapeutic enterprise. Clients may well

present themselves for treatment and describe emotional problems associated with same-sex attraction. In such circumstances, the therapist has an obligation to carefully explore how patients arrive at the choices they wish to make. At times, motives may result from social pressures or experiences with homophobic environments. No type or amount of individual psychotherapy will modify social prejudices. In addition, as part of informed consent to treatment, clients must understand the potential consequences of any treatment, including those intended to modify sexual orientation. Clients must understand that so-called reparative treatments lack any validated scientific foundation and may prove harmful. Finally, our clients ought to know from the outset that no reputable organizations representing the mental health professions consider homosexuality a mental disorder.

Two major ethical concerns accompany so-called reparative treatments. First, to what extent does offering such treatments comport with the issues of therapist responsibility and consumer welfare? Second, given that rigorous empirical studies fail to show that conversion therapies work, do therapists offering such interventions without clear disclaimers and cautions mislead clients (Greene, 2007; Haldeman, 1994; Morrow, 2000; Schneider et al., 2002; Spiegel, 2002; Super & Jacobson, 2011)? The APA addressed these issues with a “Resolution on Appropriate Therapeutic Responses to Sexual Orientation” (APA, 1998), and similar positions have emanated from other professional groups (American Psychiatric Association, 1998, 2000; National Association of Social Workers, 2000). These standards essentially allow therapists to address the stated needs of clients as long as they fully inform clients regarding known limitations, although some states (e.g., California Senate Bill 1172 and New Jersey’s N.J.S.A. 45:1-54, -55) have passed laws against such treatments for minors; these laws have been upheld in the federal appellate courts (American Psychiatric Association, 2014; I. Moss, 2014; Robson, 2014).

Why do adult gay, lesbian, and bisexual people seek such treatments? In one study,

investigators interviewed 202 consumers of sexual orientation conversion interventions and asked two basic questions: What motivates people to pursue conversion therapy and ex-gay groups? How do they perceive its harmfulness and helpfulness? The results indicated that a majority failed to change sexual orientation, and many reported that they experienced harm as part of conversion interventions. A minority reported feeling helped, although not necessarily with their original goal of changing sexual orientation (Shidlo & Schroeder, 2002).

Case 4-13: At age 30, Frank Faithful, who had self-identified as gay since his late teens, sought treatment. He had never felt entirely comfortable with being gay, in part because of his upbringing in a Pentecostal faith that strongly condemned homosexuality. He had struggled to find a common ground between his strong Christian religious beliefs and his clear lack of sexual or romantic attraction to women. He had many female friends, whose company he enjoyed because he felt no sexual pressure in those relationships. He sought treatment from pastoral counselor Ida Knoway, M.Div., who informed Frank that he was “not really gay,” and that his same-sex desires were the result of having been abandoned by his father as a child. For many months, Frank worked with the therapist on reorienting his sexuality using cognitive, behavioral, and imaginal techniques. He followed her instructions to withdraw from contact with gay male friends and stayed away from gay male communities where he had previously socialized. He prayed and attended church even more frequently than in the past. At the end of this time, Frank found himself feeling depressed, despondent, and a failure because, despite his best efforts, he continued to feel no sexual or romantic attraction toward women. His previously good friendships with women became so fraught with tension as he sought to achieve heterosexuality that he became more socially isolated. He reported feeling spiritually bereft as well, as if “God was not listening to my pleas.”

We adapted this case from one of the excellent vignettes presented for discussion by Schneider and her colleagues (Schneider et al.,

2002). One hopes that Ms. Knoway's training program in pastoral counseling included substantive content on psychodiagnostics, psychopathology, and psychotherapeutics, even though her behaviors do not reflect competence in those arenas. The data suggest she may have leapt to diagnostic conclusions without foundation and had an ideological predisposition to do so. She has overlooked the need to first "do no harm" (Morrow, 2000). In the end, she left Frank in significantly worse condition than before he sought counseling.

Case 4-14: Connie Fused had dated boys in high school because it seemed expected in her community and social group. Although she actually felt more sexual and romantic attraction toward some female friends, she never felt comfortable expressing those feelings. When Connie left home to attend college in another state, the new environment gave her a sense of freedom to explore. She developed an intimate relationship with another young woman. During the semester break she "came out" to her parents, who became alarmed and insisted on enrolling her at the Healing Eternal Love Lodge, a residential program designed to literally straighten out people who had "homosexual leanings." Wanting to please her parents and feeling unsure of her own identity, Connie entered the program. A few weeks later, she finished the program, moved back to her parents' home, and transferred to a nearby college. The Healing Eternal Love Lodge kept in touch with Connie by phone on a weekly basis at first and then monthly. If she reported any "backsliding," the staff at the lodge promised to send a treatment team to her home to provide "booster sessions." Connie reported that the program had worked, dated a few young men, and moved away from her home community after college. She realized that she still felt greater attraction to women but kept these feelings and her relationships with women secret from her family. The follow-up calls from the Healing Eternal Love Lodge still come in every few months, and she still tells them that the treatment worked so that they will leave her alone.

The situation experienced by Connie illustrates the familial and social pressures that can

affect clients' decision making in such cases. We have no information on the competence or credentials of the counseling staff at the Healing Eternal Love Lodge. They probably think that they collect great follow-up data and consider Connie's case a successful outcome because of what they hear when they follow up with her. Connie just wants the pressure off and finds it easier to keep important aspects of her life private.

The key to an ethical response in any treatment involving matters laden with social, political, or religious significance includes conducting a careful assessment and offering an intervention that has proven efficacy and meets the preferences and needs of the client apart from preordained biases of the therapist. We cannot avoid the influence of societal and professional beliefs and biases concerning gay, lesbian, and bisexual people, and too often education and training programs devote inadequate attention to such issues (APA, 2012; Biaggio, Orchard, Larson, Petrino, & Mihara, 2003; Flentje, Heck, & Cochran, 2014; Greene, 2007; Lasser & Gottlieb, 2004; McGeorge, Carlson, & Toomey, 2014; Super & Jacobson, 2011).

Behavioral Techniques

As in the case of sex therapy, the application of behavioral techniques such as operant conditioning, classical conditioning, aversive therapies, and other types of physical interventions (e.g., physiological monitoring, biofeedback, stress management, etc.) require specialized training of an interdisciplinary nature (Farmer & Nelson-Gray, 2005; Martin & Pear, 1996). This may include training in anatomy and physiology as well as the analysis of behavior and application of learning theory. In addition, one must also maintain a keen awareness of special caveats, such as knowing when a medical consultation is indicated or when a certain instrumental procedure may edge toward the violation of a client's rights. Although many behavioral and cognitive interventions originated as the work of psychologists, other types of therapists have access to training in the use of complex approaches involving an assortment

of cognitive and behavior therapies in ways unimaginable to the earliest practitioners of these approaches (Farmer & Nelson-Gray, 2005; Reamer, 2006). The depth and breadth of training across therapists from different professions vary widely.

The application of behavioral techniques usually involves the assumption of a substantial degree of control over the client's environment. Generally, this takes place with the active involvement and consent of the client (J. S. Bailey & Burch, 2006; Martin & Pear, 1996). In some instances, however, the client may be technically or literally incompetent to consent, as in the case of developmentally disabled or severely psychotic clients. When the client is incompetent to fully consent and powerful environmental controls are enforced, special substituted judgment procedures using independent advocates may be warranted (Bregman et al., 2005; Koocher, 1976, 1983).

From time to time, there have been outcries in the mass media about the application of behavioral techniques in schools, prisons, and other settings. For example, consider the issue of behavior therapy in correctional settings in the context of the popular political mantra of "getting tough on crime." Many behavioral techniques (e.g., increased privilege levels as rewards for good behavior) have long found use in such institutions. Privately operated correctional systems now frequently contract with state and local governments to manage facilities. Should behavior therapists develop a niche of their own within the private incarceration industry? Expanding work with a private or for-profit prison system may lead to ignoring ethical, theoretical, and scientific principles (Wong & Wong, 2003).

Many mental health professionals have historically called for, produced, or rebutted the need for specialized guidelines to be used in applying behavioral techniques (Bregman et al., 2005; Davidson & Stuart, 1975; Stolz, 1977; Thaw, Thorne, & Benjamin, 1978; Turkat & Forehand, 1980). We find that behavioral therapies are no more or less in need of regulation per se than other forms of treatment also subject to abuse. As Stolz (1977) noted, behavioral

clinicians, like other therapists, should follow the ethics code of their professions; also, the ethics of all intervention programs should undergo evaluation in terms of existing ethics codes.

Specific complaints regarding behavior therapies commonly encountered by ethics committees are illustrated in the following several cases:

Case 4-15: Gordon Convert, M.D., agreed to treat Billy Prissy, age 5, whose parents were concerned about his "effeminate" behaviors. Dr. Convert devised a behavioral program for implementation in the office and at home involving the differential reinforcement of toy choice, dress-up play, and a variety of other activities of a stereotyped sex-role nature. When reports of this project appeared in professional journals, a storm of protest resulted.

The case of Dr. Convert is typical of those complaints that revolve around the matter of client choice and goal setting in therapy and also smacks of the problems associated with so-called reparative therapies discussed previously. It is not possible to tell from the brief information we have given here just how appropriate or inappropriate the program was. The context and nature of decision making and treatment goal setting are critical (Bregman et al., 2005; Stolz, 1978). In this case, Billy's viewpoint demands just as much consideration as the preferences expressed by his parents. In addition, many of the criticisms of conversion therapies that focused on gay men, as described in this chapter, may also apply here.

These issues were well illustrated historically in a series of comments to a manuscript on alternatives to pain medication (Cook, 1975; Goodstein, 1975; Karoly, 1975). The original report focused on a 65-year-old man admitted to a psychiatric ward with symptoms of chronic abdominal pain and a self-induced drug habit to control the pain (Levendusky & Pankratz, 1975). He was successfully withdrawn from the drug using a treatment procedure that involved some deception and lacked fully informed consent. The ethical dilemma here is the matter of client involvement in making choices rather than the technique itself.

Case 4-16: Seymour Diversion, Ph.D., worked in a state hospital for children with emotional problems. He designed a specialized program that applied aversive stimulation (e.g., brief application of an electric shock rod) to interrupt self-injurious behavior in a head-banging child. The child had caused permanent damage to one eye and was in danger of losing the other as well. Less-drastic means of interrupting the behavior had failed. A nurse at the hospital was outraged and informed local newspapers of how Dr. Diversion was "torturing" the child.

An ethics committee asked Dr. Diversion to respond to the complaint, and he did so with openness and in detail. Several less-invasive attempts to prevent the child from destroying his remaining eye by head banging had been unsuccessful. A special panel had been asked to review the case and approve the trial of aversive techniques independently of Dr. Diversion and the hospital. Diversion managed the program personally and noted that he had been prepared to discontinue the use of aversive stimuli promptly if no benefit resulted for the child. The committee agreed that every appropriate precaution had been taken, and that Diversion had behaved appropriately, given the severe nature of the child's self-injury.

Case 4-17: Thelma Splatter, L.M.H.C., designed an aversive treatment program to deal with severely developmentally disabled residents of a state facility who were toileting in public on the grounds of the school and in the corridors. The program involved an operant reward system as well as a spray of ice water in the face, administered from a small squirt bottle. Some of the attendants were inadequately trained in the rationale and application of the technique. One evening, an attendant caught a male resident of the school smearing feces and pushed the man's face into a toilet bowl while flushing it several times. He reported that he did not have the spray bottle with him.

Ms. Splatter's program may have been adequately conceptualized, but it was poorly implemented. The attendant clearly did not

discriminate between the intended shock value of the ice-water spray and the sadistic and punitive act of holding a person's face in the toilet. The unethical behavior here was chiefly Splatter's failure to adequately supervise the people charged with executing her treatment program. If she were unable to adequately supervise all of those participating in the program she designed, then she should have carefully limited the scope of the program to those she could adequately supervise. Although the attendant remained responsible for his own behavior, Dr. Splatter may have inadvertently provided a context within which the act seemed appropriate to him.

During a conversation hour at an APA convention many years ago, the late B. F. Skinner spoke bemusedly about the controversy that seemed to focus on labels as opposed to practice. He noted that a school board had promulgated a threat to fire any personnel who used behavior modification. Skinner then wondered aloud what would happen the next payday when "reinforcements" were handed out in the form of paychecks. This illustrates again that it is not the technique itself that presents ethical problems but the manner in which it is applied and labeled.

Unfortunately, not all therapists who attempt to employ behavioral techniques are well trained in underlying learning theory. Confusion on the distinction between the concepts of "punishment" and "negative reinforcement" constitutes one prime example of a common problem. In other instances, aversive treatment protocols have occasionally been introduced without first trying less-restrictive techniques.

It is especially important that therapists show careful concern for ethical problems inherent in the use of aversive stimuli with relatively powerless clients. This would include, for example, institutionalized, incarcerated, or incompetent individuals, as well as children or other people not fully able to assert their rights. The next example is closely adapted from an actual case.

Case 4-18: Marquis deSique, Ph.D., operated a private residential facility for emotionally disturbed and delinquent children. The parents of

a 10-year-old boy filed ethics charges when they discovered multiple bruises and lacerations all over their son's body during a visit. Dr. deSique explained that the boy required several beating sessions each week to "break his strong will" and permit more appropriate behavior to emerge. It was later discovered that all of the residents were routinely subjected to such sessions, conducted in a specially equipped punishment room. In addition, Dr. deSique would also take nude photographs of them following the beatings.

This sort of case causes sensitive, objective, and competent behavioral therapists considerable outrage because Dr. deSique's "treatments" do not conform to standards of professional practice or ethics. The practices also have no basis in empirical data or learning theory. It seems more likely that deSique was satisfying some peculiar needs of his own at the expense of his vulnerable wards.

Psychotherapeutic Devices

The now-ancient report of the APA Task Force on Psychologists' Use of Physical Interventions (APA, 1981) listed more than a score of instruments and devices used for clinical assessment and psychotherapy at the time. These included a variety of electrodes and monitors used in biofeedback training, as well as an assortment of color vision testers, dynamometers, audiometers, restraints, and even vibrators. In the years since that report came forth, the number of devices used in psychotherapeutic treatments (Barlow, 2004) or in psychodiagnostic assessment with proven efficacy (i.e., excluding quackery) has grown exponentially.

Case 4-19: Reeka Sniff, Psy.D. offers her clients a "new form of adjunct therapy" designed to substantially reduce stress and other emotional disturbances. She also informs her clients that alternative therapies are now recognized by the National Institutes of Health (NIH). She has purchased an "aromatherapy decoder wheel" that assists her in mixing just the right blend of some 100 different fragrant oils. She places the mix in a container warmed by a small candle to help

disperse the fragrance on a small table between herself and the client. They then continue the counseling sessions as usual.

On the one hand, Dr. Sniff's use of fragrance probably causes no harm, assuming that the client has no allergic reactions. If the client likes the aromas, they may even offer a placebo benefit. However, Dr. Sniff has engaged in some elements of misdirection. The comment about NIH appears intended to legitimize her use of the technique. One can find aromatherapy wheels and scents sold commercially, but these have not been validated as medical or psychological treatments. In addition, if Dr. Sniff sells such supplies to clients, she will have crossed a critical multiple-role boundary involving an unproven or quack product.

Psychiatrists have seen a resurgence of interest in electroconvulsive therapy (ETC) for the treatment of severe refractory depression (Dukakis & Tye, 2006), and some have worked with neurosurgeons to explore the viability of deep brain stimulation (DBS) in severe cases (Carpenter, 2006; Fitzgerald, 2006; Glannon, 2006). Some of these devices that involve connection to or insertion in the human body are regulated by the U.S. Food and Drug Administration (FDA), and most require specialized training for proper use.

Biofeedback devices, ranging from skin temperature and heart rate to plethysmographic monitors, have seen enormous market growth. Despite considerable controversy, the use of lie detectors or deception involving the alleged ability to detect lying still abound. Virtual reality devices and a burgeoning market full of other devices and computer applications with varying levels of proven efficacy appear regularly in publications aimed at mental health professionals (Newman, 2004; Rizzo, Strickland, & Bouchard, 2004; Sampson, 1983; Wiederhold & Wiederhold, 2005). One particularly interesting approach involves the development of virtual reality programs that engage all of the senses in an effort to apply realistic exposure interventions to help reduce posttraumatic stress among military personnel returning from combat (Jardin, 2005; Rizzo et al., 2004).

The advent of the Internet, Wi-Fi, smartphones, and short-distance wireless technologies (e.g., Bluetooth) along with a variety of wearable sensing devices have led the FDA to begin evaluating the need to regulate some as mobile medical devices and applications (see <http://www.fda.gov/MedicalDevices/Products andMedicalProcedures/ConnectedHealth/ MobileMedicalApplications/ucm255978.htm>). In addition, the potential for ethical challenges related to monitoring device telemetry in mental health practice will continue to grow along with the use of technology in the future of psychotherapy. Skip ahead to the case of Dr. Anna Sthesia (Case 13–20) to see an example of technology-related negligence, but also consider the following examples:

Case 4–20: Sparky Pinktooth, Ph.D., developed a smartphone application for use treating clients who abuse drugs purchased illegally on the street. The treatment protocol involved sending periodic text messages to which clients would respond with a brief indication of their mental status and time since last drug use. Dr. Pinktooth was thus able to respond with encouragements or cautions (depending on the clients' reports) and link the timing of their reports to geographic locations, such as home or workplace.

Case 4–21: Willa Catheter, M.D., a psychotherapist and inventor, has developed a new smartphone application, dubbed SkinnyMeter Weight Loss System, that combines proven technologies using a wristband to measure activity, heart rate, blood glucose, and skin conductance along with manual data entry of caloric intake and depression ratings. She has begun advertising the product as a “powerful tool to potentiate the treatment of overweight and eating disordered clients.”

Dr. Pinktooth may have found a way to extend treatment beyond the traditional office, but we hope clients understand the potential confidentiality hazards inherent in transmitting information about illicit drug use and physical location over public airways and leaving records of such transmissions on both a client's own phone and therapist records. We hope

that Dr. Catheter has a solid evidentiary base for her advertised claims (see Chapters 11 and 12) and FDA approval for her planned uses of the SkinnyMeter. Even if some individual apps and devices have been approved by the FDA or proved effective in particular circumstances, Dr. Catheter's new combination approach may lack documentation for safe and effective use.

The basic caveat is as follows: All psychotherapists should recognize the boundaries of their competence, especially when attempting to make use of new technologies (Newman, 2004; Wiederhold & Wiederhold, 2005). They must avoid using unsafe or unproven devices, not to mention those that might prove dangerous to clients through electric shock, inaccurate readings, or other hazards. Nonphysician therapists must also remain mindful that they should never attempt treatment of problems with possible organic causes without a collaborative relationship with a qualified physician. This mandate applies equally to psychiatrists and psychiatric nurse practitioners, whose internal medicine expertise may be quite limited. In addition, federal law governs the licensing and use of some instruments, and practitioners have an obligation to keep themselves abreast of these statutes and resulting duties.

Coercive Therapies

As noted in Chapter 3, psychotherapy has sometimes been considered a means of social control (Hinshelwood, 2012; Hurvitz, 1973) and compared in some ways with brainwashing (Dolliver, 1971; Gaylin, 1974). The use of “coercive persuasion,” “deprogramming,” and hypnotic suggestion techniques (Fromm, 1980; Kline, 1976; Newton-Howes & Mullen, 2011) have all been discussed from the viewpoint of client manipulation. Many other types of coercive practices have become central to some psychotherapeutic approaches with strong public approval (Hinshelwood, 2012; Newton-Howes & Mullen, 2011). These types include court-ordered therapy for a range of conditions (e.g., anger management issues, driving while intoxicated, sexual acting out); restrictions placed on nonincarcerated sex offenders (Schopp, 2003); restrictions

in educational settings (Sidman, 1999); and coercive restraint or forced holding therapies for children (Koocher & Gill, 2016; Mercer, 2003). To what extent do certain psychological techniques permit the psychotherapist to manipulate or control the client by force or threat and at what cost (Roche, Madigan, Lyne, Feeney, & O'Donoghue, 2014; Whitecross, Seeary, & Lee, 2013)? In Chapter 3, we also discussed the right to refuse treatment, and we cite these issues here as examples of techniques that from time to time have been the object of complaints. More recent concerns have included the possible role of professionals in dealing with alleged terrorist detainees held by military authorities. However, those roles do not involve psychotherapy.

Case 4–22: Thinny Asarail, age 16, has “felt fat” for many years, and despite the fact that her 5 foot 4 inch tall body weighs a mere 75 pounds, she still believes she must restrict her food intake. Her battle with anorexia nervosa has left her with significant health problems and often unstable vital signs, prompting her parents to send her to a residential treatment program. Still, she refuses many meals. When she will not eat, a nurse and hospital attendant restrain Thinny as a physician passes a nasogastric (NG) tube through her nostril and into her stomach to deliver a nutritional supplement. After removal of the NG tube, Thinny must sit in view of the staff for at least 90 minutes to ensure that she does not attempt to vomit the feeding.

Thinny’s medical condition demands such care to ensure her survival, even though she does not agree. Her parents and the medical team have authorized this treatment over her objections. When Thinny reaches the age of majority, she can no longer be coerced into such treatment unless a court rules her mentally incompetent. One hopes that psychotherapeutic intervention and nutritional support will help effect a cure and avoid the need for prolonged coercive intervention.

In general, it is unethical for a psychotherapist to coerce a client into treatment or to force certain goals or outcomes against the client’s wishes. In Chapter 15, we discuss some special

problem situations along these lines (e.g., clients who are in the military or are involuntarily confined in institutions such as prisons). It is most difficult to be sensitive to the more subtle aspects of coercion: group pressure, guilt induction, introduction of cognitive dissonance, attempts at total environmental control, and the establishment of a trusting relationship with the goal of effecting change in another person (Dolliver, 1971; Hinshelwood, 2012; Newton-Howes & Mullen, 2011; Steinert, Birk, Flammer, & Bergk, 2013). It is critical that the therapist attempt to remain aware of potentially coercive influences and avoid any that do not offer full participation, discussion, and choice by the client. The constant critical reexamination of the strategies and goals of treatment involving both client and therapist is the best means to this end.

Teletherapy

Rapid advances in microelectronics have made portable communication, data, image, sound storage, and transmission devices affordable and readily available in much of the world. A broad array of personal communications and business transactions now occur in the realm of cyberspace. We must expect that mental health practitioners will increasingly face expectations by our clients to provide services in the context of their preferred modes of communication (Matthews, 2014). As we move away from the traditional context of sitting face to face with our client across a room, the Greek prefix *tele*, meaning from a distance, leads naturally to considering the ethics of delivering services as teletherapy or remote assessment. Many colleagues have used *telehealth* as a term in medicine and mental health for a variety of models for providing professional services via telephone and other electronic means (Barnett & Scheetz, 2003; Drum & Littleton, 2014; Fisher & Fried, 2003; Jerome & Zaylor, 2000; Maheu, Whitten, & Allen, 2001; Nickelson, 1998; VandenBos & Williams, 2000). Radiology and cardiology are just two of many medical specialties that have regularly used these techniques for consultation among professionals. What we have traditionally

agreed to in forming alliances and contracts with individual clients and professional standards will certainly require rethinking. In recognition of these circumstances the APA, Association of State and Provincial Psychology Boards (ASPPB), and The Trust (formerly known as the APA Insurance Trust) formed the Joint Task Force for the Development of Telepsychology Guidelines for Psychologists (2013) to describe best practices.

From the perspective of professional ethics, consider the four Cs: contracting, competence, confidentiality, and control (Davis, 2014; Drum & Littleton, 2014; Koocher, 2007). In the context of teletherapy, these questions arise:

- What contracts or agreements for providing distance services will we make with our clients?
- What competencies and standards of care will apply when offering services remotely?
- What new factors will constrain confidentiality protections and retention of any recorded or captured transmissions?
- Who will control the practice of teletherapy (i.e., the regulation of practice and data access across jurisdictions)?

When we agree to work with clients via telemetry, the nature and terms of how we relate will change. We will need to reach accords on new contracts or agreements regarding the nature of psychological services and manner of providing them. For example, we will have to obtain and document clients' informed consent to communicate with them electronically (APA: 2.10a; ACA [American Counseling Association]: H4; NASW [National Association of Social Workers]: 3.03.e, 1.07.m). Such consent will doubtless require many changes, such as requiring us to establish reasonable security and encryption precautions and to provide precise instructions regarding the nature of the services, access, and emergency coverage (APA: 4.02c; ACA: H4; NASW: 3.03.e). Still other questions must be answered:

- Will we contract to provide services remotely only with existing therapy clients, or will we

readily accept new referrals of people we have never met for any or all of our professional services?

- What standards of care and liability obligations will apply?
- Will we agree to conduct all assessment, consultation, or therapy relationships entirely via telemetry or only a limited range of services?
- Will we promise real-time electronic access 24/7/365?
- How will record keeping change given the ease with which both therapists and clients can capture, store, and alter such communications?
- Will fees and reimbursement policies differ from office-based services?
- Will we offer emergency coverage? If so, what backup must we organize for clients who live hundreds or thousands of miles away?

New standards of care and professional competencies will apply when we offer direct services remotely. The APA has not chosen to address teletherapy directly in its ethics code (APA Ethics Committee, 1997), and by this intentional omission has created no rules prohibiting such services. The report of the Joint Task Force for the Development of Telepsychology Guidelines for Psychologists (2013) offered some consensus among psychological organizations. The NASW and Association of Social Work Boards also provided some guidance (2005), and the ACA did so in its 2014 Code of Ethics (particularly Section H). The American Association for Marriage and Family Therapy (AAMFT) Code of Ethics (2015) has a full standard dealing with technology-assisted professional services (Standard VI). Most professional boards and ethics committees will need to address any complaints regarding such matters on a case-by-case basis. The APA referred psychologists to apply the same standards used in "emerging areas in which generally recognized standards for preparatory training do not yet exist" by taking "reasonable steps to ensure the competence of their work and to protect patients, clients, students, research participants, and others from harm" (APA: 2.01e).

A substantial and growing body of literature has documented the process of combining technological advances with established methods for the provision of mental health services (Barnett, 2005; Fisher & Fried, 2003; L'Abate, 2013; Lemma & Caparrotta, 2014; Maheu, 2003; Maheu, McMenamin, & Pulier, 2013; Matthews, 2014; Newman, 2004; Ragusea & VandeCreek, 2003). Psychotherapists have long used electronic means to keep in touch with traditionally established clients during vacations, relocations, and emergencies. A growing body of research has also demonstrated the potential benefits of delivering psychological interventions by telephone (Bastien, Morin, Ouellet, Blais, & Bouchard, 2004; Heckman et al., 2004; McKay et al., 2004; Mermelstein, Hedeker, & Wong, 2003; Sandgren & McCaul, 2003). The practical value of electronically mediated health and mental health care delivery (L'Abate, 2013; Jerome & Zaylor, 2000; Maheu & Gordon, 2000) as well as clinical supervision (Rousmaniere, Abbass, & Frederickson, 2014; Wood, Miller, & Hargrove, 2005) and assessment (Butcher, 2013) have been well documented. The number of mental health-related applications or mHealth apps has also proliferated (Maheu, Pulier, & Roy, 2013). Not surprisingly, however, some research has shown ratings of therapeutic alliances formed via videoconferencing fall significantly below similar ratings of interactions under face-to-face conditions (Rees & Stone, 2005). We actually know little about which specific competencies of individual psychotherapists translate into which types of alliances (effectively or ineffectively) for particular clients. Some types of therapeutic intervention will not easily translate into electronic activities (e.g., play therapy with young children or interventions involving therapeutic touch), while some others, such as exposure-based therapies, have made advances via virtual reality technology (Turner & Casey, 2014). This challenging domain remains one of the most rapidly evolving areas of professional practice and the ripest areas for clinical research.

We must also not overlook the obvious potential for mischief. Both those offering to provide services and those seeking to obtain

them may more easily engage in misrepresentation. How can one be certain that the person on the other end of the phone line or computer terminal is the person he or she claims to be? How accurate are the claims of teletherapy practitioners regarding their credentials, skills, and success rates with remote interventions? How will you feel when someone intent on a modern-day replay of Rosenhan's famous study (Rosenhan, 1973) or an angry former client posts edited excerpts of their "sessions" with you on YouTube.com or Stupidvideos.com? Will teletherapy lead to greater caution and reduced liability (e.g., by reducing the risk of client–therapist sexual intimacy) or greater risk (e.g., reduced ability to respond across distances with suicidal clients)? We will doubtless have more answers to such intriguing questions in the not-so-distant future.

Questions about the control or regulation of teletherapy practice remain highly fluid. The Federation of State Medical Boards (FSMB) has worked at developing a new licensure system for physicians wishing to practice across state lines (Downey, 2013). Among the principles cited as part of the plan, the practice of medicine would be defined as occurring where the patient is located at the time of the physician–patient encounter. This would require the physician to practice under the jurisdiction of the state medical board where the patient is located. Such interstate compacts would establish a mechanism whereby all physicians practicing in any given state will be known by, and under the jurisdiction of, the state medical board where the practice of medicine occurs. Such interstate agreements could obviate the need for a national license while allowing continued state-level controls.

The work of the Joint Task Force for the Development of Telepsychology Guidelines for Psychologists (2013) and discussions among national groups of regulatory boards may lead to similar progress for mental health clinicians. However, at present little agreement exists regarding standards for interstate or international telepractice in mental health. Those mental health practice jurisdictions that have set policies on this issue do claim regulatory

authority over services to clients sitting in their respective jurisdictions. However, the multiplicity of regulatory layers across mental health professions is far greater than in medicine. As described in Chapter 2, most jurisdictions require psychologists to have an accredited earned doctorate for licensing, although some extend limited privileges to certain individuals with master's degrees. In social work and other mental health fields, some licenses may be issued to those with a bachelor's, master's, or doctoral degree at differing levels of autonomous practice. Such variations may complicate interstate compacts.

If something goes wrong during telepractice, to whom can one complain? Will a domestic licensing board even open a complaint against one of its licensees who has treated a client residing outside their geographic jurisdiction? If they do, will the state government's enforcement branch authorize prosecution, and will the courts recognize jurisdiction? Will telepractice ultimately qualify as interstate (or international) commerce exempt from state licensing authorities? We simply do not know the answers at this time.

We do have some specific suggestions for colleagues who choose to communicate with clients using electronic media; these are compiled in Box 6-1.

Use of Emerging Technologies

Apart from teletherapy as a *specific* practice, novel or emerging technologies will continually create new ethical issues. Ethical standards related to competence (APA: 2.01e; AAMFT: 3.1, 3.10; ACA: C.2.b, C.2.f; NASW: 1.04.b) apply when clinicians wish to develop or implement new practice techniques for which generally agreed-on scientific or professional qualifications do not yet exist. For example, therapists using electronic means to provide behavioral health services to clients at a distance are practicing in relatively uncharted territories. Harm to clients served via telemetry may occur when therapists inappropriately diagnose a disorder, fail to identify suicidal or homicidal ideation, or reinforce maladaptive behavior, such as

helping socially phobic clients to remain isolated at home.

Consider some cases involving novel treatments for which generally recognized techniques and procedures have not been established:

Case 4-23: Neuro Transmitter, Psy.D. works in Paramus, New Jersey, and provides services through a service known as ShrinkMe.com of Dallas, Texas. One afternoon, he is connected via a Skype video call with a new client to the service, Ann Hedonia of Simi Valley, California. After 20 minutes of the session, Dr. Transmitter recognizes that Ms. Hedonia is seriously depressed with suicidal ideation and is feeling at the edge of her ability to cope. He gently suggests that perhaps she ought to think about hospitalization near her home. Ms. Hedonia replies, "Even you don't care about me! That's it. I'm going to do it!" and disconnects.

How does one conduct an adequate suicide risk assessment of a brand new client via an Internet connection to enable formulation of an adequate treatment plan? How does one intervene in the event of suicidal or homicidal ideation? How does one ensure privacy from electronic eavesdropping? Suppose Ms. Hedonia has a complaint about Dr. Transmitter. Which licensing board would be the one if she seeks a remedy: California, Texas, or New Jersey? Which state's law applies for professional practice, confidentiality, or licensing qualifications? Must Dr. Transmitter even have a state license to offer this service? Arguably, Dr. Transmitter did not personally solicit services but simply provides them via ShrinkMe.com, which in turn may argue that its services constitute interstate commerce, so no single state's laws (and licensing board) may have clear authority. What remedies does an aggrieved client have? What responsibilities do Dr. Transmitter and ShrinkMe.com have?

Similar issues apply to a plethora of new assessment and treatment services offered on the World Wide Web. One service invited people to submit questions that will be answered privately within 48 hours "by a person with at

least a master's degree in counseling." That service charged according to the byte size of the reply, possibly inviting the longest replies the consultant can generate. Another service offers to answer individual questions for a flat \$100 fee and provides a listing of half a dozen doctoral-level clinicians who will field the items submitted. Still a third service invites participants to a private real-time dialogue with a therapist via a video chat service of unspecified security. All require payment in advance by credit card, and all raise the same questions.

Case 4–24: Dr. Transmitter later checked in with Psych-Autix Limited, a "secure" international electronic chat network for mental health practitioners. He finds a private posting from one of his clients, Art Tonomy, who sent the message by Internet from his workstation at the accounting firm of Dewey, Cheatem, and Howe, L.L.C. Mr. Tonomy feels somewhat guilty about a secret extramarital affair he has begun with the wife of one of the firm's senior partners. He seeks some confidential guidance but is unaware that the accounting firm has established an "echo capture system" that records all incoming and outgoing messages as redundant protection against loss. In reviewing the external e-mail traffic the following week, the head of computer security will find Mr. Tonomy's message and call it to the senior partner's attention. There is nothing illegal about doing so.

In this situation, Dr. Transmitter used a "secure" system but could not provide a detailed warning about this particular limitation on privacy or confidentiality because he had no knowledge about the corporate employer's system where the message originated.

Although the idea of bringing psychotherapy consultation swiftly and efficiently to people who might not find their way to a therapist's office is appealing, a headlong rush into new technological approaches without thoughtful and accountable professionalism invites disaster. Psychotherapy presents many challenges when a client presents him- or herself in your office, and these can become compounded when telemetry becomes involved. In addition to the lack of clear nonverbal

communication typical of a telephone conversation, e-mail services remove voice, pitch, tone, and other verbal and bodily cues as clinical data. Videoconferencing services can reduce the problem but, depending on the broadband capacity and equipment available, may also provide less information than a live exchange. This can only increase the potential for errors and problems. However, for the moment we have significant concerns about the relative lack of consumer-oriented regulation. (See Box 4–1 for guidance on use of social media with clients and discussions of mental health professionals' use of social media and cyberadvertising of services in Chapter 11.)

UNTESTED OR FRINGE THERAPIES

From time to time, ethics complaints will develop in response to a new or unusual form of psychotherapy or supposedly psychotherapeutic technique. Often, these so-called treatments are of questionable merit or frankly dangerous. Notwithstanding the importance of evidence-based practice, as discussed at the beginning of this chapter, there must be room for appropriate innovation and the development of new treatment strategies in any scientific field. However, rigorous standards must be applied to avoid misleading, or actually harming, potential clients. No program of psychotherapy should be undertaken without a firm theoretical foundation and scientific basis for anticipating client benefits. New approaches to psychotherapy should be labeled as experimental with appropriate informed consent when that is the case and should be discontinued at the first indication that any harm is accruing to the clients.

This Is Therapy?

Jacobson and his colleagues provided a number of excellent and detailed illustrations in their book on controversial therapies for developmental disabilities (Jacobson et al., 2005). These include so-called emotional freedom techniques (EFTs), thought field therapy

Box 4–1 Special Considerations When Using E-Mail, Text Messaging, Social Media, or Other Electronic Means to Communicate With Clients

- Consider carefully and in advance which services and types of communication you want to provide electronically (e.g., appointment scheduling, impromptu requests, clinical updates, emergency messages, or actual clinical service delivery).
- Discuss with clients those topics that you are willing to discuss via electronic messaging, as well as the potential benefits, risks, and limitations involved with such communication (e.g., including the potential access by others to unencrypted messages).
- Emphasize limitations and constraints on access to you via such modalities (e.g., Do you plan to offer 24/7/365 coverage? Can a client expect a response within a particular time frame?).
- In most cases, you will want to advise clients to go to the nearest emergency room rather than rely on electronic communication in a true mental health emergency.
- Obtain and document (via a personally or electronically signed document) patients' informed consent to communicate with them in this manner.
- Establish security and encryption precautions compliant with the Health Insurance Portability and Accountability Act (HIPAA) prior to using electronic means for mental health communications with patients.
- Make sure that any information posted on your practice's website is up to date and accurate.
- Monitor online scheduling programs or access by others to your account carefully to ensure that confidentiality is preserved.
- Check your electronic message accounts frequently.
- Print or otherwise preserve all electronic message exchanges with patients and keep them with patients' treatment records.
- If you plan to deliver clinical services via electronic means, follow current best practices regarding contracting, competence, confidentiality, and control while also complying fully with the laws of your own licensing jurisdiction and that of the client.

(TFT), neurolinguistic programming (NLP), and the visual/kinesthetic dissociation (v/k-d) technique. These have attracted some attention as posttraumatic therapies (Lohr, Hooke, Gist, & Tolin, 2003). A series of Delphi polls of experts also called attention to mental health theories (e.g., Bettelheim's 1967 assertions that emotionally detached "refrigerator mothers" caused childhood autism) and treatments or techniques once in popular use but now deemed discredited (Koocher et al., 2014; Norcross et al., 2006, 2010). Examples of such treatments and techniques include angel therapy; the use of aromas, crystals, and divine spirits to promote mental health; and Reich's use of orgone energy accumulators or orgone boxes (Reich, 1948a, 1948b). Some specific case examples follow.

Case 4–25: Millard Brute, Ph.D., prepared a video for experimental use in implosive exposure-based desensitization of child abusers. The high-fidelity animation used virtual characters (realistic non-human depictions) to illustrate successively escalating physical assault on a child, culminating in the dismemberment and cannibalization of the corpse. The tape was played for a professional audience, and one outraged participant filed an ethics complaint as well as complaints to local criminal authorities.

Dr. Brute informed the ethics committee that the tape did not constitute an actual treatment tool but rather an experimental project he used for illustrative purposes with audiences exclusively composed of professionals. He also cited the Supreme Court's ruling in *Ashcroft v. Free*

Speech Coalition (2002) as protection from any criminal prosecution for using virtual child pornography to support his case. Nonetheless, the committee noted the intensely emotional nature of the tape and advised Dr. Brute to give more consideration to his audiences' sensitivities in the future. Certainly, the intense nature of exposure therapy regimens would require thorough discussion with any client prior to implementation. Some might question whether adequate data exist on which to predicate such treatment.

Case 4–26: Renee Roper, M.S.W., is a proponent of "harassment therapy." This sometimes involves extended verbal attacks on particular clients and in other situations involves tying clients up and forcing them to struggle to get loose. When an ethics complaint was filed, Ms. Roper explained her belief that this "paradoxical intervention" was necessary to be "harsh" on "the whimpering dependent types" to help restore their self-esteem.

Case 4–27: Gwendolyn Strange, Ph.D., required her individual therapy clients to participate in group therapy sessions at her home on a biweekly basis. They were required to sit in a circle on floor pillows while Dr. Strange perched above them on a stool, clothed in a black leotard, and read aloud to them from a book manuscript she was writing.

Case 4–28: Tanya Teton, L.M.H.C., is a proponent of "radical reparenting" therapy and strongly believes that she must help her clients to "recover from defective early nurturance" by fostering "regression and renurturing." Early in treatment, she asks her adult clients to sit in her lap and drink from a baby bottle. At times, clients are instructed to wear a diaper, and Dr. Teton powders their behinds. As treatment intensifies, she has occasionally invited these clients to nurse from her bare breast. One client complained to an ethics committee that the treatment seemed "way out of line."

The theoretical rationales of Ms. Roper and Dr. Strange are vague and questionable at best. It is difficult to imagine that either one has advised their clients of the potential emotional risks or lack of scientific support involved in

the so-called treatments. One must also wonder whether any of their clients have received objective description of alternative, more conventional, better-proven, readily available treatments for their problems. Dr. Teton seemed surprised by the "empathic failure" of the client who complained about her to an ethics committee. The male client was experiencing confusing feelings of sexual arousal during the nursing experience, but Dr. Teton discounted this in her response to the ethics panel, noting that there was "nothing sexual about it" as far as she was concerned. Often, it is the most ego-centric and least competent practitioners who come to the attention of ethics committees via this sort of complaint.

We have disguised the next case, but one can find a number of actual sites with similar offerings.

Case 4–29: One website describes "force intensity therapy" as "a form of energy psychotherapy methodology that integrates principles of human force psychology, mental control, and intensity therapy." The website also advertises a number of educational opportunities in the use of this technique, noting: "A previous background in intensity therapy is desirable but not required for training."

The website promoting force intensity therapy provides no scientific data, vague terminology and theoretical underpinnings, and considerable commercial advocacy. Sadly, many unlicensed practitioners lure members of the public with a mix of new age appeal and psychobabble.

Case 4–30: Flyers on community bulletin boards advertise the services of Rhonda Rooter by explaining that she "begins with the premise that every physical symptom has a mental energy component." She uses her innovative psychotherapy, called conflicting belief reinvention (CBR), to treat people with a wide range of physical ailments. These include high blood pressure, cancer, allergies, hypothyroidism, HIV, vaginismus, and sugar addiction. It seems that Rooter first recognized that the subconscious mind consists of a constellation of parts—each holding its own unique beliefs

about the self and the universe. Conflicting beliefs, desires, and goals create confusion and stress, according to Rooter. She says, "CBR ingeniously works to resolve such differences and reinvents essential collaboration between the subconscious and conscious mind, thus sidestepping psychological labeling and interpretation."

We have no clue about Rooter's credentials or the validity of her treatment techniques. Perhaps she actually helps some people, but aspects of her practice seem potentially scary. A number of the physical conditions she claims to improve have significant medical complexities. Her sales pitch makes no anatomical or theoretical sense, leaving concern that people seeking her help may find themselves in worse condition after her intervention than before, possibly delaying needed proven medical treatment.

Sometimes, things go terribly wrong. Applying a "new age" therapy technique, intended to bring Candace Newmaker closer to her adoptive mother by having the 10-year-old girl push her way out of a blanket to simulate birth, ended tragically (Sarner, 2001). In a 70-minute videotape of an April 18, 2000, session, Candace begged for her life as she tried to escape the blanket meant to represent a womb. She died of asphyxiation the next day. Prosecutors charged two psychotherapists, Connell Watkins, a purported expert on children with reactive attachment disorder, and her colleague Julie Ponder with child abuse resulting in death. The video showed Candace struggling and gasping for breath as the therapists and two assistants pushed on either side of her in an effort to simulate her rebirth. On April 20, 2001, in Golden, Colorado, Watkins and Ponder were found guilty of reckless child abuse resulting in death. In addition, Watkins was convicted of a second felony, criminal impersonation, and of two misdemeanors—obtaining a signature by deception and unlawful practice of psychotherapy. They were each sentenced to 16 years in prison. On April 17, 2001, then-governor of Colorado Bill Owens signed a bill into law (i.e., Candace's law) that now specifically prohibits the use of so-called rebirthing

techniques by mental health professionals in Colorado (Colorado Revised Statutes Section 2, 12-43-222).

Proprietary or "Brand-Name" Psychotherapy

From time to time, systems of psychotherapy have been developed and marketed as unique approaches to dealing with human problems. Any student of psychotherapy will think of Sigmund Freud as associated with psychoanalysis, Carl Rogers as linked to client-centered psychotherapy, and Albert Ellis as the founder of rational emotive therapy. As in the case of many systems and techniques of psychotherapy, research took place, books were written, lectures given, and students taught. In some cases, valuable brands resulted, and people earned a living catering to the brand. Some of these brands have developed significant proprietary aspects.

Characteristics of such systems usually include required specialized training, for which substantial fees are paid only to specifically designated instructors. The usual justification involves maintaining quality control or monitoring the purity of the intervention. As a result, there is often an aura of secrecy and lack of scientific scrutiny surrounding such approaches to treatment. Two modern examples that have become well known to professional communities and the public, but with very distinct differences in their scientific underpinnings and marketing, are Eye Movement Desensitization and Reprocessing (EMDR) and Erhard Seminars Training (est).

Eye Movement Desensitization and Reprocessing

The EMDR technique was developed by Francine Shapiro (Shapiro, 1995; Shapiro & Forrest, 2004; Shapiro, 2005; Wesselmann & Shapiro, 2013) and is described as a comprehensive method for treating disturbing experiences, such as trauma associated with sexual abuse, violence, combat, grief, or phobias. The treatment incorporates eight stages: taking

the client's history and treatment planning, preparation, assessment, desensitization and reprocessing, installation of positive cognition, body scan, closure, and reevaluation (Abel & O'Brien, 2015; Knipe, 2015; Luber, 2014). The treatment requires the client to describe aspects of traumatic memories, including images associated with the event, their emotional and physiological responses, the negative feelings of self-inherent in the memories (induced by the traumatic experience in the case of posttraumatic stress disorder [PTSD]), and to describe an alternate, desired, more positive self-perception. This sequence of steps is repeated until the client's Subjective Units of Distress Scale (so-called SUDS rating) approaches zero.

Eye Movement Desensitization and Reprocessing has become among the fastest-growing interventions in the annals of psychotherapy, and its progression has many similarities with the history of mesmerism (McNally, 1999). EMDR as a treatment for PTSD has received widely divergent reactions from the scientific and professional community. Perkins and Rouanzoin (2002) noted that many points of confusion exist in the published literature on this technique, including its theoretical and historical foundation, placebo effects, exposure procedures, the eye movement component, treatment fidelity issues, and outcome studies. These authors described the scientific process and charges of "pseudoscience" surrounding EMDR and concluded that the confusion in the literature and the controversy seem linked to five factors: the lack of an empirically validated model capable of convincingly explaining the effects of the technique; inaccurate or selective reporting of research; some poorly designed studies; inadequate treatment fidelity in some of the outcome studies; and multiple biased or inaccurate reviews by a relatively small group of authors.

One of the interesting questions about EMDR involves the inclusion of many elements of cognitive behavioral therapies along with the lateral eye movements, causing some to wonder whether what is effective about

EMDR is actually not particularly innovative, and whether what may seem innovative about EMDR is actually effective (McNally, 1999). Francine Shapiro (comments on Reed and Johnson, personal communication to G. P. Koocher via e-mail, January 17, 2007) argued that EMDR actually integrates many components in addition to cognitive behavioral elements used in cognitive behavioral therapy, including those used in psychodynamic and experiential therapies. In one book (2002), she asked experts of the various orientations in experiential, cognitive, and psychodynamic treatment to identify the elements in EMDR that made it effective. Each one identified elements of their own orientation as the pivotal factors.

Various reviews of the related eye movement research have provided a range of conclusions. Some reviewers (Lohr, Lilienfeld, Tolin, & Herbert, 1999) stated that there is no compelling evidence that eye movements contribute to outcome in EMDR treatment, and the lack of unequivocal findings has led some reviewers to dismiss eye movements altogether (e.g., McNally, 1999). Other reviewers (e.g., Chemtob, Tolin, van der Kolk, & Pitman, 2000; Feske, 1998; Perkins & Rouanzoin, 2002) identified methodological failings (e.g., lack of statistical power, floor effects) and called for more rigorous study.

Nonetheless, many studies have demonstrated beneficial outcomes for some people using EMDR, and we cite a recent sampling of overviews here (Abel & O'Brien, 2015; Knipe, 2015; Luber, 2014; Wesselmann & Shapiro, 2013). The Department of Veterans Affairs and Department of Defense (2004) have listed EMDR as a potentially effective treatment in their *Clinical Practice Guideline for the Management of Post-Traumatic Stress*.

Although EMDR has clearly proved beneficial for some types of clients, the marketing, restrictions on teaching the technique, and aura of secretiveness that result have contributed to a sense of mystique and controversy at times. Shapiro has attempted to ensure a standard quality in the training of the technique (Shapiro, 1995; Shapiro & Forrest, 2004;

Shapiro, 2005). A nonprofit professional organization named EMDR International Association (EMDRIA) was created as a forum “where practitioners and researchers seek the highest standards . . . by promoting training, research and the sharing of the latest clinical information . . . assuring that therapists are knowledgeable and skilled in the methodology” (according to its website at <http://www.emdria.org/>). Nonetheless, her work has spawned some creative innovators who probably cause consternation to well-trained clinicians. Consider the following examples:

Case 4–31: “Quick REMAP is a set of tools (seven protocols) that will help you to find relief from high stress events that often leave a painful and long lasting impact on the landscape of the emotional brain. Too frequently, people do not understand the effects of painful events and how they can lead to anxiety, depression, panic attacks, phobias, post traumatic stress disorder, repressed anger and unending grief. . . . When the thinking part of your brain and your emotional brain get in conflict, your sympathetic nervous system can take you on a high stress, emotional rollercoaster ride that is far more frightening than fun.”

The text in Case 4–31 was taken from the website of Steve B. Reed, L.P.C., L.M.S.W., L.M.F.T. (<http://www.psychotherapy-center.com>) in January 2015. REMAP stands for Reed Eye Movement Acupressure Psychotherapy, as practiced by Reed. He has taken some elements of EMDR, added other components, and branded it with his own name. The key ethical questions revolve around taking elements of different therapeutic approaches and then promoting the unresearched package as effective treatment. Readers will want to examine material offered by Reed’s site and draw their own conclusions regarding the validity and efficacy of REMAP, which he also describes as, “Better than chocolate for rapid stress relief.”

Case 4–32: Ranae N. Johnson, whose website for the Rapid Eye Institute describes her as the mother of 7 children, 22 grandchildren, and 4 great-grandchildren, also cites a Ph.D. in psychology

from the unaccredited American Pacific University of Honolulu, Hawaii, and another doctorate in clinical hypnotherapy from the unaccredited American Institute of Hypnotherapy, Santa Ana, California. The site suggests that she attended three other colleges but lists no degrees. She also reports graduating from the Institute of EMDR, Pacific Grove, California, with training in eye movement desensitization and reprocessing. Her website includes an animated demonstration of online rapid eye technology.

Francine Shapiro (comments on Reed and Johnson, personal communication to G. P. Koocher via e-mail, January 17, 2007) reported that Ms. Johnson took the first part of the two-part program in 1991 under another licensed clinician’s supervision. The requirements for attendance involved having either a mental health practice license or ability to provide mental health services under the supervision of a licensed clinician (e.g., in a licensing track). Ms. Johnson apparently started her rapid eye therapy based on that limited experience and never proceeded to licensure. At one time, Ms. Johnson tried to link her method to EMDR, claiming its research base supported her work, but she removed such claims from the website after being confronted about it (F. Shapiro, comments on Reed and Johnson, personal communication to G. P. Koocher via e-mail, January 17, 2007). Because Johnson calls her trainees “technicians,” they may circumvent state laws aimed at regulating psychotherapy practice.

Erhard Seminars Training

Werner Hans Erhard, the developer of est (Latin for “it is”), was born John Paul Rosenberg and became a skilled salesman with no professional training as a psychotherapist. His programs evolved to become the “Forum” seminars (Efran, Lukens, & Lukens, 1986; Finkelstein, Wenegrat, & Yalom, 1982; Wistow, 1986) and exist currently as the Landmark Education or the Forum, a genre of so-called large-group awareness programs sold to some of his employees in the 1990s. The basic approach focused

on challenging participants' sense of psychological identity or, as one commentator noted, systematic escalation and discounting of each participant's "adapted child," eventually forcing the participant into their "free-child" state, thereby releasing a large amount of "bound energy" (Klein, 1983, p. 178). Other articles have described est as "brainwashing" (C. B. Moss & Hosford, 1983), and there was a report that a patient suffered a psychotic episode following his participation in an est program (Higgitt & Murray, 1983). One of the few careful attempts to study Erhard's techniques in a rigorous fashion showed no long-term treatment effects and concluded that claims of far-reaching effects for programs of the Forum were exaggerated (Fisher et al., 1989). Many of Erhard's personal foibles were also revealed around the time he sold what had become a thriving business (Gelman, Abramson, & Leonard, 1991), and embarrassments followed his successors (Ross, 2005).

The ability of skilled salespeople, such as Erhard, to promote and morph their programs to unquestioning consumers in the face of criticism by behavioral scientists is impressive. The central message from an ethical perspective is the obligation of therapists to have a sound scientific foundation for their psychotherapeutic work. Proof of efficacy should precede mass marketing of new techniques to the public or to colleagues.

WHAT TO DO

- Therapists should remain sensitive to their own values with respect to the family or group and attempt to facilitate the growth of all concerned within the clients' value systems.
- Keep abreast of evolving standards and regulations governing the use of specialized techniques and devices.
- Only empirically validated or clinically proven approaches to treatment should be presented to clients as established treatment. Experimental procedures must be described to clients as such, and to

minimize risk, extreme caution should be used in the development of new modalities of treatment.

- If you plan to deliver services via telemetry, take steps to ensure that you comply with professional guidelines and applicable laws (e.g., HIPAA and state licensing laws).

WHAT TO WATCH FOR

- When treating more than one person at a time, as in group or family therapy, take care to respect, protect, and balance the rights of all the clients.
- When conducting group treatment or educational programs, carefully define and articulate the goals, methods, and purposes of each group. Communicate these in a way that enables each potential client to make a fully informed choice about participation.
- When practicing specialized therapeutic techniques that require dedicated training, including (but not limited to) sex therapy, behavior modification, hypnosis, and the use of medical and psychological devices, ensure that your training adequately qualifies you to use the technique in question. Any mechanical or electrical devices (e.g., biofeedback equipment) must be free from defects that could harm a client and be appropriately sanitized.
- When symptoms or techniques could raise special emotional or public policy questions, remain sensitive to the issues and discuss them and their implications with clients.

WHAT NOT TO DO

- Coercion rarely becomes an appropriate component of a psychotherapeutic program. To the extent that subtle coercive pressures enter into a therapeutic relationship, therapists should attempt to ensure that these do not cause detriment to clients.
- Avoid overpromising. When marketing or promoting your practice or psychotherapeutic techniques and products, exercise

appropriate caution and accuracy with respect to claims made and persons certified as competent to use the tool with clinical efficacy.

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5

Ethical Challenges in Working With Human Diversity

I don't want to belong to any club that will have me as a member.

Groucho Marx

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WHY HERE, WHY NOW?

Prior editions of this textbook attempted to cover ethical issues related to diversity in each chapter. We determined that a better course for this edition would be not only to note special issues as they arise throughout the book, but also to include a focused chapter calling

attention to the challenges inherent in doing one's best to act as an ethical practitioner, educator, or researcher in a global context. The goal of this chapter is not to provide a comprehensive list of ethical challenges to competent multicultural practice or to provide an authoritative or exhaustive guide to optimize ethical conduct across peoples and cultures. Rather, we

employ case materials with a goal of sensitizing readers and triggering self-reflection about the best ways to offer professional services in the most appropriate and respectful manner. This becomes particularly important when working with people who are very different from you in important ways that bear on their cognitive, social, or emotional functioning.

Fowers and Davidov (2006) described six central features of virtue ethics and linked those features to encompass multiculturalism. They described the key elements as

- pursuit of a worthwhile goal that
- requires personal strengths or virtues, which in turn are
- informed by knowledge of virtues,
- expressed through consistent actions,
- motivated by a sincere desire to seek the goals, and
- pursued wisely.

By integrating a discussion of cultural competence with virtue ethics, Fowers and Davidov developed an illuminating way for mental health professionals to understand and express the personal self-examination, commitment, and change required for learning and practicing in a culturally competent manner. In the context of virtue ethics, adopting a multicultural perspective represents the pursuit of valuable goals requiring personal strengths or virtues, knowledge, consistent action, appropriate motivation, and applied wisdom. Attention to cultural matters promotes human flourishing and the successful work of the mental health professional.

When practicing in a multicultural context, some mental health professionals seem oblivious to cultural nuance, subject to biases inherent in the majority culture, or too ready to buy in to social and ethnic stereotypes. Sociologists would warn us to remain mindful about “otherness” and the inherent power associated with societal majority status whether that involves gender, race, religion, national origin, sexual expression, social class, socioeconomic status, or other circumstances that place a person outside the cultural mainstream to which the

mental health practitioner belongs (Leong, Comas-Díaz, Nagayama Hall, McLoyd, & Trimble, 2014; McIntosh, 2004; Rosenbaum & Travis, 2015). Those with greater awareness of multicultural issues may at times feel trapped in an either/or situation. Either they must follow the ethical guidelines of their professional organization, and in so doing act in a manner they consider inappropriate, or they may take what feels like a more appropriate action while bending or violating ethical guidelines (Comas-Díaz, 2011; Pack-Brown & Williams, 2003). We have no easy solutions but encourage active engagement in thinking through these issues with grounding in individual differences and a thoughtful decision-making process.

A Problem of Definitions

The major mental health professions approach definitions very differently, largely as a result of their origins and traditions. The American Psychological Association (APA) does not include the word *diversity* in its ethics code, but includes respect for the rights and dignity of others as a main principle (APA: Preamble, Principle E), citing vulnerable populations and calling out age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status. The American Association for Marriage and Family Therapy (AAMFT) also does not use the word *diversity* in its code but cites responsibility to clients as an aspirational core value (AAMFT: Preamble) and calls for nondiscrimination based on race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, sexual orientation, gender identity, or relationship status (AAMFT: 1.1). The American Counseling Association (ACA) code cites diversity and multiculturalism more than 20 times (Preamble and Principles A, B, C, E, F, and G). The ACA calls out discrimination based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital/partnership status, language preference, socioeconomic status, immigration, status, or any basis proscribed by law

(ACA: C.5). The National Association of Social Workers (NASW) calls for respect for others and for diversity in several sections of its code, including a call for social action and preventing oppression on such matters (NASW: Preamble, 1.05, 2.01, 4.02, and 6.04). NASW calls out race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.

The nuances regarding why we find some specific protected categories in only one profession's ethics remains a mystery. These include age (APA), health status (AAMFT), political beliefs, (NASW), immigration status (NASW), partnership status (ACA), and spirituality (ACA). The differences may result from social trends at the different times when the codes were adopted but may also reflect particular values of each professional association's membership. One hopes that inappropriate discrimination on any basis would not be tolerated by any of the mental health professions.

The APA focuses its approach on the assumption that personal and human rights will be respected across all people (Preamble), and stresses application of scientific concepts by such steps as stressing validity and appropriate language use in assessments (APA: 9.02 b, c). The ACA calls out a need for multicultural perspectives in assessment (E.8), personal values (A.11.b), boundary setting (C.2.a), client rights (B.1.a), responsibilities to patients (B.5.b), continuing education (C.2.f), gatekeeping F.6.b), education (F.7.c, F.11.a–c), and research (G). The NASW focuses on fundamental rights (Preamble), cultural competence (1.05), respect (2.01), discrimination (4.02), and social/political action (6.04).

The APA has also gone on to offer detailed practice guidelines for many populations, including "Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations" (1993), "Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists" (2003), "Guidelines for Psychological Practice with Girls and Women" (2007), "Guidelines for Assessment of and Intervention With

Persons With Disabilities" (2012a), "Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change" (2012b), "Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients (2012c), and "Guidelines for Psychological Practice with Older Adults" (2014). Underpinning all of the vulnerabilities and special population needs is a recognition that respect for all people will require patience and attention to context.

The Fabric of Difference

In the health professions, we often use jargon and diagnostic codes to signal behavior or symptom patterns. The term *schizophrenia*, for example, denotes disturbed thinking and possibly delusions or hallucinations. However, not all individuals with schizophrenia will show the same behavior, voice the same concerns, or respond to the same interventions. At times, it seems too easy to categorize patient populations with a kind of shorthand label (e.g., Black, Latino, Asian, Christian, Jewish, Muslim, middle class, undocumented, etc.), but in reality, as with the schizophrenia label, such classifications tell us little.

Consider people with dark skin living in the United States. The term *Black Americans* could describe individuals with dark skin whose ancestors came to America on slave ships and who had the experience of growing up in the South, with keen recognition of that history. It could include individuals with a range of skin colors, reflective of interracial ancestry. It could include individuals born in the United States of parents who immigrated from Africa or the Caribbean with no clear link to the era of slavery. The term *African American* or *Afro Caribbean* might apply to some of those with dark skin whose ancestors were enslaved, but it could also refer to people who voluntarily migrated from Africa to North America or to Caucasians born in Africa under colonial rule or after.

North America's history of slavery leads into the important consideration of how nonindigenous people came to live here and how that

process bears on subsequent generations. Some arrived here kidnapped into slavery and had lives of forced servitude for generations. Some came as immigrants, deliberately seeking a better life. Others came as refugees, forced to leave their country to escape persecution, war, famine, or natural disasters. These origins play an important role in shaping the psychological status of first and subsequent generations, too often overlooked by mental health clinicians.

Consider the population of the United States with a heritage of Spanish as a first language. Did they come to the mainland from Puerto Rico, a U.S. territory, as non-English-speaking U.S. citizens? Did their ancestors cross the border from Mexico without documentation? Did they migrate from the Caribbean or Central or South America? Did their families cross from Cuba to Florida on an overcrowded boat? Did they come to the United States from Europe? Do variations in their skin color or language use subject them to discrimination even within the Spanish-speaking community?

Even North America's indigenous peoples have disparate life experiences that bear on their identities and the problems they have encountered as a result of their differentness. Native Americans who grew up in poverty on a rural reservation, or who were forcibly removed from their families as children, will have different life contexts from members of tribes more assimilated and far from a reservation or who benefitted from tribal casino revenues. Did their ancestors live in coastal forests, plains, or pueblos? Were their ancestors nomadic hunters or agrarian? How have their tribes' interactions with the immigrant settlers to North America influenced their traditions, native language, cultural practices, living circumstances, and social integration today?

How about citizens or residents with roots on the Asian continent? China or Taiwan, South or North Korea, India or Pakistan, Japan, Cambodia, and Thailand all have different languages, traditions, cultures, and life experiences. Similar variations in language, culture, education, and experience can be found among racial and ethnic groups who share some language or phenotypic similarities but are all quite different.

Religious traditions also may not translate across phenotype and easily fall prey to stereotypes. What does it mean to be Catholic, Protestant, Lutheran, Methodist, Presbyterian, Southern Baptist, or Christian? Are all Jews basically the same, from the ultraorthodox to the secular reformed? What values differ between the Sunni and Shiite traditions of Islam? How about the Baha'i faith, Hinduism, Jainism, Paganism, Sikhism, Taoism, and Zoroastrianism? What happens to religious beliefs across racial and national lines?

The past few decades have seen some remarkable shifts in public acceptance and tolerance of people whose gender and sexual preferences vary from the dominant preferences of society at large. Terminology and classification include many nuances that would leave most members of the public and many mental health professionals clueless. Some people may believe that they understand the concepts of being gay, lesbian, bisexual, or transsexual, but how about: pansexual (attraction to a person of any sex or gender), queer (a kind of umbrella term for sexual and gender minorities who are not heterosexual), intersex (genetic variations that are not clearly male or female), or cisgender/cissexual (an individual whose experiences of their own gender match the sex they were assigned at birth)?

What can one do? No practitioner or researcher will have the knowledge or cultural competence to serve everyone who walks through their office door. At times, such differences may well require the clinician to confront challenges created by a privileged, sheltered, or simply quite different upbringing from that of the client. However, we should know enough to recognize the power of gender, sexuality, race, religion, culture, language, exclusion, and other factors in shaping people's behavior and stand prepared to respectfully serve them whether that entails making a referral, seeking consultation, or otherwise focusing on how best to meet their needs.

The ADDRESSING Framework

Hays (2008) has noted that clinical literature on multiculturalism in mental health has tended

to focus almost entirely on race and ethnicity. Whatever the reason, that state of affairs ignores many minority populations facing special cultural issues and related needs, for example, elderly people, urban teenagers, gay men, lesbians, religious minorities, people with sensory or mobility disabilities, and people with a serious illness such as HIV/AIDS. Hays suggested a framework to conceptualize individual differences, assigning the acronym ADDRESSING, meaning

- Age
- Disabilities, acquired
- Disabilities, developmental
- Religion
- Ethnicity
- Socioeconomic status
- Sexual orientation
- Indigenous heritage
- Nationality
- Gender.

Despite the egalitarian appeal of the ADDRESSING concept, we must not lose sight of how critical race and ethnicity are in the United States. Given that the percentages of people of color credentialed as psychotherapists in the United States sits in the low double digits, most individuals of color who seek psychotherapy will of necessity receive treatment from European Americans. Although all mental health professions and all accredited programs must incorporate teaching on matters of diversity, accomplishing this in a sensitive and effective manner is extremely difficult. Tatum (2003) illustrated the problems inherent in teaching about racism effectively by describing and delineating the extent of guilt, anger, and distress involved in confronting issues of racism, even in a supportive setting. Despite frequent encouragement for therapists to become multiculturally competent, we often do not intervene in multiculturally responsive ways. One survey of 149 psychologists regarding their practices and beliefs reported that for 86% of the individual items explored, participants did not practice what they preached. For example, 42% of the respondents rarely or never

implemented a professional development plan to improve their multicultural competence, 39% rarely or never sought culture-specific case consultation, and 27% rarely or never referred a client to a more culturally qualified provider (Hansen et al., 2006).

FORGING AN ALLIANCE

A number of investigators have documented the importance of the therapeutic alliance in the multicultural therapeutic relationship, using the term *culture* in the broadest sense to include ethnicity, race, gender, age, sexual orientation, social class, physical ability, religion and spirituality, nationality, language, immigration and refugee status, and generational level and the interactions among these characteristics (Comas-Diaz, 2011; Moodley & Palmer, 2006). Box 5–1 provides a list of 10 critical considerations about which therapists should remain mindful as they attempt to function effectively in a multicultural clinical context (La Roche & Maxie, 2003). Forming a therapeutic alliance and attending to the client's distress are paramount.

Klutzy Behavior and Microaggression

Psychiatrist and Harvard University professor Chester M. Pierce coined the word *microaggression* in 1970 to describe insults and dismissals he said he had regularly witnessed non-Black Americans inflict on Black people (Delpit, 2012; Sue, 2010; Treadwell, 2013). Between 1973 and 1989, Massachusetts Institute of Technology (MIT) economist Mary Rowe produced a series of papers extending the term to include similar aggressions directed at women (Rowe, 1990). Eventually, the term has come to encompass the casual degradation of any socially marginalized group, such as poor people, disabled people, and sexual minorities (Paludi, 2010).

Perpetrators of microaggressions among mental health professionals seem more often awkward, clumsy, or foolish rather than malevolent. Derald Wing Sue (2010) defined microaggressions as brief, everyday exchanges that

Box 5–1 Key Considerations on Addressing Cultural Issues in Psychotherapy

1. Recognize that cultural differences are subjective, complex, and dynamic.
2. Understand that forming a good therapeutic alliance requires addressing the most salient cultural differences first.
3. Addressing similarities can form a good prelude to discussion of cultural differences.
4. Recognize that the client's level of distress and presenting problem will influence appropriate timing for discussion of cultural differences in psychotherapy.
5. Consider cultural differences as assets that can advance the therapeutic process.
6. Understanding the client's cultural history and racial identity development is critical to assessing how best to conceptualize presenting problems and achieve treatment goals.
7. The meanings and salience of cultural differences are influenced by ongoing issues within the psychotherapeutic relationship.
8. The psychotherapeutic relationship exists embedded within the broader cultural context, which in turn affects the relationship.
9. The therapist's cultural competence will have an impact on the way differences are addressed.
10. Having a sensitive dialog about cultural differences can alter the client's cultural context about an issue.

Source: Adapted from "Ten Considerations in Addressing Cultural Differences in Psychotherapy," M. J. La Roche and A. Maxie, 2003, *Professional Psychology*, 34,180–186. doi:<http://dx.doi.org/10.1037/0735-7028.34.2.180>

send denigrating messages to certain individuals as a function of nothing more than their group membership. He described microaggressions as generally triggered below the level of the perpetrator's awareness, often by well-intentioned members of the dominant culture, who blindly view themselves as highly accepting and tolerant of differences. Such microaggressions are categorized differently from overt, deliberate acts of bigotry, such as name-calling with racist or derogatory epithets, because the people perpetrating the microaggressions often intend no offense and are unaware of the harm they cause (Delpit, 2012; Sue, 2010; Treadwell, 2013).

Mary Rowe (1990), who served as the ombudsperson reporting directly to the president of MIT for many years, described the same types of events as "microinequities," defining them as often ephemeral and hard-to-prove events that are covert, often unintentional, and frequently unrecognized by the perpetrator. She noted that such microinequities occur wherever people are perceived to be "different,"

such as Caucasians in a Japanese-owned company, Black Americans in a white firm, women in a traditionally male environment, or Jews and Muslims in a traditionally Protestant environment. Examples from her writing include these quotations drawn directly from cases she encountered at MIT:

"She cannot represent us in Washington; she isn't even pretty!"

"Don't try to build a career in that company, Aaron; they are very traditional. Because of who you are, you will never make it to the top."

"Check his work for a few weeks, will you, Henry? His grades are good, but you can't tell with someone from a black college."

"He said that my joke was racist. Do you think he is really on the team?"

"If she weren't black, she would have been fired long ago, but nobody has ever said a thing to her."

"My God, you think no better than my wife; why don't you go home and have babies!"

"Hey, Paul Wu, you made a mistake in math!
How come? I thought you guys never made
a mistake!"

"We hired a Hispanic engineer and he was
incompetent; never again."

"Iharass everybody, Mary. I don't discriminate."

While such mechanisms of prejudice against persons of difference typically seem small in nature, their effects are not trivial. They feel especially powerful when taken together. Just as one drop of water has little effect, a continuous flow of drops can become destructive; one racist slight may seem insignificant, but many such slights cause serious damage. Microinequities work both by excluding the person of difference and by making that person less self-confident and less productive. Rowe also discussed microaffirmations, mentoring, and affinity networks as ways to fight such problems, promote diversity, and foster inclusion, noting that employers may prevent damage by developing programs on diversity, such as valuing differences and promoting team building.

A recent photo essay depicting examples of microaggressions heard on a daily basis by students in Manhattan (Nigatu, 2013) illustrates that the sorts of problems cited by Rowe more than two decades ago have not gone away. The essay included the following quotations:

"No, where are you really from?"

"So, like, what are you?"

"You don't speak Spanish, but your name is Sanchez?"

"So what do you guys speak in Japan, Asian?"

"You don't act like a normal black person,
ya know."

"Courtney, I never see you as a black girl."

"So, you're Chinese, right?"

"You're really pretty for a dark skin girl."

Consider the following examples drawn from actual encounters with mental health professionals:

Case 5–1: Ned Numbskull, M.S.W., enthusiastically gabbed to colleagues at the Mid-Town Mental Health Center about his recent study tour to China, which involved some Mandarin language classes. Assigned to do an intake evaluation

with a new client, Min-Jun Yoo, Mr. Numbskull walked into the waiting room and greeted Min-Jun with a perfectly articulated: Xiàwǔ hǎo (good afternoon). Min-Jun seemed confused, asking, "What did you say?" Numbskull explained he had tried to say "good afternoon" in Chinese. Min-Jun replied, "We don't speak Chinese in South Korea, and I grew up speaking English in Los Angeles."

Case 5–2: After walking through the airport metal detector, Mindy Mouthslip, M.D., saw the TSA (Transportation Security Administration) inspector open her carry-on medical bag containing medication in opaque tubes. On a recent trip, an inspector had spilled some pills on the floor while looking in the bag. Recalling that episode, Dr. Mouthslip called out, "Be careful, you people are too careless with medication samples!" The Black American TSA inspector looked up and said, "What do you mean, you people?"

In these cases, spontaneous comments or behavior that made contextual sense to the actor, a European American, delivered an unintended insult to a person of color. A sincere apology and explanation by Mr. Numbskull and Dr. Mouthslip might improve the situation slightly, but the bell cannot be unrung. The insult was delivered; just as many other such comments are delivered in the daily lives of people living in cultures where they constitute a noticeable minority.

Of course, race is not the only difference that can trigger microaggressions. Consider the following examples:

Case 5–3: When Sally Senior, age 75, arrived at her psychotherapist's office for an initial appointment, Rita Receptionist handed her a packet of forms to sign (e.g., consent to treatment, HIPAA [Health Insurance Portability and Accountability Act] notice, etc.). Ms. Senior, a retired college professor, began to read the forms carefully. As she continued reading, Ms. Receptionist grabbed the papers out of her hand and said, "Here, I will help you." She printed Ms. Senior's name and date, then said, "So then you sign here."

Case 5–4: Jacob Jumble, Ph.D., began couples therapy with Lee and Blake Blurry. Dr. Jumble

continues to misgender Lee, calling the transitioning husband “him” when referring to her, even though Lee now identifies as “she.” Dr. Jumble never asks, “What is your preferred gender pronoun?”

Ms. Receptionist had good intentions but made an offensive attribution regarding Ms. Senior’s behavior, possibly because few people actually read the forms before signing and because she assumed that the elder client was having difficulty. She could have simply asked, “Do you need any help or additional information?” Knowing of the transgender context, Dr. Jumble could have asked Lee and Blake Blurry what pronouns they preferred and offer a simple apology for any slips or confusion in pronoun use.

A special section of *Professional Psychology* (Borden, 2015) addresses a range of issues focused on challenges and dilemmas involved in treating transgender and gender-nonconforming individuals. As public acceptance grows, this population will certainly become more visible in society and more prevalent in the offices of psychotherapists.

Failed Attempts at Alliance

We have adapted the next set of case vignettes from reports about a prior therapist made by clients to subsequent therapists, who shared them with us for teaching purposes. In each case, some beliefs, biases, or missteps by the therapist compromised their ability to form a good working alliance with their client.

Case 5–5: During her first session with Nan Turner, a 28-year-old Black American woman, Darla Dense, M.D., a 50-something woman of Euro-American heritage, asked about where in the urban ghetto Turner had grown up. Turner explained that she grew up in the same suburban community as Dr. Dense, but the psychiatrist said she could not believe some of the experiences Turner reported. Dr. Dense’s perceptions of the suburban town were quite different from Ms. Turner’s, and Dense could not recognize the possibility of such things happening, so she

concluded that Turner was either misrepresenting her past due to shame or had poor reality-testing abilities.

Case 5–6: When Henry Hightower, a Black American college student over 6 feet tall, went to the University Counseling Center for help in dealing with difficulties he was experiencing on campus, he was assigned to Biff Jerko, Psy.D. In an effort to “forge an early alliance,” Dr. Jerko attempted to greet Mr. Jackson with a “fist bump” instead of a more traditional handshake. During the course of the session, Dr. Jerko continued his “attempt to connect” by using profanity and slang that he regarded as emulating “street talk.” Mr. Jackson wanted to talk about the fact that his imposing stature and dark skin seemed to make people uncomfortable. He reported that campus security seemed to ask to see his ID card more frequently than those of his White peers. Dr. Jerko quickly attempted to reassure Mr. Jackson that he would be judged only by his character and studies on campus and resisted exploring the impact of prejudice that may accrue to tall black males. Neither the hand greeting nor the slang use were a part of Mr. Jackson’s background, and both were perceived as alienating. Adding insult to injury, Dr. Jerko asked Mr. Jackson whether he planned to try out for the college basketball team. Jackson did not have the energy or assertiveness to attempt reeducation of the therapist, and he never returned for another appointment.

Case 5–7: Carlotta Hernandez, a Chicana in her early 20s who was born in Texas to undocumented parents, was struggling with emotional issues involving her relationship with her mother when she sought consultation with Carl Cutoff, M.S.W. Ms. Hernandez was the first college-educated person in her extended family and felt torn between feeling traditional obligations to family and her newly experienced social mobility. Mr. Cutoff praised her academic achievement and encouraged her to sever or at least minimize contact with her family, which continued to reside in a poor rural community. He did not understand the importance of her struggle to balance family connections with individual achievement. Ms. Hernandez needed to pursue options of how to stay connected in an emotionally healthy way.

The more Mr. Cutoff pressed her to disconnect, the more depressed she became.

Case 5–8: Pam Passer, a very fair-skinned biracial Black American, was concerned about just how “Black” she was given that she could “pass” as White. Robert Blinders, L.M.H.C., her therapist, dismissed such concerns, stating that she should just see herself “as an American.” Passing for White might give her greater social and professional mobility, but the emotional cost felt to Pam as though she would be disconnected from half of her family and the community in which she was raised. Dr. Blinders could not hear the implications of the disconnections for her as these were not his values.

Case 5–9: While leading a course in personality assessment at the Frobisher School of Professional Psychology, new faculty member Nelly Nudnik, Psy.D., a European American, sought to establish rapport with a Black American student by referring to her as “sister girl” in class. She similarly referred to a female student of Puerto Rican heritage as “mamacita.” The students complained to the dean, who met with Dr. Nudnik, who began to sob. Nudnik described herself as a long-time donor to civil rights causes, the adoptive parent of a biracial child, and a volunteer worker at an inner-city community clinic, where some of the Black American female workers had taken to calling her sister girl as they worked together. She did not understand how the students could possibly view her attempts to connect as inappropriate.

These case examples illustrate a range of inappropriate behaviors with varying degrees of adverse consequences, but a common theme is insensitivity or inadequate attention to the individualized needs and feelings of clients who are different because of race, ethnicity, or social class. Dr. Dense made damaging assumptions regarding her client and could not entertain the concept that the client’s reality of living in the same town might be different from her own. Dr. Jerko based his feeble attempt at establishing rapport on caricature stereotypes and could not recognize or acknowledge the impact of being a tall Black American man on

Mr. Jackson’s day-to-day experiences in a biased society.

Mr. Cutoff and Dr. Blinders could not grasp the struggle for acceptance and accomplishment balanced with the need to value family connections that is very much a part of life for many ethnic minorities. Being uninformed, unwilling to learn, unable to hear, and relying on stereotypes as reality remain major ethical problems to which too many mental health professionals are inadequately attentive. In each case described here, the clinician has behaved in ways that are certainly not going to have the desired effect and could lead to premature termination or actual harm.

Dr. Nudnik demonstrated some behaviors that betokened inappropriate stereotyping and misperceptions, despite best intentions. Her political life and internalized self-image define her as a “White liberal” European American who wants to do the right thing and does so in some aspects of her life. Still, she seems prone to overgeneralize and behaved insensitively. She did not adequately differentiate the clinic setting where some Black American coworkers seem to have affectionately called her sister girl from the classroom, where she has an unequal power differential over students she does not know well and who seek to define themselves as young professionals interacting with the faculty. The epithet appropriate to one context is inappropriate in the other. Use of the term *mamacita* becomes even more complicated because of the implicit sexual connotations of that word, of which Dr. Nudnik seems clueless.

Acquiring multicultural awareness demands active ongoing pursuit (Inman, DeBoer, & Kreider, 2013; Penn & Post, 2012;). The most competent professionals strive over time to acquire and enhance their skills to deliver the most culturally appropriate and effective services (Ancis & Ladany, 2010). The responsibility for supporting and encouraging such behavior falls on training programs and supervisors to prepare students, clinical trainees, faculty members, and supervisors for the ongoing pursuit of multicultural competence.

IMPROVING DIVERSITY EDUCATION AND TRAINING

Most professional training accreditation bodies stress multicultural training as part of their accreditation standards, although the ACA calls out the need for such training in its ethics code (ACA: C.2.f, F.1.a–b, F.7.c, and F.11.a–c). The NASW also calls this out as an education and competence prerequisite general term (1.05.c), as does the APA in its Preamble E. However, what is the best way to infuse such training? The key seems to be engaging supervisors or colleagues to help engage others in discussion whenever opportunities arise.

Self-Assessment

Consider the culturally biased assumptions inherent in mental health practice (Pack-Brown & Williams, 2003):

- Diagnosis and treatment of mental illness are defined and influenced by cultural beliefs.
- Culture provides our framework for defining normality in the world and by extension abnormal behavior and pathology.

- Research supports the notion that manifestation of symptoms is affected by cultural contexts.
- Diagnostic categories are framed and assigned by the dominant culture.
- Mental health care providers are predominantly members of the majority culture.
- Members of nondominant culture are proportionately overrepresented among those defined as mentally ill.

In the context of remaining as aware as possible of one's own biases and challenges in meeting the needs of a diverse client population, consider the self-assessment items detailed in Box 5–2. Save your self-assessment and reflect on it from time to time as your experience broadens and your employer or client population shifts.

Critical Events Framework

The critical events model (Ladany, Friedlander, & Nelson, 2005) stresses an interpersonal approach to emphasize using incidents as effective training in multiculturally competent counseling and supervision. The framework emphasizes supervisee learning and growth and considers the supervisory working alliance

Box 5–2 Self-Assessment

1. What thematic personal and cultural values are most important to my personal and professional identity?
2. Do I have clients who differ significantly on these dimensions? If so, what have I done to improve my cultural competence and awareness of their values and identity?
3. What are the key cultural values of my employer (including its client policies) or my professional association (with its ethics codes and practice guidelines)?
4. Could I be encouraging or abetting unethical behavior because of incongruity between my values, my employer's values, or my professional association's values and those of the clients I serve?
5. As I seek to protect myself, what are my ethical obligations when I notice a cultural incongruity in values between my professional association, my employer, legal obligations, and the people I serve?
6. What have I done to improve my multicultural education or arrange for consultation, if needed?

that includes multiculturalism as “the foundation for effective supervision” (Ladany et al., 2005, p. 11).

Supervisors who intentionally include multicultural sensitivity in their practice or supervision can facilitate supervisee growth and clinical competence in this arena (Burkard et al., 2006; Inman et al., 2013; Ladany et al., 2005; Mori, Inman, & Caskie, 2009). Alternatively, a lack of supervisory awareness or competence in multicultural contexts can limit supervisees’ development and self-efficacy (Ladany et al., 2005). Given the gate-keeping role that supervisors play, it is incumbent that supervisors fully accept responsible for their own multicultural competence (Ladany et al., 2005) and aid the development of supervisees’ multicultural competence in knowledge, client conceptualization, and skills through clinical experiences (Inman, 2006). (See also Chapters 10 and 14.)

Just as one cannot reasonably expect that any given therapist will have the ability to adequately meet the treatment needs of every client, it is also unreasonable to expect that the ideal therapist (i.e., in terms of ethnicity, culture, etc.) or supervisor for any given client will be readily available in every community. In unusual situations, one can often learn much simply by asking direct questions. We use the following case vignette to illustrate one way in which supervisors may use the critical events model to provide effective supervision in a multiculturally competent manner.

Case 5–10: Annie Pueblo was a 5-year-old Native American who had relocated along with her mother from her home on a reservation to a major urban center by the Federal Indian Health Service. Annie was in critical need of an organ transplant and was “on standby” at a large medical center. A nurse became concerned after overhearing a partial conversation in which Annie and her mother were talking about communicating with the dead. The nurse expressed her concern to the consulting psychologist on the organ transplant team: “Conversations about such things are certain to depress the child.”

The psychologist met with the child, who told him of a dream: “Dead people are trying to give me food, but I’m not gonna take it!” The child’s mental status and behavior were normal aside from these unusual remarks, so the psychologist sought out the child’s mother and asked for her help by noting, “I’m not familiar with the ways of your people. Do you have any ideas about why Annie is saying this?” The mother laughed and explained that Annie had reported dreaming of an old woman in distinctive costume who offered her food. The mother explained that she did not know who it could be, so she telephoned her own mother on the reservation. Annie’s grandmother listened to the report of the dream and immediately recognized the spirit of her own grandmother. The dream spirit was interpreted as Annie’s long-deceased great-great-grandmother coming to watch over her. This was a good and protective omen; however, it is also very important that one not accept food from spirits of the dead. Doing so requires that you join them. It was important that Annie know how to accept the protection but decline the food (e.g., pretend you don’t hear the offer or politely say, “Thank you, but I’m not hungry”).

By seeking information, the psychologist picked up valuable data that could be used to assure the nursing staff that Annie was in no way depressed or being put at risk. In fact, Annie had been given culturally appropriate information that helped her to feel cross-generational social support in a way that the local health care team could not provide. By recognizing that this family was culturally different and by respectfully seeking information about those differences, the psychologist was able to defuse misunderstandings and educate others on the hospital staff.

Case 5–11: Mrs. Garcia, a Spanish-speaking Chicana, was presented for treatment of postpartum depression at an inner-city health clinic serving low-income families. The case was assigned to Greta Greenhorn, M.A., a graduate student in psychology who had good Spanish language skills, having spent a semester studying in Mexico as an undergraduate. Greta planned to design a

preventive intervention program for depression for her dissertation research. After forming an initial rapport while completing intake forms, Ms. Greenhorn reported to her supervisor to express a plan to start using a short-term cognitive behavioral therapy (CBT) approach she studied in her graduate program. Dr. Sally Sage, Greta's supervisor, had a different suggestion and tried to use the event as a critical teaching moment.

Dr. Sage did not have a Chicano cultural background but tried to keep current on the research literature relevant to the population treated at the clinic. She called Greta's attention to a meta-analysis of the treatment of perinatal depression in socially disadvantaged women that suggested a culturally adaptive interpersonal therapy (IPT) approach was significantly more effective than standard CPT protocols (Rojas-Garcia, Gonçalves, Rodriguez-Barranco, & Ricci-Cabello, 2014). While not as dramatic as the prior case, Dr. Sage recognized this as a critical event and helped her supervisee to think about whether the manualized approach to CBT she had learned in her graduate program might not work as effectively to engage and assist Mrs. Garcia as one that focused on more interpersonal alliance building at the outset. The same meta-analysis also led Greta to begin rethinking her dissertation, as IPT also seemed more effective than prevention programs in this poverty-affected population. But, wait, Dr. Sage may be making an error similar to Ms. Greenhorn, with a research mask as overlay. Mrs. Garcia is an individual and may or may not fit expectations for the research literature. Taking a strong cue from research evidence is important, but it is equally important to engage Mrs. Garcia in a discussion of options to assess her comfort preferences. One can always switch approaches after treatment has begun if the client does not seem to benefit from the initial therapeutic strategy.

Promoting multiculturalism with those we train undoubtedly strengthens character and provides knowledge about and modeling of openness to the other. This includes both general and specific aspects of culture that inform openness and makes it possible (Fowers &

Davidov, 2006). The research literature has demonstrated that attending to power and diversity in supervision enhances both trainee learning and satisfaction (Green & Dekkers, 2010). We also have good evidence that a supervisor's multicultural competence helps to form a solid supervisory working alliance and results in better supervision satisfaction (Inman, 2006). Similarly, when working in supervision with international students, students with lower acculturation levels but who experienced greater cultural discussion, showed more satisfaction with supervision. In addition, supervisors who engaged in cultural discussions were perceived as having cultural competence and providing more satisfying supervisory experiences (Mori et al., 2009).

Aversive Racism

The term *aversive racism* originated with physician and social activist Joel Kovel, who used it to describe "the subtle racial behaviors of any ethnic or racial group who rationalize their aversion to a particular group by appeal to rules or stereotypes" (Gaertner & Dovidio, 1986, p. 62). The concept became well articulated in the work of Gaertner and Dovidio (Gaertner & Dovidio, 1986, 2012; Hodson, Dovidio, & Gaertner, 2010), who demonstrated how negative evaluations of racial and ethnic minorities can flow from a persistent avoidance of interaction with other racial and ethnic groups. This way of thinking contrasts with more typical overt racism, characterized by expressed hatred for and discrimination against minorities. Aversive racism reflects a more complex and ambivalent set of expressions and attitudes (Hodson et al., 2010).

Psychological triggers for aversive racism flow from the human disposition to cognitively categorize people and experiences (Gaertner & Dovidio, 2012; Kite & Whitley, 2012). Sorting people into different groups highlights the differences that exist between the group(s) with whom we identify and "the others." After recognizing such differences, people normally attempt to control their environment when interacting with outgroups. In this way, we

generally seek to generate positive experiences, especially when interacting with minorities. Such behavior typically occurs beyond conscious awareness (Gaertner & Dovidio, 2012; Kite & Whitley, 2012).

Suppose that you are referred for a consultation to a psychotherapist or that you serve on a committee admitting students to a graduate program. Two equally well-qualified names appear on the list, and you must choose one. If one is named Amy, Molly, or Claire and the other is Lakisha, Ebony, or Shanice, who will you choose? If the male names include Greg, Jake, or Scott versus DeShawn, Jamal, or Terevon, who will you choose? Why will you make that choice? In making your decision, will you consciously recognize that these are among the 20 "Whitest" and "Blackest" names in the United States (Levitt & Dubner, 2006)? On some level, you will have such an awareness, and it may guide your choice deliberately or unconsciously (Bertrand & Mullainathan, 2003). The choice may flow from stereotypes related to competence, from a wish to have the most positive experience possible, or from some other driving motive, but you will make a choice, and your imaginings or imputed meaning about the person based solely on the person's name will play a role. You may even review the data again and cognitively frame a rationale that has "nothing to do with the name," but are you certain? Consider these issues when reflecting on your behavior and consider making use of teaching tools to educate others on these issues (Pearson, Dovidio, & Gaertner, 2009).

SPECIAL CHALLENGES

We address some general content related to special challenges in general psychotherapeutic practices in Chapter 3 (see Cases 3–3 and 3–4). We also do so with respect to test biases and assessment issues in Chapter 7 (see Cases 7–8 and 7–9, as well as the litigation in *Larry P. v. Riles* and *PASE v. Hannon*). We also touch on examples related to confidentiality in Chapter 6 (see Case 6–8) and certain work settings in Chapter 15 (see Cases 15–14 and 15–15). At

times, the diversity issues can prove even more complex.

When Core Values Run Afoul of Law

One need look no further than the passionate debate over gay marriage in the United States to see the intensity of social, religious, family, and individual feelings on a single issue. Access to abortion, responses to domestic violence, racial profiling, mandatory drug sentences, and many other such issues raise powerful feelings about risk, discrimination, and personal values. Mental health professionals will have strong views on these issues, as will our clients. Legislation and court decisions may seem to settle matters, but that does not necessarily alter people's feelings or keep such matters out of the psychotherapy office.

One key ethical issue involves the need to rely on sound evidence, as opposed to personal opinion, when speaking out as a mental health professional on such topics. As an example, a considerable amount of research informs our field regarding the facts of parent–child families when a family member identifies as gay, lesbian, or bisexual. When asked to offer public comments on such relationships and outcomes, we must be prepared to function as informed professionals, even if we have religious or social policy objections as individuals (Breshears & Lubbe-DeBeer, 2014; Borden, 2014; Diamond & Shpigel, 2014; Feinstein, Wadsworth, Davila, & Goldfried, 2014; Goldberg, Kinkler, Moyer, & Weber, 2014; Horn & Wong, 2014).

When dealing with clients who are immigrants, refugees, or whose strongest cultural roots lie outside North America, our laws may seem strange. Western legal culture relies on ideas such as corporations, contracts, estates, and individual rights. These concepts do not exist in some cultures and are treated quite differently in others. Often, such differences relate to personal decision making, family life, religion, sexuality, and even the definition or meaning of what mental health practitioners in North America might deem psychopathology.

For example, traditional law in traditional African culture is based on natural justice

without abstract concepts that depend on written language to elaborate concepts into theory. Traditional African law focuses on social considerations and resolving disputes via restitution of social relationships rather than a definition of right or wrong. As another example, traditional Islamic law engages the larger culture where knowledge, right, and human nature play central roles. This might include attention to social origins, connections, and identity. The key values of traditional law in Islamic society focus on restoring relationships and easing the resolution of disputes with considerable negotiation and judicial discretion (Post, 2003).

Consider how some cases with legal ramifications might play out in the context of individual differences:

Case 5–12: Rivka Cohen has been in an unhappy marriage with her husband, Shlomo, for 5 years. They are Orthodox Jews and had consented to marry through a professional matchmaker arranged through their parents. Rivka has sought treatment for depression and anxiety in the context of documented physical and emotional abuse with Dee Lemma, L.M.F.T. Shlomo has refused to participate in treatment, calling it “a waste of time.” Rivka tells Ms. Lemma that she has asked Shlomo for a divorce, but he has refused. When Ms. Lemma explains that a wife can file for divorce without her husband’s permission, Rivka explains that under Jewish law, a wife seeking a divorce must obtain her husband’s consent in the form of a signed document called a “get” or the divorce cannot happen. A civil divorce in the absence of the religious document would put her at odds with her community. After seeking renewed assurance of confidentiality, Rivka explains that she has hired a “special rabbi” to kidnap Shlomo and force him to sign the “get.” For \$50,000, paid by Rivka’s parents, the rabbi’s team will snatch Shlomo on his way home from work and use isolation and a cattle prod to obtain his signature.

Case 5–13: Haruto Watanabe, M.D., completed his medical training in Japan and is now a psychiatric resident at County General Hospital. He was asked to consult on the case of Mrs. Sato, an 80-year-old woman, who lives with her daughter

and son-in-law in the United States. Mrs. Sato speaks only Japanese, although her daughter and son-in-law are fluent in both Japanese and English. Mrs. Sato has been admitted to the hospital with abdominal pain and is quite anxious. The diagnosis is gallbladder cancer, but the only people at the hospital capable of communicating the diagnosis to Mrs. Sato are Dr. Watanabe and members of her family. The gastroenterologist has asked Dr. Watanabe to help explain the diagnosis and treatment options, but the family members express a wish to do it themselves. They tell Dr. Watanabe in Japanese that they do not believe Mrs. Sato can handle the news and plan to tell her that it is a simple gallstone (Bever, 2014).

Ms. Lemma, a Catholic, has little familiarity with Orthodox Judaism, but feels that she appreciates Rivka’s need to have a religious divorce as well as a civil divorce. She understands how emotionally distressed Rivka feels but is stunned by the kidnapping plan. Rivka will not be talked out of the plan, and Ms. Lemma now wonders whether she has a duty to breach confidentiality to warn Shlomo or to report a planned criminal act (kidnapping) to the authorities. After investigating the situation via online searching, Ms. Lemma learned of a Federal Bureau of Investigation sting operation to stop such practices (Bever, 2014) and wonders whether her client might become the victim of further violence from Shlomo if she warns him or face prosecution as a coconspirator if she contacts the police. This might be an opportune time for Ms. Lemma to discuss potential repercussions with Rivka.

While attending medical school in Japan, Dr. Watanabe learned that physicians (in Japan) do not have a legal duty to inform patients of a cancer diagnosis (Masaki, Ishimoto, & Asai, 2014). Concepts of informed consent in Japan and the United States have many significant differences, and it is not unusual for physicians in Japan to deal chiefly with family members rather than involving the patient directly in medical decision making. Still, Dr. Watanabe wonders about his obligations under U.S. law, while recognizing that he could honor the family’s request without ever letting the rest of the

English-speaking medical team know the truth. Perhaps, instead of allowing himself to be used as a linguistic interpreter, Dr. Watanabe can try to educate his American colleagues by interpreting the cultural issues involved and engaging in a more interactive approach between the family and medical staff.

Multiple Relationships and Communities

We spend considerable detail discussing non-sexual multiple-role boundary problems that can occur within communities large and small in Chapter 8. At times, however, a subcommunity composed of a diverse population segment can raise important nuances.

Case 5–14: Sarah Sappho, Ph.D., practiced psychotherapy in Middlesize City with a population of 650 thousand people. Dr. Sappho openly identified as lesbian and had married another woman in a public ceremony. Many women with feelings of romantic or sexual attraction to other women sought her out as a therapist because of her competence and reputation as a person who knew and understood the issues and complexities of personal, family, and community life related to their sexual preferences. Several sessions into a psychotherapeutic relationship with Marla Menace, it became clear to Dr. Sappho that Marla's acting out and threatening behavior ruin any hope of a continuing therapeutic alliance. Dr. Sappho decided to plan for termination of treatment; however, Ms. Menace stormed out of the office when Dr. Sappho brought the matter up and attempted a transfer. Over the next several weeks, some of Dr. Sappho's patients mentioned that Ms. Menace had posted hostile comments on about Dr. Sappho's "dumping" of her on several lesbian community blogs and at a Lezbein Middlesize Community Association meeting.

As a professional and member of the lesbian community in Middlesize City, Dr. Sappho faced the challenge of respecting her professional ethical obligations to Ms. Menace and defending her own reputation. Dr. Sappho must respect the confidentiality of her client, and

that could require remaining silent in the face of the public criticism by Ms. Menace in the relatively small Middlesize City lesbian micro-community. In the more complex case from which we crafted this brief example, the therapist explained to those contacting her about the angry ex-client's comments that she had to honor her duty of confidentiality to all clients and could not confirm or deny client status or any other details. Not surprisingly, the community soon came to understand Ms. Menace's true personality by observation (Brown, 2011).

When Does Culturally Different Discipline Become Abuse?

Parenting, child rearing, and disciplinary practices differ widely across cultures (Tharp, 1991). What happens when statutory protective mandates come into apparent conflict with differing cultural beliefs?

Case 5–15: Kiab Hnub, M.S.W., was born in the United States to refugee parents from the mountains of Laos, who came to this country near the end of our conflict with Vietnam. She works in the Hmong community of St. Paul, Minnesota, and came to her consultation group with a question about the case of a boy who seemed a bit more emotionally distant than the other children in the Hmong community. He had told Ms. Hnub that his mother hits him frequently, although he has no visible bruises and seems only marginally withdrawn. At first, the mother denied hitting him, but then told Ms. Hnub that she does hit him "for discipline."

Does a child abuse reporting mandate exist here? Any such report will have a powerful effect on the therapeutic relationship as well as Ms. Hnub's reputation and that of her agency in the Hmong community. To a community where people grew under authoritarian regimes or spent time in refugee camps, the authorities are always a problem, and Ms. Hnub may suffer a critical loss of effectiveness if she becomes seen as an ally of those authorities.

When she consults with her colleagues, one suggested that Ms. Hnub talk with the

boy's father, but she responded that she would not feel comfortable doing so. Even though she holds professional credentials and relates to males in the profession as equals, in the Hmong community "men come first." When questioned about what "she" believes, she responded "I'm Hmong." She does not see the question as one she can answer as "herself," an individual. That individual perspective is alien to her culture. The bottom line is that she is not willing to approach the father. She also makes it clear that, "At home, I obey my husband." Ms. Hnub notes that no physical injury seems imminent and proposes the potential solution of having a second social worker who is male to meet with the husband. She notes that having any female social worker would not be a good idea.

A number of other traditional Hmong practices, including capturing of young brides, medicinal use of opium, and ritual sacrifice of animals, have brought those living in the United States into conflict with our laws (Ly, 2001). Some of these may seem more exotic than the stern discipline reported in Case 5–15; however, these also could lead to reporting situations. The results might be handled significantly differently if the therapist were not also immersed in the culture. A particular challenge for Ms. Hnub involves the conflict between identity and potential reporting mandate.

Case 5–16: Daleela Abbas, age 16 years, emigrated with her family from Iraq a decade ago. She comes from a devout Muslim family and has come by a community clinic on her own complaining of depression. During an initial intake visit, she begins to sob and discloses that she had sex with a 19-year-old boy who graduated from her high school last year. Because of the age differential or other factors, this might trigger a mandated report to child protective services. However, the girl fears that if her parents are told (or learn of it from seeing clinic records), that she will not be alive for more than a week. She says male relatives in her family will carry out an "honor killing." A cultural liaison to the clinic confirms that this would be very likely and certainly not preventable by police or child protective services.

This case presents many layers of complexity and to some extent may depend on state law, insofar as whether a mandate exists to notify authorities about the self-reported intimacies with the 19-year-old. The critical issue involves protection of the most vulnerable party, Daleela. Taking protective steps seems urgent, and those could involve the necessity of seeking protective orders and alternative, well-protected living arrangements. Expert assistance from culturally knowledgeable individuals will be needed to plan the best course of action. Any protective actions will doubtless trigger intense social pressures to cease discussions of personal issues with those outside her family and to return home, while also putting her at great risk. Creating incomplete records by not documenting the facts may result in failure of authorities to act effectively. At the same time, access to such records by family members could also create a significant hazard.

In both of these cases sophisticated cultural knowledge will be required to craft interventions that adequately protect the children. The mental health clinician must stand ready to work for a suitably protective solution. In all such cases, culture, tradition, or religion cannot become an explanation or excuse for not taking protective actions. We may not have the ability to protect vulnerable parties from harm beyond our sphere of professional control, but we cannot ethically neglect our obligations to our clients.

Gifts in Cultural Context

The exchange of gifts, particularly expensive items, raises many ethical issues related to boundaries and avoiding exploitation (Barnett, 2011). Some gifts easily fall within the range of acceptability, such as a picture drawn by a child or an offering of homemade cookies. Other gifts may warrant clinical exploration as part of treatment or outright refusal. In a cultural context, some gifts may take on particular meaning, and declining the offer may cause distress or emotional complications.

Case 5–17: Carlos Santiago, a 40-year-old immigrant to the United States from Chile, experienced significant anxiety and moderate depression as he settled into his new job with a wine importer in a small southern city. Mr. Santiago spoke English fluently and sought treatment from Nomor Worries, Psy.D. After 9 months of working together, Mr. Santiago's symptoms and concerns had resolved, and his adjustment seemed quite solid. Dr. Worries planned termination with him, and at the end for the final session, Mr. Santiago opened his briefcase and presented Dr. Worries with two gifts: a bottle of Chilean burgundy and a book of Pablo Neruda's poetry.

Dr. Worries did not have much time in which to respond. These seemed gifts from the heart, with significant emotional meaning from an immigrant who took pride in his country's agriculture and literary tradition. Recognizing the nature of the offering, Dr. Worries accepted the gifts with thanks and later wrote a personal note to Mr. Santiago reflecting his understanding of the client's thoughtfulness and his attempt to introduce him to Chilean wine and literature. (See more about client gift giving in Chapter 8.)

Students' Beliefs versus Client Welfare

What happens when a person's deeply held personal beliefs pose a challenge to multicultural training expectations?

Case 5–18: Julia Ward entered Eastern Michigan State University's counseling program in 2006. She made her religious beliefs regarding treatment of clients' personal values clear, stating that the best thing to do would be to refer the client to a counselor whose values were more compatible with the client's. When she expressed these views, faculty members disagreed, sometimes kindly, sometimes less so. However, they consistently made the point that, as a school counselor, she "must support her clients' sexual orientation, whatever that may be" (*Ward v. Polite*, 2012, p. 730).

Difficulties began when she was assigned a case during training that involved a gay client.

Ms. Ward contacted her supervisor and asked if she should refer the client since she could not support his same-sex behavior. She was assigned no further clients and received an informal review with her supervisor and her advisor. She was given the option of completing a remedial program, leaving the counseling program voluntarily, or requesting a formal hearing. Ward opted for a formal hearing and was ultimately dismissed from the program because her behavior had violated the ACA's ethics code (ACA: A.4) (Hancock, 2014).

The ACA code states that counselors must avoid imposing their values on clients and may not discriminate on the basis of sexual orientation. Ward's refusal to provide such services posed difficulty because she planned to become a school counselor. LGBTQI (lesbian, gay, bisexual, transgender, queer or questioning, and intersex) students have been shown to be vulnerable to bullying and harassment and are at risk for depression and suicide (Hancock, 2014). A Michigan court upheld Ms. Ward's dismissal from the school counseling program (*Ward v. Wilbanks*, 2010), but the Sixth Circuit Court of Appeals remanded the case to the Eastern District of Michigan for retrial (*Ward v. Polite*, 2012). The university settled the case, and Ms. Ward received a monetary settlement and had her dismissal expunged from her record. The university's educational policies and procedures remained intact in the settlement, but the long-term effects of this case remain to be seen (Hancock, 2014).

Case 5–19: Jennifer Keeton, a counseling student at Augusta State University, sued the university after being required to complete a remediation program for perceived deficiencies in her multicultural competence relating to treating LGBTQI clients. Keeton had stated in class discussions, written assignments, and conversations with faculty members that, if a client disclosed his homosexuality to her, she would tell him that it was morally wrong and make an effort to change his behavior (Hancock, 2014). She added that, if unable to do so, she would refer him to a conversion therapist and urge fellow students to do likewise (*Keeton v. Anderson-Wiley*, 2011).

Concerned that Keeton might have difficulty separating her religious values from her professional duties, the faculty developed a remedial plan to assist her in learning to practice in accordance with the ACA ethical code (ACA: A.4). The plan included attending multicultural workshops, reading peer-reviewed articles on counseling effectiveness with LGBTQI populations, increased exposure and interaction with the LGBTQI community, and written reflection papers about what she learned. Keeton asserted that this plan violated her First Amendment rights. She argued that the university counseling program was trying to alter her beliefs via the plan (Hancock, 2014). The 11th Circuit Court of Appeals rejected Ms. Keeton's claims, finding no evidence that asking her to comply with the ACA code was designed to make her alter her religious beliefs (*Keeton v. Anderson-Wiley*, 2011). In the initial decision of the earlier court on this matter, Judge J. Randal Hall stated that "the policies which govern the ethical conduct of counselors ... with their focus on client welfare and self-determination, make clear that the counselor's professional environs are not intended to be a crucible for counselors to test metaphysical or moral propositions" (*Keeton v. Anderson-Wiley*, 2010).

In an analysis of the Keeton and Ward cases, Behnke (2012) noted apparent agreement by the courts that (a) educational institutions have the prerogative to adopt antidiscrimination policies based on the relevant professional ethical codes, and (b) programs can prevent students from imposing their beliefs on clients. When students choose to seek a career in a profession regulated by the state and professional association (c), they must understand and accept that their personal beliefs may not supersede the professional and regulatory mandates. Rather, as practitioners we must serve the best interests of our clients (Behnke, 2012).

As a closing thought, we note that the complexity of diversity sensitivity and multicultural awareness presents one of the greatest ethical challenges in mental health practice. The key points to focus on involve a personal commitment to increasing one's own multicultural awareness and competence. Framing personal

strategies to accomplish this through continuing education and training will start the process.

WHAT TO DO

- Recognize the complexity inherent in the individual and cultural factors that our clients bring with them when seeking our services (e.g., race, age, ethnicity, socio-economic status, disability, gender, health status, religion, national origin, sexual orientation, etc.).
- If necessary, create a checklist of things to think about (particularly invisible diversity factors) as you meet new clients.
- Treat each client with respect and openness in an attempt to understand the diversity fabric of their lives.
- Discuss diversity as part of teaching and supervision.
- Recognize that many issues related to boundaries, family practices, gift giving, and community norms vary by context and require thoughtful ethical analyses.

WHAT TO WATCH FOR

- Consider your own potential for biases and aversive racism.
- Monitor yourself for microaggressive behavior and if appropriate offer apologies or corrective actions.
- Students may have religious or other personal beliefs that may complicate their ability to focus on client welfare. Stay attuned to these and address them in the context of ethical codes.
- Anticipate, seek out, and read new population-focused guidelines as they emerge from our professional organizations.

WHAT NOT TO DO

- Do not assume that others share your beliefs and experiences, or that your beliefs,

experiences, and values are somehow more valid than those of others.

- Do not presume to understand the culture or values of another based merely on their appearance, language, or other attributes. When in doubt about what constitutes the most appropriate action, ask.
- Do not forget to consider diversity across all aspects of professional activity, including assessment, consulting, and research, as well as in psychotherapy.
- Do not assume that you can do it all yourself. Seek consultation when confronted with a new cultural challenge.

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6

Confidentiality, Privacy, and Record Keeping

Three may keep a secret, if two of them
are dead.

Benjamin Franklin

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What do you know, and who will you tell? The confidential relationship between mental health professionals and their clients has long stood as a cornerstone of the helping relationship. The trust conveyed through assurance of confidentiality seems so critical that some have gone so far as to argue that therapy might lack all effectiveness without it (Epstein, Steingarten, Weinstein, & Nashel, 1977). In the words of Justice Stevens, citing the amicus briefs of the American Psychological and Psychiatric Associations:

Effective psychotherapy . . . depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment. (*Jaffe v. Redmond*, 1996)

The changing nature of societal demands and information technologies have led many to express concerns about the traditional meaning of confidentiality in mental health practice and even whether true privacy exists any more (Fisher, 2013; Froomkin, 2000).

HISTORICAL CONTEXT

For most us, confidentiality in mental health practice stands in the background as an everyday issue of fundamental importance in our work. We uphold this obligation reflexively, understanding that breaches of confidentiality can cause distress or hurt our clients. Some breakdowns of this obligation have had rather unexpected and dramatic consequences for the people involved. To understand and manage the most common ethical challenges we face in dealing with confidentiality issues, we begin with some rare and remarkable cases. These atypical cases nonetheless have historical significance

and illustrate the extraordinary effect of breaching people's privacy in sensitive matters.

While not focused on mental health matters, the website WikiLeaks.org and activities of Edward Snowden (Greenwald, 2014) have certainly demonstrated both the reach of government to private lives and the high cost of releasing sensitive confidential materials. American history provides ample public examples of how breaches in confidentiality of mental health data have had major implications for both the clients and society. Thomas Eagleton, a U.S. senator from Missouri, was dropped as George McGovern's vice presidential running mate in 1968 when it was disclosed that he had previously been hospitalized for the treatment of depression (Post, 2004). Dr. Lewis J. Fielding, better known as "Daniel Ellsberg's psychiatrist," certainly did not suspect that the break-in at his office by Federal Bureau of Investigation (FBI) agents on September 3, 1971, might ultimately lead to the conviction of several high officials in the Nixon White House and contribute to the only resignation of an American president (Morganthau, Lindsay, Michael, & Givens, 1982; Stone, 2004). Disclosures of confidential information received by therapists also played prominently in the press during the well-publicized murder trials of the Menendez brothers (G. G. Scott, 2005) and O. J. Simpson (Hunt, 1999). In the Menendez case, threats made by one brother to the other's psychotherapist, Dr. Jerome Oziel, contributed to their conviction. In the Simpson case, a psychotherapist who had briefly treated the late Nicole Simpson drew national attention when she felt the need to "go public" shortly after the homicide, revealing content from the therapy sessions.

Secrets of Dead People

Should a mental health professional's duty of confidentiality end when a client dies? Consider the following actual cases:

Case 6-1: After the deaths of Nicole Brown Simpson and Ron Goldman (see Hunt, 1999, and <http://www.usc.edu/dept/LAS/SC2/pdf/hunt>.

pdf), Susan J. Forward, a clinical social worker who had held two sessions with Ms. Simpson in 1992, made unsolicited disclosures regarding her deceased former client. Ms. Forward commented in public that Ms. Simpson had allegedly reported experiencing abuse at the hands of O. J. Simpson (Hunt, 1999).

The California Board of Behavioral Science Examiners subsequently barred Ms. Forward from seeing patients for 90 days and placed her on 3 years' probation. In announcing the decision, Deputy Attorney General Anne L. Mendoza, who represented the board, commented, "Therapy is based on privacy and secrecy, and a breach of confidentiality destroys the therapeutic relationship" (Associated Press, 1995). Ms. Mendoza also noted that Ms. Forward had falsely represented herself as a psychologist in television interviews. Ms. Forward later asserted that she had not violated patient confidentiality because the patient was dead but had agreed not to appeal the board's decision to avoid a costly legal fight.

Case 6–2: On July 20, 1993, Vincent Walker Foster Jr. was found dead in Fort Marcy Park, near Virginia's George Washington Parkway. Mr. Foster served as a deputy White House counsel during President Clinton's first term. He had also been a law partner and personal acquaintance of Hillary Clinton. Foster had struggled with depression and had a prescription for trazodone, authorized by his physician over the telephone just a few days earlier. His body was found with a gun in his hand, and gunshot residue was on that hand. An autopsy determined that he died as the result of a gunshot in the mouth. A draft of a resignation letter, torn into 27 pieces, lay in his briefcase. Part of the note read, "I was not meant for the job or the spotlight of public life in Washington. Here ruining people is considered sport" (Apple, 1993). Following investigations conducted by the U.S. Park Police, the U.S. Congress, and independent counsels Robert B. Fiske and Kenneth Starr, his death was ruled a suicide.

Shortly before his death, Mr. Foster had met with James Hamilton, his personal attorney.

Kenneth D. Starr, the special prosecutor investigating the Clinton administration, sought grand jury testimony from Foster's lawyer. Foster's family refused to waive the deceased man's legal privilege, and Hamilton declined to testify. The case quickly reached the Supreme Court, which deemed by a 6-to-3 vote that communications between a client and a lawyer were protected by attorney-client privilege even after the client's death. The majority opinion by Chief Justice Rehnquist noted that, "A great body of case law and weighty reasons support the position that attorney-client privilege survives a client's death, even in connection with criminal cases" (*Swidler & Berlin and James Hamilton v. United States*, 1998).

Case 6–3: Author Diane Middlebrook set out to write a biography of then-deceased Pulitzer Prize-winning poet Anne Sexton with the permission of Sexton's family (Middlebrook, 1991). Martin Orne, M.D., Ph.D., served as Sexton's psychotherapist for the last years of her life. At Sexton's request, Dr. Orne had tape-recorded the sessions so that Sexton, who had a history of alcohol abuse and memory problems, could listen to them as she wished. Dr. Orne had not destroyed the tapes, and Ms. Middlebrook sought access to them to assist in her writing. Linda Gray Sexton, the poet's daughter and executrix of her literary estate, granted permission, and Dr. Orne released the tapes as requested.

Dr. Orne's release of the audiotapes caused considerable debate within the profession despite authorized release (Burke, 1995; Chodoff, 1992; Goldstein, 1992; Joseph, 1992; Rosenbaum, 1994). Unlike the Simpson and Foster cases, the Sexton case involved release of the audio records approved by a family member with full legal authority to grant permission. In some circumstances, courts may order opening a deceased person's mental health records. Examples might include assisting an inquest seeking to rule on suicide as a cause of death or to determine the competence of a person to make a will should heirs dispute the document at probate. Cases 6–1 through 6–3 involved situations with clear

legal authority; however, often mental health professionals will encounter circumstances in which the solution must rely on ethical principles as well as legal standards (Werth, Burke, & Bardash, 2002). For example, in some situations, the legal standard may allow disclosure, whereas clinical issues or the mental health of others may lead to an ethical decision in favor of nondisclosure.

Consider the following case:

Case 6–4: Sam Saddest had cystic fibrosis with severe lung disease. In his mid-20s, Sam no longer had enough energy and financial resources to live independently, although his illness did not seem likely to prove fatal for at least 2 to 3 more years. His medical condition forced him to give up his own apartment and move in with his divorced father, who had plans to marry again, this time a woman with two children, none of whom Sam liked. Sam discussed with his therapist, Michael Muted, M.D., his sadness about his mortality, unhappiness about the impending living situation, and resulting thoughts about suicide. Despite excellent clinical care and suicide precautions, Sam killed himself without reporting increased suicidal ideation or giving a hint of warning to anyone. Sam's father subsequently met with Dr. Muted in an effort to understand Sam's death. Dr. Muted discussed Sam's frustration with his terminal illness and inability to continue living independently, knowing that the father understood those issues well. However, Dr. Muted never disclosed Sam's distress about the father's planned remarriage or unhappiness with the soon-to-be blended family situation.

In this case, the therapist made efforts to assist the survivor of a family member's suicide to cope. The father readily understood and had known about these issues through discussions with his son over the prior months. Sam had not discussed his feelings about his father's remarriage openly as he did not want to hurt his father or stir up a sense of guilt. Dr. Muted's decision to keep Sam's confidence postdeath respected Sam's preferences and avoided causing incremental distress to the surviving family members. The key to resolving such issues will

involve remembering that clients do have some rights to confidentiality that survive them and giving due consideration to the welfare of the survivors.

Espionage

More recently, following the attack on the World Trade Center, the Foreign Intelligence Surveillance Act (FISA) and Section 215 of the USA PATRIOT Act (i.e., officially known as "Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001") have made it clear that the illegal break-in to Dr. Fielding's office in 1971 could conceivably become a routinely legal practice just three decades later (Morganthau et al., 1982; Stone, 2004).

Case 6–5: Theresa Marie Squillacote (also known as Tina, Mary Teresa Miller, The Swan, Margaret, Margit, Lisa Martin) and her husband, Kurt Stand, were convicted of espionage. Squillacote had earned a law degree and worked for the Department of Defense in a position requiring security clearance. In 1996, the FBI obtained a warrant to conduct clandestine electronic surveillance, including the monitoring of all conversations in Squillacote's home, calls made to and from the home, and Squillacote's office. Based on the monitored conversations, including Squillacote's conversations with her psychotherapists, a Behavioral Analysis Program (BAP) team at the FBI prepared a report of her personality for use in furthering the investigation. The BAP report noted that she suffered from depression, took antidepressant medications, and had "a cluster of personality characteristics often loosely referred to as 'emotional and dramatic.'" The BAP team recommended taking advantage of Squillacote's "emotional vulnerability" by describing the type of person with whom she might develop a relationship and pass on classified materials. Ultimately, she did transmit national defense secrets to a government officer who posed as a foreign agent and used strategies provided by the BAP team (*United States v. Squillacote*, 2000).

Although we know of no instance in which a mental health professional has faced secret searches of client records based on national security (nor could we), the well-documented case of Theresa Squillacote illustrates the potential intrusion of security agencies into the realm of psychotherapy. The lawful surveillance and ethically appropriate psychological consultation to law enforcement led to severe consequences for the patient who committed criminal acts.

We address ethical issues involved in use of mental health professionals and behavioral scientists in law enforcement and national security activities in Chapters 15 (dealing with specialized settings). In addition, privacy problems related to modern technologies are addressed in Chapter 4 (psychotherapy techniques).

Sensitivity to Technological Developments

We cannot ignore the special sensitivity of information gleaned by both clinicians and behavioral scientists in their work, whether assessment, psychotherapy, consultation, or research. Unfortunately, the complexity of the issues related to the general theme of confidentiality often defy easy analysis. Bersoff (1995) wrote of confidentiality that, "No ethical duty [is] more misunderstood or honored by its breach rather than by its fulfillment" (p. 143). Modern telecommunications and information technology have substantially complicated matters. So-called big data, massive electronic databases of sensitive personal information, are readily created, searched, cross tabulated, and transmitted around the world at the speed of light. Even prior to the Internet and the World Wide Web, mental health professionals expressed concerns about the threats posed to individual privacy and confidentiality by computerized data systems (Sawyer & Schechter, 1968), and the complexity of the issues has grown exponentially.

Lax transmission practices provide but one example of ways that technology can lead to unintended or inadvertent betrayal of confidentiality.

Case 6–6: Edgar Fudd, Ph.D., decided to send the third billing notice to a slow-to-pay client to the fax machine in the client's office. However, the client was not in the office that day. The bill labeled "psychological services rendered" with the client's name and "Third Notice—OVERDUE!!" handwritten with a bold marker sat in the open-access mail pickup tray of the busy office all day.

Case 6–7: Senda Haste, M.S.W., was in a hurry to turn in her billing slip and medical record notations at the hospital where she worked. The usual practice involved slipping the forms into a scanning system that e-mailed copies to the central record-processing office. As she quickly punched in the e-mail address, an autocompletion function entered the address of her bridge club list server. Nearly 100 of her fellow players received electronic copies.

Fudd's behavior was obviously improper, and he should have known better. Even if he was angry at the client for ignoring his bill, he should have figured that others in a place of business likely had access to the fax machine. Obviously, no private or sensitive material should be sent by fax unless it is known for sure that the recipient is the only one with access to it or a telephone call verifies that the intended party is standing by the machine, ready to retrieve it. In addition, as described in Chapter 13, Fudd's creditor message sent to the client's workplace may violate debt collection laws.

Haste's error illustrates the danger of transmitting confidential information in error. She hastily sent a message to the bridge club explaining the error and asking them to delete the prior message without reading it. To make matters worse, several of her fellow bridge club members "replied all," saying "What an awful accident," thereby calling even more attention to the error. Of course, she had no idea how many read the confidential patient information or deleted it. Ms. Haste had to report the error to her institution, which in turn had to notify the patient of the record breach under federal law.

Mental health professionals have both ethical and legal obligations to keep records of various sorts (e.g., interactions with clients

and research participants, test scores, research data, and even patient account information) and must safeguard these files. Increasingly, people seek all types of medical and psychological information about others and about themselves. This leads to an entirely new subset of problems on the matter of records: What is in them? Who should keep them? How long should they be kept? Who has access? Is this a legal matter or a professional standard? How do these policies have an impact on the ethical principle of confidentiality? What about the rights of our students and research subjects? We attempt to address all such matters in this chapter, although confidentiality in the context of social media is also addressed in Chapter 11. Further discussion of confidentiality and privacy rights of research participants is found in Chapter 16.

A PROBLEM OF DEFINITIONS

Confusion about three commonly used terms—privacy, confidentiality, and privilege—often complicates discussions of ethical problems in this arena. At least part of the confusion flows from the fact that, in particular situations, these terms may have narrow legal meanings quite distinct from broader traditional meanings attached by mental health practitioners. Many difficulties link to a failure on the part of professionals to discriminate among the different terms and meanings. Still other difficulties grow out of the fact, discussed in Chapter 1, that legal obligations do not always align with ethical responsibilities.

Privacy

The U.S. Constitution does not confer specific privacy rights. However, some amendments—freedom of speech and to peaceably assemble, protection from unwarranted search and seizure, and to be secure in their persons, houses, papers, and effects—provide safeguards against unbridled government intrusion, as expanded in Justice Brandeis's oft-cited dissent in *Olmstead et al. v. U.S.* (1928).

The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings, and of his intellect. They knew that only a part of the pain, pleasure and satisfactions of life are to be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be let alone—the most comprehensive of rights, and the right most valued by civilized men.

Privacy, then, involves the basic entitlement of people to decide how much of their property, thoughts, feelings, or personal data to share with others. In this sense, privacy has seemed essential to ensure human dignity and freedom of self-determination. The concepts of both confidentiality and privilege grow out of the broader concept of an individual's right to privacy. Concern about electronic surveillance, the use of lie detectors, and a variety of other observational or data-gathering activities fall under the heading of privacy issues. The issues involved in public policy decisions regarding the violation of privacy rights parallel concerns expressed by therapists regarding confidentiality violations (Smith-Bell & Winslade, 1994). In general, clients of mental health professionals may find their privacy rights compromised when their behavior seriously violates social norms or somehow endangers others. An example would be the issuance of a search warrant based on “probable cause” that a crime has taken place or may soon occur. We discuss these principles from the psychological perspective in greater detail in this chapter. However, mental health professionals must also give consideration to the concept of privacy as a basic human right due all people and not simply limited to their clients.

We readily acknowledge that some societies, particularly in Africa and Asia, do not place the same value on individual, as opposed to community, rights as do most Western societies. As discussed more fully in Chapter 5, therapists must remain sensitive and respectful to cultural differences in this regard. At the same time, we

must also obey the laws of the jurisdictions in which we practice. At times, this may create tensions that require helping people from other cultures to understand applicable laws and regulations that apply in the immediate circumstances at hand.

Case 6–8: Shana Shalom, an orthodox Jewish émigré from Israel, sought counseling regarding her unhappy marriage from Hebrew-speaking therapist Tanya Talmud, L.M.F.T. Ms. Shalom later complained to the state licensing board that Ms. Talmud had discussed matters she disclosed in therapy to the family rabbi without her knowledge or consent. The rabbi in turn communicated some of the content to Ms. Shalom's spouse. Ms. Talmud replied to the licensing board that in Israel's orthodox Jewish communities, soliciting the aid from a couple's rabbi often proves a useful way to address marital problems.

The licensing board censured Ms. Talmud, reminding her that she treated Ms. Shalom in her capacity as a licensed marriage and family therapist in the United States, not Israel. In addition, basic ethical principles of autonomy and human dignity entitled Ms. Shalom to have a voice in any decision about disclosing material she had offered in confidence.

Confidentiality

Confidentiality refers to a general standard of professional conduct that obliges a professional not to discuss information about a client with anyone. Confidentiality may also originate in statutes (i.e., laws enacted by legislatures), administrative law (i.e., regulations promulgated to implement legislation), or case law (i.e., interpretations of laws by courts). But, when cited as an ethical principle or standard, confidentiality implies an explicit contract or promise not to reveal anything about a client except under certain circumstances agreed to by both parties. Although the roots of the concept are in professional ethics rather than in law, the nature of the relationship between client and therapist does have substantial legal recognition (see, e.g., <http://jaffee-redmond.org/>).

One can imagine, for example, that clients who believe that their confidences were violated could sue their psychotherapists in a civil action for breach of confidentiality and possibly seek criminal penalties if available under state law. For instance, a New York appeals court ruled that a patient may bring a tort action against a psychiatrist who allegedly disclosed confidential information to the patient's spouse, allowing the patient to seek damages for mental distress, loss of employment, and the deterioration of his marriage ("Disclosure of Confidential Information," 1982; *MacDonald v. Clinger*, 1982).

The degree to which one should, if ever, violate a client's confidentiality includes some historical controversy (see, e.g., Siegel, 1979), despite uniform agreement on one point: All clients have a right to know the limits on confidentiality in a professional relationship from the outset. The initial interview with any client (individual or organizational) should include a direct and candid discussion of limits that may exist with respect to any confidences communicated in the relationship (American Psychological Association [APA]: 4.02; American Association for Marriage and Family Therapy [AAMFT]: 1.2, 1.13; American Counseling Association [ACA]: B.1.d; National Association of Social Workers [NASW]: 1.07). State and federal laws require providing such information in both health care (e.g., Public Law 104-191, Health Insurance Portability and Accountability Act of 1996 [HIPAA]) and forensic contexts (e.g., *Commonwealth v. Lamb*, 1974; *Estelle v. Smith*, 1981). Not only will failure to provide such information early on constitute unethical behavior, and possibly behavior illegal in health care settings, but also such omissions may lead to clinical problems later. In some contexts, conveying such information orally may suffice, but documenting the conversation becomes critical.

All health (including mental and behavioral health) care providers will need to provide a formal written HIPAA notice, and those who provide non-health-related services may want to do likewise or possibly provide "new client information" in a pamphlet or other written

statement. Every therapist should give sufficient thought to this matter and formulate a policy for his or her practice that complies with applicable law, ethical standards, and personal conviction, integrated as meaningfully as possible given the legal precedents and case examples discussed in the following pages.

Privilege

The concepts of privilege and confidentiality often become confused, and the distinction between them has critical implications for understanding a variety of ethical problems. The concept of *privilege* (or privileged communication) describes certain specific types of relationships that enjoy protection from disclosure in legal proceedings. Designation of privilege originates in statute or case law, and such rights belong to the client in the relationship. Normal court rules provide that anything relative and material to the issue at hand can and should be admitted as evidence. When privilege exists, however, the client has a degree of protection against having the covered communications revealed without explicit permission. If the client waives this privilege, the clinician must testify on the nature and specifics of the material discussed. The client cannot usually permit a selective or partial waiver. In most courts, once a waiver is given, it covers all of the relevant privileged material.

Traditionally, such privilege extended to attorney-client, husband-wife, physician-patient, and certain clergy relationships. Some jurisdictions now extend privilege to the relationships between clients and mental health practitioners, but the actual laws vary widely, and clinicians have an ethical obligation to learn the statutes or case law in force for the jurisdictions where they practice. Prior to 1996, many states addressed the primary mental health professions (i.e., psychologists, psychiatrists, and social workers) while omitting mention of psychiatric nurses, counselors, or generic psychotherapists (DeKraai & Sales, 1982). The same authors also noted that no federally created privileges existed for any mental health profession, and that the federal courts generally

looked to applicable state laws. All that changed in 1996 when the U.S. Supreme Court took up the issue based in part on conflicting rulings in different federal appellate court districts (*Jaffe v. Redmond*, 1996).

Case 6–9: Mary Lu Redmond served as a police officer in Hoffman Estates, Illinois, a suburb of Chicago. On June 27, 1991, while responding to a “fight-in-progress” call, she fired her weapon and killed Ricky Allen Sr. as he pursued, rapidly gained ground on, and stood poised to stab another man with a butcher knife. After the shooting, Officer Redmond sought counseling from a licensed clinical social worker. Later, Carrie Jaffe, acting as administrator of Mr. Allen’s estate, sued Redmond, citing alleged U.S. civil rights statutes and Illinois tort law. Jaffe wanted access to the social worker’s notes and sought to compel the therapist to give oral testimony about the therapy. Redmond and her therapist, Karen Beyer, refused. The trial judge instructed the jury that refusing to provide such information could be held against Officer Redmond. The jury awarded \$545,000 damages based on both the federal civil rights and state laws.

On June 13, 1996, the Supreme Court overturned the lower court decision by a vote of 7–2, upholding the existence of a privilege under Federal Rules of Evidence to patients of licensed psychotherapists. In a decision written by Justice John Paul Stevens, the court noted that this privilege is “rooted in the imperative need for confidence and trust,” and that “the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment” (*Jaffe v. Redmond*, 1996, 4492–4493). Writing for himself and Chief Justice Renquist, Justice Scalia dissented, arguing that psychotherapy should not be protected by judicially created privilege, and that social workers were not clearly expert in psychotherapy and did not warrant such a privilege (Smith, 1996). Nonetheless, this case has set a new national standard that affords privilege protections across jurisdictions, generally implying that a federal privilege extends to licensed mental health professionals.

LIMITATIONS AND EXCEPTIONS

Almost all of the statutes addressing confidentiality or providing privileges expressly require licensing, certification, or registration of mental health professionals under state law, although some states extend privilege when the client reasonably believes the alleged therapist to be licensed (DeKraai & Sales, 1982). Clients of students (including psychology interns, unlicensed postdoctoral fellows, or supervisees) may not specifically have coverage under privilege statutes. In some circumstances, trainees' clients may have privilege accorded to communication with a licensed supervisor, but state laws vary widely, and practitioners should not take this for granted. The oral arguments before the Supreme Court (http://www.oyez.org/cases/1990-1999/1995/1995_95_266) relied on the reasonable expectation of the client on such protection, but left unclear whether the clients of unlicensed therapists are protected.

Some jurisdictions permit a judge's discretion to overrule privilege between clinician and client on determination that the interests of justice outweigh the interests of confidentiality. Some jurisdictions limit privilege exclusively to civil actions, whereas others may include criminal proceedings, except in homicide cases. In many circumstances, designated practitioners have a legally mandated obligation to breach confidentiality and report certain information to authorities. Just as some physicians must under some state laws report gunshot wounds or certain infectious diseases, mental health practitioners may have an obligation to report certain cases, such as those involving child abuse, to state authorities. These restrictions could certainly affect a therapeutic relationship adversely, but the client has a right to know any limitations in advance, and the clinician has the responsibility both to know the relevant facts and to inform the client as indicated (APA: 02: 3.10 and 4.02; AAMFT:2.1; ACA: B.1.d; NASW: 1.07.e).

Other circumstances, such as a suit alleging malpractice, may constitute a waiver of privilege and confidentiality. In some circumstances, a

client may waive some confidentiality or privilege rights without fully realizing the extent of potential risk. In certain dramatic circumstances, a therapist may also face the dilemma of violating a confidence to prevent some imminent harm or danger from occurring. These matters are not without controversy, but it is important for mental health professionals to be aware of the issues and think prospectively about how one ought to handle such problems.

When law and ethical standards diverge (e.g., when a confidential communication does not qualify as privileged in the eyes of the law), the situation becomes extremely complex, but one cannot ethically fault a therapist for divulging confidential material if ordered to do so by a court of competent authority. On the other hand, one might reasonably question the appropriateness of violating the law if one believes that doing so has become necessary to behave ethically. Consider, for example, the clinician required by state law or court order to disclose some information learned about a client during the course of a professional relationship. If the therapist claims that the law and ethical principles conflict, then by definition the ethical principles in question would seem illegal. The therapist may choose civil disobedience as one course of action, but does so at personal peril in terms of the legal consequences. Ethics codes advise psychologists to attempt to resolve such conflicts but also provide that when such conflicts seem irresolvable, psychologists may ethically adhere to the requirements of the law, regulations, or other governing legal authority (APA: 1.02; AAMFT: Preamble; ACA: 1.1c; NASW: Preamble). In the aftermath of so-called enhanced interrogation techniques advocated by the administration of President George W. Bush, the APA amended its code to specifically exclude violations of human rights as excusable, even if mandated by law.

Students of ethical philosophy will immediately recognize a modern psychological version of the controversy developed in the writings of Immanuel Kant and John Stuart Mill. Which matters more: the intention of the actor or solely the final outcome of the behavior? For example, if competent therapists,

intending to help their clients, initiate interventions that cause unanticipated harm, have they behaved ethically (because they had good intentions) or unethically (because harm resulted)? Clearly, we do not have the answer. Each situation presents different fact patterns, but the most appropriate approach to evaluating a case would involve considering the potential impact of each alternative course of action and choosing with regard to the outcomes one might reasonably expect. Perhaps the best guidepost we can offer involves a kind of balancing test in which the clinician attempts to weigh the relative risks and vulnerabilities of the parties involved. Several of the cases discussed in this chapter highlight such difficult decisions. (Also, see Chapter 17 for more on decision making.)

Statutory Obligations

As noted, in some circumstances the law specifically dictates a duty to notify certain public authorities of information that might be acquired in the context of a therapist-client relationship. The general rationale on which such laws are predicated holds that certain individual rights must give way to the greater good of society or to the rights of a more vulnerable individual (e.g., in child abuse or child custody cases; see Fisher, 2013; Kalichman, 1999). Statutes in some states address the waiver of privilege in cases of clients exposed to criminal activity as the perpetrator, victim, or third party. One might presume that violation of a confidence by obeying one's legal duty to report such matters (in the states where such duties exists) could certainly hinder the therapist-client relationship, yet the data on this point seem mixed (DeKraai & Sales, 1982; Kalichman, 1999; Nowell & Sprull, 1993; Woods & McNamara, 1980). Some commentators have argued that the therapeutic relationship can survive a mandated breach in confidentiality as long as a measure of trust is maintained (Kalichman, 1999; Watson & Levine, 1989).

At times, state laws can be confusing and complicated:

Case 6–10: Euthan Asia was full of remorse when he came to his initial appointment with Oliver Oops, Ph.D. After asking and receiving assurance that their conversations would be confidential, Mr. Asia disclosed that, 2 months earlier, he had murdered his wife of 50 years out of compassion for her discomfort. Mrs. Asia was 73 years old and suffered from advanced Alzheimer's disease. Mr. Asia could not stand to see the woman he loved in such a state, so he gave his wife sleeping pills and staged a bathtub drowning that resulted in a ruling of accidental death by the medical examiner.

In some jurisdictions, Dr. Oops would be obligated to respect Mr. Asia's confidentiality because those states do not mandate reporting of past felonies that do not involve child abuse risk. If the conversation took place in Massachusetts, however, Dr. Oops would be required by law to report Mr. Asia twice. First, Dr. Oops would have to notify the Department of Elder Affairs that Mr. Asia had caused the death of a person he was caring for over the age of 60. Next, he would be obligated to report to another state agency that Mr. Asia had caused the death of a handicapped person. Although every American state and Canadian province has mandatory child abuse reporting laws (Kalichman, 1999), not all have statutes mandating reporting of issues involving so-called dependent persons, and the nature of actual requirements for reporting such as covered persons and triggering events vary widely. As a result, mental health professionals have an affirmative ethical obligation to know all applicable exceptions for the jurisdiction in which they practice and provide full information on these limits to their clients at the outset of the professional relationship (APA: 4.02b; AAMFT: 2.1; ACA: B.2; NASW: 1.01).

Some therapists worry about the potential obligation to disclose a client's stated intent to commit a crime at some future date to authorities (Appelbaum, 2013). Shah (1969) argued that, in most cases, such disclosures of intent essentially constitute help-seeking behavior rather than an actual intent to commit a crime.

Siegel (1979) also argued that interventions short of violating a confidence will invariably prove possible and more desirable, although he acknowledged that one must obey any applicable laws. No jurisdictions currently mandate mental health professionals to disclose such information. The prime exception to treating statements of intent to commit crimes confidentially involves the special context when particular clients pose a danger to themselves or others, discussed in the following material as the “duty to warn or protect.”

Malpractice and Waivers

Although not all states have specifically enacted laws making malpractice actions an exception to privilege, accused therapists have a right to defend themselves by revealing otherwise-confidential material about their work when sued by former clients. Likewise, no licensing board or professional association ethics committee could investigate a claim against a mental health practitioner unless the person complaining waives any duty of confidentiality that the clinician might owe. In such instances, the waiver by the client of the therapist's duty of confidentiality or any legal privilege constitutes a prerequisite for full discussion of the case. While some might fear that the threat to reveal an embarrassing confidence would deter clients from reporting or seeking redress from offending clinicians, procedural steps can allay this concern. Ethics committees, for example, generally conduct all proceedings in confidential sessions and may offer assurances of privacy to complainants. In malpractice cases, judges can order spectators excluded from the courtroom and place records related to sensitive testimony under seal from the public's view.

In some circumstances, a therapist may want to advise an otherwise-willing client not to waive privilege or confidentiality.

Case 6–11: Barbara Bash, age 23, suffered a concussion in an automobile accident, with resulting memory loss and a variety of neurological aftereffects. Her condition improved gradually,

although she developed symptoms of depression and anxiety as she worried about whether she would ever fully recover. She sought a consultation from Martha Muzzle, Ph.D., to assess her cognitive and emotional state, subsequently entering psychotherapy with Dr. Muzzle to deal with her emotional symptoms. During the course of her treatment, Ms. Bash informed Dr. Muzzle that she had previously sought psychotherapy at age 18 to assist her in overcoming anxiety and depression linked to a variety of family problems. Some 10 months after the accident, Bash had continued treatment and made much progress. A lawsuit remains pending against the other driver in the accident, and Bash's attorney wonders whether to call Dr. Muzzle as an expert witness at the trial to document the emotional pain Ms. Bash suffered, thus securing a better financial settlement.

If consulted, the therapist should remind Ms. Bash's attorney and inform Ms. Bash that, if called to testify on Ms. Bash's behalf, that Bash would have to waive her privilege rights. Under cross-examination, the therapist might have to respond to questions about preexisting emotional problems, prior treatment, and a variety of other personal matters that Ms. Bash might prefer not to have brought out in court. In this case, the legal strategy involved documenting Bash's damages, with the intent of forcing an out-of-court settlement. But, the client ought to know the risks of disclosure should her attorney call the therapist as a witness.

Employers, schools, clinics, or other agencies may also apply pressure for clients to sign waivers of privilege or confidentiality. Often, the client may actually not wish to sign the form but may feel obligated to comply with the wishes of an authority figure or feel fearful that requested help would otherwise be turned down. HIPAA specifies that a care provider or institution may not require the release of psychotherapists' records as a condition of treatment, payment, or eligibility for benefits. Other laws protect against such requests by employers. If a mental health professional has doubts about the wisdom or validity of a client's waiver in such circumstances, the best course

of action would call for consulting with the client about any reservations prior to supplying the requested information.

The Duty to Warn or Protect Third Parties From Harm

No complete discussion of confidentiality in the mental health arena can take place without reference to the *Tarasoff* case (*Tarasoff v. Board of Regents of the University of California*, 1976) and a family of so-called progeny cases that have followed in its wake (Quattrocchi & Schopp, 2005; VandeCreek & Knapp, 2001; Werth, Welfel, & Benjamin, 2009). Detailed historical analyses of the legal case have evolved in the literature (Everstine et al., 1980; Quattrocchi & Schopp, 2005), but a brief summary follows for those unfamiliar with the facts.

Case 6–12: In the fall of 1969, Prosenjit Poddar, a citizen of India and naval architecture student at the University of California's Berkeley campus, shot and stabbed to death Tatiana Tarasoff, a young woman who had spurned his affections. Poddar had sought psychotherapy from Dr. Lawrence Moore, a psychologist at the university's student health facility, and Dr. Moore had concluded that Poddar posed a significant danger. This conclusion stemmed from an assessment of Poddar's pathological attachment to Tarasoff and evidence that he intended to purchase a gun. After consultation with appropriate colleagues at the student health facility, Dr. Moore notified police both orally and in writing that he feared Poddar posed a danger to Tarasoff. He requested that the police take Poddar to a facility for hospitalization and an evaluation under California's civil commitment statutes. The police interrogated Poddar and found him rational. They concluded that he did not really pose a danger and secured a promise that he would stay away from Ms. Tarasoff. After his release by the police, Poddar understandably never returned for further psychotherapy, and 2 months later stabbed Tarasoff to death.

Subsequently, Ms. Tarasoff's parents sued the regents of the University of California, the student health center staff members involved,

and the police. Both trial and appeals courts initially dismissed the complaint, holding that, despite the tragedy, no legal basis for the claim existed under California law. The Tarasoff family appealed to the Supreme Court of California, asserting that the defendants had a duty to warn Ms. Tarasoff or her family of the danger, and that they should have persisted to ultimately ensure his confinement. In a 1974 ruling, the court held that the therapists, indeed, had a duty to warn Ms. Tarasoff. When the defendants and several amici (i.e., organizations trying to advise the court by filing *amicus curiae*, or "friend of the court," briefs) petitioned for a rehearing, the court took the unusual step of granting one. In their second ruling (*Tarasoff v. Board of Regents*, 1976), the court released the police from liability without explanation and more broadly formulated the obligations of therapists, imposing a duty to use reasonable care to protect third parties against dangers posed by a patient.

Currently, most states expect therapists to take protective action when clients make specific threats as alluded to in the final opinion of the California Supreme Court.

We shall explain that defendant therapists cannot escape liability merely because Tatiana herself was not their patient. When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances. (*Tarasoff v. Regents of University of California*, 1976)

Although the influence of the decision outside California was not immediately clear, the issue of whether mental health professionals must be police or protectors or otherwise have a "duty to protect" rapidly became a national

concern, with related laws in 33 states (see, e.g., Bersoff, 2014; Leonard, 1977; Paul, 1977; Quattrocchi & Schopp, 2005; VandeCreek & Knapp, 2001; Werth et al., 2009). A former president of the APA (Siegel, 1979) even argued that if Poddar's psychologist had accepted the absolute and inviolate confidentiality position, Poddar could have remained in psychotherapy and never harmed Tatiana Tarasoff. Siegel expressed the belief that the therapist "betrayed" his client, asserting that, if the psychologist had not considered Poddar "dangerous," no liability for "failure to warn" would have developed. This claim may have some validity; however, many therapists would argue the need to protect the public welfare via direct action. From both legal and ethical perspectives, a key test of responsibility remains whether therapists knew or should have known (in a professional capacity) of the client's dangerousness. No single ethically correct answer will apply in all such cases, but the therapists must also consider their potential obligations.

Perhaps the ultimate irony of the *Tarasoff* case in terms of outcome involves the outcome for Mr. Poddar. His original conviction for second-degree murder was reversed because the judge had failed to give adequate instructions to the jury concerning the defense of "diminished capacity" (*People v. Poddar*, 1974). He was convicted of voluntary manslaughter and confined to the Vacaville medical facility in California, subsequently won release, went back to India, and claimed to be happily married (Stone, 1976).

A variety of decisions by courts outside California and since *Tarasoff* have dealt with the duty of therapists to warn or protect potential victims of violence at the hands of their patients (Knapp & VandeCreek, 2000; Truscott, 1993; VandeCreek & Knapp, 1993, 2001; Eisner, 2006; Werth et al., 2009; Yufik, 2005). The cases are both fascinating and troubling from the ethical standpoint.

We have not disguised or synthesized examples in the next several cases but rather drew from public legal records that form a portion of the continually growing case law on the duty

to warn. The cases themselves do not necessarily bespeak ethical misconduct. Rather, we cite them here to guide readers regarding legal cases that interface with the general principle of confidentiality.

Case 6–13: Dr. Shaw, a dentist, participated in a therapy group with Mr. and Mrs. Moe Billian. Shaw became romantically involved with Mrs. Billian, only to be discovered one morning at 2:00 a.m. in bed with her by Mr. Billian, who had broken into Shaw's apartment. On finding his wife in bed nude with Dr. Shaw, Mr. Billian shot at Shaw five times but did not kill him.

Dr. Shaw sued the psychiatric team in charge of the group therapy program because of the team's alleged negligence in not warning him that Mr. Billian's "unstable and violent condition" presented a "foreseeable and immediate danger" to him (*Shaw v. Glickman*, 1980). In this case, the Maryland courts held that, although the therapists knew Mr. Billian carried a handgun, they could not necessarily have inferred that Billian might have had a propensity to invoke the "old Solon law" (i.e., a law stating that shooting the wife's lover could constitute justifiable homicide) and may not even have known that Billian harbored any animosity toward Dr. Shaw. The court also noted, however, that even if the team had this information, they would have violated Maryland law had they disclosed it.

Case 6–14: Lee Morgenstein, age 15, had received psychotherapy from a New Jersey psychiatrist, Dr. Michael Milano, for 2 years. Morgenstein used illicit drugs and discussed fantasies of using a knife to threaten people. He also told Dr. Milano of sexual experiences and an emotional involvement with Kimberly McIntosch, a neighbor 5 years his senior. Morgenstein frequently expressed anxiety and jealousy about Ms. McIntosch's dating other men, and he reported to Dr. Milano that he once fired a BB gun at a car in which she was riding. One day, Morgenstein stole a prescription blank from Dr. Milano, forged his signature, and attempted to purchase 30 Seconal tablets. The pharmacist became suspicious and called

Dr. Milano, who advised the pharmacist to send the boy home. Morgenstein obtained a gun after leaving the pharmacy and later that day shot Kimberly McIntosch to death.

Dr. Milano had reportedly tried to reach his client by phone to talk about the stolen prescription blank, but intervened too late to prevent the shooting. Ms. McIntosch's father, a physician who had read about the *Tarasoff* decision, and his wife ultimately filed a civil damage suit against Dr. Milano for the wrongful death of their daughter, asserting that Milano should have warned Kimberly McIntosch or taken reasonable steps to protect her.

Dr. Milano sought to dismiss the suit claiming that the *Tarasoff* principle should not apply in New Jersey for four reasons. First, to do so would impose an unworkable duty because the prediction of dangerousness is unreliable. Second, violating the client's confidentiality would have interfered with effective treatment. Third, assertion of the *Tarasoff* principle could deter therapists from treating potentially violent patients. Finally, Milano claimed that all of this might lead to an increase in unnecessary commitments to institutions. The court rejected each of these arguments and denied the motion to dismiss the case (*McIntosch v. Milano*, 1979). The court noted the duty to warn as a valid concept under New Jersey law, and despite the fact that therapists cannot be 100% accurate in predictions, they have the ability to weigh the relationships of the parties. The court drew an analogy comparing the situation with warning communities and individuals about carriers of a contagious disease and stated that confidentiality must yield to the greater welfare of the community, especially in the case of imminent danger. Ultimately, a jury did not find Milano liable for damages, but the *Tarasoff* principle had moved east.

Case 6–15: A juvenile offender, known in court documents as "James," was incarcerated for 18 months at a county facility. During the course of his confinement, James threatened that he would probably "off some kid" (i.e., murder a child) in the neighborhood if released, although he did not

mention any particular individual. James obtained temporary release to his mother's custody and did indeed kill a child shortly thereafter.

In the litigation that resulted from this case (*Thompson v. County of Alameda*, 1980), the chief concern focused on whether the county had a duty to warn the local police, neighborhood parents, or James' mother of his threats. While recognizing the duty of the county to protect its citizens, the California Supreme Court declined to extend the *Tarasoff* doctrine it had created a few years earlier to this case, noting that doing so would prove impractical and negate rehabilitative efforts by giving out general public warnings of nonspecific threats for each person paroled. The court also deemed warning the custodial parent futile because one would not expect her to provide constant supervision ("*Tarasoff Duty to Warn*," 1980).

After many years of state court decisions clarifying the *Tarasoff* doctrines, a 1991 Florida decision (*Boynton v. Burglass*, 1991) complicated matters still further:

Case 6–16: The Florida State Appeals Court declined to adopt a duty to warn and held that a psychiatrist who knew or should have known that a patient presented a threat of violence did not have a duty to warn the intended victim. The case was brought against Dr. Burglass, a psychiatrist who had treated Lawrence Blaylock. Mr. Blaylock shot and killed Wayne Boynton, and Boynton's parents alleged that Burglass should have known about the danger to their son and should have warned him. The trial court dismissed the case for failure to state a cause of action. The appeals court declined to follow the *Tarasoff* case, ruling that such a duty seemed "neither reasonable nor workable and is potentially fatal to effective patient–therapist relationships." The court cited the inexact nature of psychiatry and considered it virtually impossible to foresee a patient's dangerousness. The court also noted a common law rule that one person has no duty to control the conduct of another. Although a "special circumstance" may create such an obligation in some cases, this did not seem true in Blaylock's case because the treatment occurred with Blaylock as a voluntary outpatient.

The bottom line for psychotherapists is this: consult a lawyer familiar with the standards that apply in your particular jurisdiction. Such consultation proved helpful to the two practitioners who treated Billy Gene Viviano:

Case 6-17: In March 1985, a jury awarded Billy Gene Viviano \$1 million for injuries he had received at work. Much to Mr. Viviano's dismay, Judge Veronica Wicker overturned the verdict and ordered a new trial. During the next several months, Mr. Viviano became depressed and sought treatment from psychiatrist Dudley Stewart and psychologist Charles Moan. During the course of his treatment, Mr. Viviano voiced threats toward Judge Wicker and other people connected with his lawsuit. Drs. Stewart and Moan informed the judge of these threats, and Mr. Viviano was arrested, pleaded guilty to contempt of court, and agreed to a voluntary psychiatric hospitalization. Viviano and his family sued the two doctors for negligence, malpractice, and invasion of privacy, but the jury found that the doctors had acted appropriately. Viviano appealed, but lost again (*In re Viviano*, 1994).

In ruling for Drs. Stewart and Moan, the Louisiana Court of Appeals cited the *Tarasoff* case, noted that Dr. Stewart repeatedly consulted an attorney prior to disclosing the threats, and cited testimony by both doctors that Mr. Viviano's threats had become increasingly intense to the point at which both believed he would attempt to carry them out. After weighing these factors, the appellate court reasoned the therapists had followed the applicable standard of care in warning third parties.

What should therapists do if a threat comes to their attention from a family member rather than the patient? The California courts again emphasized the need to obtain current legal advice when challenging cases, such as the matter of *Ewing v. Goldstein* (2004), come along.

Case 6-18: David Goldstein, Ph.D., a licensed marriage and family therapist, had treated Geno Colello, a former Los Angeles police officer, for 3 years. Treatment focused on work-related injuries and the breakup of Colello's 17-year relationship

with a woman named Diana Williams, who had begun dating Keith Ewing. Dr. Goldstein talked to Mr. Colello by telephone on June 21, 2001. Colello allegedly told Goldstein that he did not feel blatantly suicidal but did admit to thinking about it. Dr. Goldstein recommended hospitalization and asked permission to talk with the patient's father, Victor Colello. Victor reportedly told Goldstein that his son was very depressed and seemed to have lost his desire to live. The father went on to report that Geno could not cope with seeing Diana date another man, and that Geno had considered harming the young man. Geno later signed himself in as a voluntary patient at Northridge Hospital Medical Center on the evening of June 21, 2001. The next morning, Dr. Goldstein received a call from Victor Colello, advising that the hospital would soon release Geno. Dr. Goldstein telephoned the admitting psychiatrist and urged him to keep Geno under observation for the weekend. The psychiatrist declined and discharged Geno, who had no further contact with Dr. Goldstein. On June 23, 2001, Geno Colello shot Keith Ewing to death and then killed himself with the same handgun.

Ewing's parents filed a wrongful death suit naming Goldstein as one of the defendants (*Ewing v. Goldstein*, 2004), alleging he had a duty to warn their son of the risk posed by Geno Colello. A judge granted summary dismissal of the case against Goldstein, who asserted that his patient never actually disclosed a threat directly to him. The California Court of Appeals, however, reinstated the case, noting,

When the communication of a serious threat of physical violence is received by the therapist from the patient's immediate family, and is shared for the purpose of facilitating and furthering the patient's treatment, the fact that the family member is not technically a "patient," is not crucial.

The court noted that psychotherapy does not occur in a vacuum, and that therapists must learn contextual aspects of a patient's history and personal relationships to be successful. The court opined that communications from patients' family members in this context

constitute a “patient communication.” This decision seems to imply that the therapists must give weight to the unsolicited suggestions of family members who they may not have ever met and whose credibility they have not assessed (Eisner, 2006; Greer, 2005). The decision leaves us wondering how the therapist must consider input from patients’ family members or acquaintances when the therapist does not know them or have a good way to assess the validity of their concerns. We recommend documenting the thoughtful reasoning used to make a decision on such input in the patient’s record. That provides a contextual record of the serious consideration given to the input, even if the subsequent actions of the therapist prove ineffective in preventing harm.

Shootings in schools and other public venues by troubled individuals have triggered considerable public concern and have led to a number of legislative efforts to use mental health professionals as a kind of early warning system. One example is the Illinois Firearm Owners Identification (FOID) Mental Health Reporting System. Based on Public Act 098-0063, passed July 9, 2013, health care facilities, physicians, clinical psychologists, and other qualified examiners are mandated to report to an online database any person adjudicated mentally disabled; voluntarily admitted to a psychiatric unit; determined to be a “clear and present danger”; or determined to be “developmentally disabled/intellectually disabled.” Presumably, this will prevent potentially dangerous persons from legally obtaining firearms. The act had not been tested in court at the time of preparing this chapter, but it again raises many ethical issues and the specter of using mental health practitioners as police (Appelbaum, 2013; Kangas & Calvert, 2014).

Bersoff (2014) argued that the *Tarasoff* doctrine is bad law and bad public policy. With respect to actual risk to public safety, few hard data exist to demonstrate that warnings effectively prevent harm, although reasonable indirect evidence does suggest that treatment can prevent violence. Obviously, ethical principles preclude direct empirical validation of

management strategies that may or may not prevent people at a high risk from doing harm to others (Douglas & Kropp, 2002; Litwack, 2001; Otto, 2000). In addition, violent behavior does not itself constitute an illness or mental disorder. We cannot treat the violent behavior, but we can treat a number of clinical variables associated with elevated risks of violence, including depression, substance abuse, and unmoderated anger (Bersoff, 2014; Douglas & Kropp, 2002; Kangas & Calvert, 2014; Otto, 2000).

The shooting in an Aurora, Colorado, movie theater by University of Colorado graduate student James Holmes on July 20, 2012, resulted in the killing of 12 people and injuring of 70 others. This case provides a more recent illustration of the issues. Holmes had reportedly been in treatment with Lynne Fenton, a University of Colorado psychiatrist. Holmes allegedly sent a notebook to Dr. Fenton before the shooting, the notebook was reportedly filled with details and drawings of how he was planning to kill people. She indicated that she had no contact with him after June 11, when she reported concerns about his mental status to campus police. As of this writing, it remains to be seen whether Holmes’s process of withdrawing from the university at the time constituted sufficient reason for the university to take no further action (Goode, Kovaleski, Healy, & Frosch, 2012). At the time of this writing, the jury has found Holmes guilty. Lawsuits filed against Dr. Fenton and placed on hold to avoid conflicts with the criminal case against Holmes will likely resume.

State laws vary regarding how or whether a duty of care to third parties applies (Benjamin, Kent, & Sirikantraporn, 2009), and unless clinicians remain abreast of the law, they function with a double burden of ignorance and anxiety. Unfortunately, many psychotherapists seem unaware of the laws in their jurisdictions, often misinterpreting a duty to warn possible victims as their only recourse (Pabian, Welfel, & Beebe, 2009). Alternative protective options depend on the case context but can include increasing the frequency of sessions and communications, minimizing environmental enablers or other elements that may encourage violent behavior,

changing medication, voluntary hospitalization or commitment, involving family members or other support systems, “do-no-harm” contracts, and consultation (Shapiro & Smith, 2011).

Of course, the ultimate goal of such laws is to save lives. However, some mental health professionals argue lives could be lost as a result of overzealous reporting mandates (Shapiro & Smith, 2011). Like Mr. Poddar in the *Tarasoff* case, clients who need therapy and are reported may not return to therapy, perhaps placing themselves or others at increased risk. Aggressive or angry persons may avoid engaging the services of mental health professionals if they suspect their confidences could be disclosed to law enforcement. In addition, those who do enter therapy may not express what they actually feel or intend to do (Ritter & Tanner, 2013).

Given that many clients report feelings of depression or anger, deciding whether a client’s threats to harm themselves or others are serious, as opposed to venting, will become an issue at some point in every psychotherapist’s career. Taking action to warn or protect an intended victim is not an easy decision. Compilations of risk factors exist as tools to help assess violence potential (Berman, 2006; Douglas, Ogloff, Nicholls, T. L., & Grant, 1999; G. T. Harris, Rice, & Camilleri, 2004; C. L. Scott & Resnick, 2006), but violent fantasies alone do not predict violent criminal behavior (Gellerman & Suddath, 2005). Forecasting imminent violent behavior remains largely in the realm of clinical judgment rather than manual-driven assessments, and the best predictor remains past behavior (Shapiro & Smith, 2011).

HIV and AIDS

Although the treatment of AIDS has improved and the rate of infection in first-world nations has declined, therapists should remain current regarding medical data, treatments, transmission risks, interventions, and state laws regarding professional interactions with HIV-infected patients. Therapists should speak openly and directly with clients about dangers of high-risk behaviors. Individuals who put others at risk typically have emotional conflicts about this

behavior and may ultimately feel grateful for a therapist’s attention to the difficult issue (Anderson & Barret, 2001; Barnett, 2010; Stein, Freedberg, & Sullivan, 1998; VandeCreek & Knapp, 2001; Werth et al., 2009). If the client continues to resist informing partners or using safe practices, clinical judgment becomes a key issue in assessing the duty to protect (Hook & Cleveland, 1999; Palma & Iannelli, 2002). After exhausting other options, the therapist may have to breach confidentiality to warn identified partners; however, one should first notify the client, explain the decision, and seek permission. The client may agree to go along with the notification. Once again, such case patterns constitute an occasion to consult colleagues and attorneys and to make certain that prejudices do not drive the decision.

Psychotherapists who work with clients infected with HIV or who have developed AIDS must consider additional issues with respect to confidentiality and reporting obligations (Parry & Mauthner, 2004; VandeCreek & Knapp, 2001). McGuire, Nieri, Abbott, Sheridan, and Fisher (1995) studied the relationship between therapists’ beliefs and ethical decision making when working with HIV-positive clients who refuse to warn sexual partners or use safe sex practices. The study focused on psychologists licensed in Florida because of a state law mandating HIV–AIDS education. Although homophobia rated low among psychologists sampled, increases in homophobia were linked significantly to the likelihood of breaching confidentiality in AIDS-related cases. This finding suggests that some degree of prejudice may drive behavior in these circumstances.

Imminent Danger and Confidentiality

At one time, the APA’s “Ethical Principles of Psychologists” (APA, 1981) authorized the disclosure of confidential material without the client’s consent only “in those unusual circumstances in which not to do so would result in clear danger to the person or others.” As a reflection of the legal developments reported here, the current APA ethics code notes:

Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (APA: 4.05b)

Other professional ethical codes do provide ethical cover when adhering to applicable laws. The NASW (1.07c) and ACA (B.2) codes also specifically address the confidentiality exception in instances of serious, foreseeable, and imminent harm. The AAMFT code does not specifically address dangerousness, although it does require a therapist to advise clients of any limitation as mandated by law (AAMFT 2.2). All of the professional codes would agree that when an urgent breach of confidentiality must occur, the minimum necessary protective information should be provided.

Consider these case examples:

Case 6–19: Bernard Bizzie, L.M.H.C., was about to leave for the weekend when he received an emergency call from a client, who claimed to have taken a number of pills in an attempt to kill herself. Bizzie told her to contact her physician and to come in to see him at 9:00 a.m. on Monday morning. He made no other attempt to intervene, reasoning that contacting others on her behalf would breach confidentiality. The client died later that evening without making any other calls for assistance.

Dr. Bizzie clearly behaved in an unethical and negligent manner by not attending more directly to his client's needs. Even those rare mental health professionals who once asserted that one should never disclose confidential information without the consent of the client in the early post-*Tarasoff* era (e.g., Dubey, 1974; Siegel, 1979) or those who continued to blindly advocate "absolute" confidentiality (Karon & Widen, 1998) would not likely counsel inaction

in the face of such a risk. Bizzie could have taken many steps short of violating the client's confidentiality. Most obviously, he should have attempted (at the very least) to learn her location and assure himself that help would reach her if he could not. Although suicidal threats or gestures may prove manipulative, rather than representing a genuine risk at times, only a foolish and insensitive colleague would ignore them or attempt to pass them off glibly to another.

Case 6–20: Mitchell Morose, age 21, received therapy from Ned Novice, a psychology intern at a university counseling center. Morose had felt increasingly depressed and anxious about academic failure and dependency issues with respect to his family. During one session, Morose told Novice that he had contemplated suicide, had formulated a plan to carry it out, and was working on a note that he would leave "to teach my parents a lesson." Novice attempted to convince Morose to enter a psychiatric hospital for treatment in view of these feelings, but Morose accused Novice of "acting like my parents" and left the office. Novice immediately called George Graybeard, Psy.D., his supervisor, for advice. Graybeard agreed with Novice about the risk of suicide, and acting under a provision of their state's commitment law, they contacted Morose's parents, who could legally seek an emergency involuntary hospitalization as his next of kin. Novice told the parents only that he had treated their son, and that their son experienced suicidal ideation and had refused hospitalization. The parents then assisted in having their son committed for treatment. Following discharge, Morose filed an ethical complaint against Novice and Graybeard for violating his confidentiality, especially by communicating with his parents.

Mr. Novice certainly had reason for concern and discussed the matter with his supervisor. (As an aside, we must assume that, early in their work together, Novice had explained his "intern" status to Morose, including the fact that he would routinely discuss the case with his supervisor.) Novice had attempted to ensure the safety of his client through voluntary hospitalization, but the client declined. Because the state laws, well known to Dr. Graybeard, provided a

mechanism that called for the involvement of next of kin, the decision to contact the parents was not inappropriate, despite going against the client's wishes. Morose had provided ample reason for Novice to consider him at risk, and the responsible parties disclosed only the data absolutely necessary to ensure his safety (i.e., that he seemed at risk for suicide and refused hospitalization). The therapist did not give the parents any other confidential details. In the end, Morose's confidence was indeed violated, and he felt angry. Under the circumstances, however, Novice and Graybeard behaved in an ethically responsible fashion. Also, in the next section, we address specific federal legislation intended to protect the privacy of health care records (i.e., HIPAA). However, even the most protective of these regulations permits limited breaches of confidentiality necessary to provide appropriate treatment.

The best approach to avoid such problems in one's practice involves three separate issues. First, each therapist should clearly advise every client at the start of their professional relationship of limits on confidentiality. Second, clinicians should think through and come to terms with the circumstances under which they will breach confidentiality or privilege. Consultation with an attorney about the law in the relevant practice jurisdiction will prove crucial because of diverse case law decisions and variable statutes. Finally, should an actual circumstance arise bearing on these issues, consultation with colleagues can help sort out alternatives that may not come to mind initially.

ACCESS TO RECORDS AND PERSONAL HEALTH INFORMATION

Mental health practitioners keep records of their work and clients for a variety of reasons—legal obligation, reluctance to rely on memory, communication to other professionals, ready availability of important data, and documentation of services provided, to name a few (Luepker, 2012). By definition, such records will often contain confidential material, and as long as they

exist, someone other than the therapist who collected the material may seek access to them. In addressing this issue, we must first consider the process of securing a client's informed consent for the release of information. We must then consider the claims and circumstances under which various parties might seek access, as well as the nature of the information sought. Finally, we consider the use of client records for teaching or research purposes, including the use of recordings and photographic materials.

Congress enacted Public Law 104-191, better known as the Health Insurance Portability and Accountability Act or HIPAA, on August 21, 1996. Regulations and implementation took several years, and many related resources now abound (see U.S. Department of Health and Human Services, 2014; LexisNexis, 2014). Congress intended that HIPAA would do exactly what its name implies: protect the portability of health insurance and the privacy of personal health information (PHI) generally and electronic PHI or ePHI. Among its provisions, HIPAA specifies notices that health care providers must give their patients about the confidentiality of records, lays out standards for authorizing the release of PHI, and addresses the security in electronic transmission. The privacy protections afforded by HIPAA preempt state laws unless the state laws provide a higher standard of protection. We address many aspects of HIPAA in this section. Interestingly, the APA ethics code had already addressed most of the key principles mandated under HIPAA, albeit with less specificity (e.g., the need to alert clients about limits of confidentiality at the outset of the professional relationship, releasing information to third parties only with a client's consent, and taking pains to protect client privacy when transmitting insurance claims or other health information). Other professions confirmed similar obligations following passage of HIPAA (AAMFT: 2.1-2; ACA: B.1.d; NASW: 1.07d-e).

Consent for the Release of Records

Transferable records can be of great assistance or substantial detriment to clients, depending

Box 6–1 Basic Requirements of Release Forms

Under HIPAA regulations (45 C.F.R. §164.508), each consent or release form must at minimum contain

1. A description of the information to be used/disclosed in a specific and meaningful form;
2. The name or specific identification of the person(s) or class of persons authorized to disclose the information;
3. The name or specific identification of the person(s) or class of persons authorized to receive the information;
4. A description of the purpose or requested use of the information;
5. An expiration date or event related to the purpose of the disclosure; and
6. The signature of the person making the authorization and date of signing. If the signer is acting on behalf of another, the relationship should be indicated.
7. Certain required statements must also appear on the release form to notify the signer that
 - a. They have a general right to revoke the authorization in writing, any exceptions, and the procedure to follow.
 - b. The care provider or institution may not require the release as a condition of treatment, payment, or eligibility for benefits.
 - c. Once released, the information could potentially be rediscovered by the recipient and thus no longer be protected.

on their contents and uses. Often, the process of obtaining consent occurs so hurriedly or perfunctorily that clients may not fully understand what they have authorized or why. Some may even sign release forms against their wishes because of a variety of subtle and obvious pressures or because no alternatives seem available (Damschroder et al., 2007; Luepker, 2012; McSherry, 2004; Rosen, 1977). The practitioner has an important role in educating and helping to safeguard the client's interests in such cases (Clemens, 2006; Rogers, 2006).

An authorization for a release-of-information form should at minimum conform to the specifications of HIPAA regulations. A summary of these essential elements appears in Box 6–1.

If you receive a release or request for information that does not seem valid or might present some hazard to the client, consider contacting the client directly to seek confirmation prior to releasing any material.

Whenever signing a consent form, the client should receive a copy, and the therapist should make the original a part of that client's files.

The practitioner should also keep a record of which materials were sent, to whom, and when. Clinical records should bear a confidential designation, and the recipient should remain aware of any limitations on their use. One should also exercise caution to see that only material appropriate to the need is sent. Consider this example:

Case 6–21: Kurt Files, Psy.D., had evaluated 8-year-old Sheldon Sputter at his family's request because of school problems. The evaluation included taking a developmental and family history, meeting with both parents, reviewing school progress reports, and administering cognitive and personality tests. Dr. Files discovered that Sheldon had a mild perceptual learning disability and was also coping poorly with a variety of family stresses, including his mother's reaction to paternal infidelity, his father's recent discovery that Sheldon was not his biological child, and a host of other family secrets that had recently come to light. He recommended appropriate psychotherapeutic intervention, and the family followed through. Several

weeks later, Dr. Files received a signed release form from the school Sheldon attended asking for "any" information he had on Sheldon's problem. Files responded with a letter describing the cognitive test results and referring in general terms to "emotional stresses in the family that are being attended to."

In this situation, the psychologist recognized the school's valid need to know information that could help better serve Sheldon. At the same time, Dr. Files recognized that some of the material bore no relevance to the school's role, and he made the appropriate discrimination despite the vague and broad request for any information. As noted previously, most professional association ethics codes follow APA's recommendation to "disclose information only to the extent necessary to achieve the purposes of the consultation" [APA: 4.06(2); AAMFT: 2; ACA: B.2.e; NASW: 1.07.c].

Client Access to Records

Clients' access to their mental health records has historically been a matter of some controversy, although the issues have varied somewhat as a function of the precise type of records involved. In the past, patients did not always have access to their own medical and mental health records. This trend began to erode in the 1980s and officially died with HIPAA, which specifies patients' access rights to their health and mental health files. Therapists should generally assume that any patient may someday ask to see his or her records, and that all who persist will ultimately be able to obtain copies, whether the therapist agrees this is a good idea or not. Some portions of therapist's office records might include material that ought to be safeguarded from disclosure to nonprofessionals (e.g., copies of intelligence test protocols or other such test materials that could compromise test security by their release). Disclosure of psychological test data and materials raises special issues, as discussed in Chapter 7.

In consideration of HIPAA, practitioners will want to recognize four special categories of records: (a) medical records, (b) psychotherapy

notes, (c) forensic reports, and (d) working notes. HIPAA and patients' rights of access apply broadly to records considered PHI.

Medical records include the general office or institutional records that chronicle appointments kept, diagnoses, prescriptions, insurance claims, procedures, and the like as part of the PHI. In this context, the term *medical record* includes the records kept by nonphysician mental health clinicians as well as the records of psychiatrists.

Psychotherapy notes have special status under HIPAA. Such notes include observations that therapists wish to record for their own use and could include details of the content and process of psychotherapy beyond the more standard documentation typically included in general medical records. Such notes must be stored in a separate file from medical records. Under the provisions of HIPAA, disclosure of psychotherapy notes requires special designation in the release or waiver form signed by the patient. In other words, a signed waiver authorizing the release of medical records does not include psychotherapy notes unless specific mention is made of that category.

Forensic reports involve data collected and reports written specifically for use in legal contexts and may not fall under the penumbra of HIPAA. Such reports for the courts might, for example, include information on competency to stand trial, criminal responsibility, or child custody evaluations. Although such reports may occasionally include health information, their purpose and utility focus on the legal system and may be governed by court rules or orders. For example, some court-ordered forensic reports may be sealed by the court and not released even with the consent of the person addressed in the report, despite HIPAA policies that generally make health records available. Forensic practice standards typically ensure that the client has reasonably informed consent regarding the purpose of the interviews and the parties who will have access to the data, even though unenthusiastically given (Connell & Koocher, 2003). At times, a client may also agree in advance not to have access to some data or reports prepared by mental health professionals,

as in the case of some preemployment or independent medical evaluation examinations.

Working notes refers to those impressions, hypotheses, and half-formed ideas that a mental health professional or trainee may jot down to assist in formulating more comprehensive reports or recommendations later. Often, these notes are reworked into psychotherapy notes or a report, used for discussion with a supervisor, or simply discarded as new data come to light. Because of the speculative, impressionistic, and temporary nature of such working notes, they may not have meaning or utility to anyone except the person who made them. Such notes are definitely not the sort of material a therapist would want released to anyone. They should be reworked into more formal office or institutional records and subsequently destroyed. Mental health professionals should remain aware that at least some risk always exists that any written materials might someday come to light in public through a court proceeding. Clinicians who keep detailed working notes should routinely consolidate them into less-sensitive summaries for all cases. This avoids the danger of an accusation the clinician has selectively edited a case file in anticipation of a client request for records or a court action. The reasons for this suggestion become clear in the following material.

One fact should remain uppermost in the reader's mind as our discussion of record access continues: The records do not belong to the client but rather are the property of the institution or private practitioner as their creator and keeper, depending on the setting involved. While clients may have a right to copies of or access to their records, and certainly an interest in them, the records themselves do not belong to the client unless expressly transferred to the client for some reason. Clients may from time to time assert the claim to a record "because I paid for that report" or "I paid for those therapy sessions." In fact, the client paid for services rendered, or perhaps a copy of a report, but not for the actual original records (e.g., case notes, process notes, or test protocols) unless specified as part of the agreement with the therapist or agency for some unusual reason.

Opponents of free client access to records have generally made two types of claims. First, they have asserted that the therapist must feel free to speculate and jot down any thought or comments. Some of these will invariably seem erroneous or misleading if taken out of context. Second, opponents of open access have sometimes claimed that harm may follow release of technical professional information to clients who are not equipped to understand or deal with it (Strassburger, 1975). Consider the case of *Godkin v. Miller* (1975):

Case 6–22: On several occasions between 1962 and 1970, Janet Godkin had undergone treatment as a voluntary mental patient at three different New York hospitals. She and her husband decided to write a book about her experiences and sought access to her records, wishing to verify some of the material. The requests were refused, which led to a lawsuit against the New York State Commissioner of Mental Hygiene and the directors of the hospitals involved ("Doctor and the Law," 1975).

The judge in the case agreed with the refusal to provide the records when the hospitals expressed a preference for releasing the records to another professional rather than to the client herself. The rationales presented by hospital staff included that the records would be unintelligible to the layperson; certain of the information might prove detrimental to the individual's current well-being; and the records could contain references to other individuals, who might be harmed by disclosure (Roth, Wolford, & Meisel, 1980). The judge also noted that records are the property of the practitioner or the hospital, and that a client consults the practitioner for services, not for records ("Doctor and the Law," 1975). Some years later, the New York Supreme Court granted Matthew C. Fox, a former patient of the Binghamton Psychiatric Center, full access to his medical records despite the center's contention that such access would be antitherapeutic (*Fox v. Namani*, 1994). Fox was suing the center for malpractice and acting as his own attorney. HIPAA has now trumped all such reasoning in favor of granting clients access to their own health records.

We generally favor full client access to their mental health records. However, there may be circumstances, such as notes on group therapy sessions or records collected on behalf of a corporate client regarding many individuals, when full access to records could violate the privacy and confidentiality of another party. Rare instances also exist when access to some recorded data might cause substantial and concrete detriment to an individual client.

Case 6-23: During an acute psychotic episode, Tyrone Propper penned a series of bizarre, sexually explicit notes to his psychotherapist. Because the notes seemed clinically relevant at the time, they remained in the therapist's private case files. Mr. Propper later recovered fully and returned to his job as a bank chief executive officer. He visited the therapist for a follow-up session and asked to review the case file to help gain perspective on what had happened to him. Propper had few memories from the psychotic period.

Case 6-24: Barry Icarus had been raised by his aunt and uncle because his parents died before his second birthday. He had suffered a reactive depression since his uncle's death from a heart attack on his 16th birthday. Six months of psychotherapy had helped him to deal with the loss successfully and go on to college away from home. A few years later, Barry's aunt died, and he returned to have a few sessions with the same psychotherapist who had helped him earlier. Barry expressed some interest in reviewing his records with respect to his prior treatment. The psychotherapist's file still contained a developmental history given by the aunt years earlier. This included the fact, still unknown to Barry, that his mother had been shot to death by his father, who later committed suicide.

In these cases, it might be appropriate for the practitioners in question to omit material (e.g., the sexually explicit notes and the precise circumstances of the parents' deaths) from the files prior to reviewing them with the clients. The notes could prove embarrassing or distressing to the recovered client. Revelation of them would serve no useful purpose and might possibly

increase emotional distress. The information on Barry's parents seems irrelevant to his reason for seeking treatment now but constituted part of a thorough developmental history needed at the time. Providing him with this material now could add stress without an immediate constructive purpose.

When situations of this sort occur, it should be possible to supply the client with the sought-after information minus those sections that might violate the rights of others. In the case of the detrimental material, the residual content could be shared directly with the client. A decision about the actual degree of detriment first ought to be made by a professional in a position to offer an unbiased consultation on the matter. However, if either client asked for their full medical record, HIPAA grants them access to the contents.

Therapists who make records available to clients should give serious consideration to the manner in which this occurs. Do you insist on being present? Do you charge for your time or consider this part of your services? Do you make your policy on such matters clear to clients before therapy (or other service delivery) starts? We believe that it is desirable to let clients know such policies early in the course of the professional relationship. We also believe that it is important for the therapist to be present during the record review to offer elaboration, explain technical terms, or deal with the client's feelings related to the material. If this would require a significant amount of time, charging a fee for this service may be warranted; however, this should be tempered with an understanding of the client's financial situation, balanced with his or her needs and rights of access in a particular situation. The client who has terminated treatment for lack of funds, for example, should not be barred from a file review for inability to pay, and HIPAA requires release of records even when a client does not wish to review them with the therapist.

Access by Family Members

Occasionally, a concerned family member will seek access to a client's records. When the

client is a child or deemed legally incompetent, parents or guardians generally have full legal entitlement to record access. Therapists should recognize the unique problems that arise when working with minors or families and should remain sensitive to each individual's right to privacy and confidentiality in such circumstances. From the outset of any such relationship, all parties should receive information about the specific nature of the confidential relationship. A discussion about what sorts of information might be shared and with whom should be raised early. This is not a difficult or burdensome process when done as a routine practice.

Case 6-25: Cynthia Childs, Psy.D., has treated 7-year-old Max Bashem for about a month. Max was referred for treatment because of secondary enuresis and acting-out behaviors of recent onset. The birth of a new sibling in the Bashem family several weeks ago seems to have contributed to the problem. Near the end of the fifth therapy session, Max expresses some anger about his new sibling and tells Dr. Childs, "Tonight after my parents go to bed, I'm gonna kill that little weasel!"

Case 6-26: Donna Rhea, age 14, also sees Dr. Childs regularly in psychotherapy. Donna feels alienated from her parents and is sexually active. Her parents discovered that she has contracted genital herpes, and in a moment of emotional distress after they learn this fact, she accused them of not being as "understanding as Dr. Childs." The parents feel furious that the psychotherapist knew their daughter was sexually active and did not tell them. They demanded a full briefing from Dr. Childs, threatening to pull their daughter out of treatment. They also threatened to file an ethics complaint.

These two cases illustrate some difficult, but not insoluble, problems (Koocher & Keith-Spiegel, 1990; Taylor & Adelman, 1989). In the case of Max, Dr. Childs must consider several factors, not the least of which concerns the seriousness of Max's threat. Does Max have a history of violence toward others? Has he exaggerated his anger in the context of therapy for emphasis? Certainly, Dr. Childs will want

to explore this issue with Max before ending the session, but suppose she does feel that he poses some risk to the sibling? Suppose that Max cannot commit himself to leave the baby unharmed in the coming week between sessions. Dr. Childs could express her concern and discuss with Max the need to help keep him from doing something he might later regret. She could talk with him about alternatives and explore a variety of them, one involving a family conference in which Max could be encouraged to share some of his angry feelings more directly. If all else fails and Childs believes that she cannot otherwise stop Max from hurting his sibling, she must discuss the matter with his parents as a duty-to-protect issue. Not to do so would constitute malpractice. While such a circumstance would be rare indeed, Childs should certainly discuss the need to violate the confidence for his ultimate benefit.

Donna's situation poses a more complex problem. Dr. Childs almost certainly would have lost the trust of her client had she chosen to violate Donna's confidence. At the same time, providing a value-free climate in psychotherapy may have the net result of unintentionally condoning Donna's sexual behavior (Baumrind, 1990). The parents may feel jealous of the trust and respect their daughter seems to have in the psychotherapist, while feeling angry and disappointed at her sexual activity and resulting infection. A conference does not seem inappropriate but would probably best succeed as a family meeting with Donna present. Dr. Childs could attempt to retain a supportive and therapeutic stance in such a session without necessarily breaking confidence. The sort of information the parents expect seems unclear. A preventive step might have included a pretreatment family conference with a discussion of the psychotherapy relationship and any attendant limitations. An outright refusal to meet with the parents in this circumstance would not serve the interests of any of the parties. Many state laws do permit minors to obtain treatment for sexually transmitted diseases or birth control information without parental consent and in confidence. Dr. Childs's behavior does not seem inherently unethical.

Access to records sought by family members of an adult should generally be denied unless some special reason justifies considering the request. Special reasons might include the imminent danger test or the legally adjudicated incapacity of the client.

Case 6–27: Marla Noma lived with cancer for many years, and during that period she occasionally consulted Michael Tact, M.S.W., about her fears and concerns related to the illness. During a surgical procedure, Marla became comatose and remained alive on life support equipment, although with little chance of recovery. Members of her family planned to seek court authorization to discontinue mechanical life-support equipment and wondered whether any of Tact's records or conversations with Marla might provide some guidance to them and the court about her wishes.

In such a case, when the client cannot speak for herself, it probably would not be unethical for Tact to respond openly to a duly authorized request for information from the next of kin. The surviving line of consent generally recognized by courts is as follows: First in line to grant consent is the spouse (even if living apart from the client, as long as they are not divorced). Second are the children of legal age, with each such child having an equal voice. Next are parents or grandparents, followed by siblings, each also having equal voice. If none of the above survive, courts will occasionally designate the next-nearest relative or closest friend.

Court Access to Records

The concept of privileged communication discussed in this chapter has a narrow focus on protecting certain material from disclosure in court. Despite privilege, however, some courts or litigants may still seek access to privileged information as well as other confidential material. While mental health professionals must certainly respect appropriate requests emanating from the courts, they must also reasonably safeguard material from inappropriate release. Some practitioners assume that their working notes fall outside the realm of materials subject

to disclosure in court, feel stunned when a subpoena duces tecum arrives, demanding that they appear in court and bring with them "any and all, files, documents, reports, papers, photographs, recordings, and notes in whatever form they exist" regarding the case in question.

In such instances, understanding the differences between a subpoena and a court order becomes critically important. A subpoena simply compels a response, and in some jurisdictions an attorney can obtain one simply by asking the court clerk. The response need not provide what the subpoena document demands. If the papers seek documents or testimony protected by privilege, the therapist should seek clarification from the client's attorney or the court. A court order, on the other hand, typically follows a hearing before a judge and compels a disclosure unless appealed to a higher court. In the end, the court must decide what qualifies as protected or not.

If a subpoena or request for documents arrives from a client's own attorney and without a release form, check with your client, not the attorney, before releasing the documents. If a signed release form does accompany the request but the therapist believes that release of the material might cause clinical or legal damage, discuss it with the client. Practitioners concerned about releasing actual raw notes can offer to prepare a prompt report or summary. In a technical sense, a request from a client's attorney has the same force as a request from the client; however, it is not unreasonable for the therapist to personally confirm the client's wishes, especially if the records include sensitive content.

On occasion, a subpoena generated by an attorney opposing the therapist's client or representing another person may arrive at a therapist's office. Under such circumstances, it is reasonable to contact the attorney who issued the subpoena and say, "I cannot disclose whether the person noted in the subpoena is now or ever was my client. If the person were my client, I could not provide any information without a signed release from that individual or a valid court order." Next, contact your client, explain the situation, and ask for permission to talk with his or

her attorney. Ask the patient's attorney to work out privilege issues with the opposing attorney or move to quash the subpoena. These steps will ensure that the person to whom you owe prime obligations (i.e., your client) remains protected to the full extent allowed by law. When in doubt, consult your own attorney for advice, but never simply ignore a subpoena. Readers will find a discussion of subpoenas intended to compel testimony and other forensic issues covered in Chapter 13.

Case 6–28: Clinical psychologist Polly Rost learned the hard way about the importance of consulting an attorney in response to a subpoena for records. The Pennsylvania Board of Psychology issued a formal reprimand to Rost for failing to seek legal advice in dealing with a subpoena. The parents of a child client sued the York Jewish Community Center because their child suffered headaches after a fall there. Rost released the records of the child to the parents' attorney, and later to the Community Center's attorney, in response to an attorney-issued subpoena. After receiving a complaint from the parents, the Pennsylvania licensing board ruled that Rost should have sought the advice of counsel before releasing records in response to the subpoena, and the courts upheld that ruling (*Rost v. Pennsylvania Board of Psychology*, 1995).

Case 6–29: In 2012, Diane Kohl, a licensed marriage and family therapist, was called to testify in Steuben County (N.Y.) family court regarding a child custody case. Both the father and his 3-year-old child had participated in court-ordered therapy sessions with her. The law guardian representing the child asked that Kohl provide all case notes from those sessions. Instead, Kohl presented a summary to the court and announced, "I refused to give up my notes. My ethics say I am not to do that. . . . I take lots of fragmented notes. They would not be helpful to the lawyer. There are only two exceptions to confidentiality—only if I have knowledge of child abuse or if someone is actively suicidal or homicidal can I breach confidentiality." Unfortunately, for Ms. Kohl, Judge Joseph Latham disagreed and signed a contempt-of-court order. A few months later, following a routine traffic stop,

Ms. Kohl found herself under arrest in handcuffs. Ms. Kohl ultimately gave her notes directly to Latham to review (Murray, 2013).

Both Rost and Kohl had their own ideas about how to handle the requests for records they received, and both were simply wrong. When dealing with the legal system, obtaining sound advice from an attorney may prove the wisest course of action.

When appropriate to release original materials from your case files, offer an authenticated notarized copy rather than the originals. If the court specifies that you must provide the originals, be certain to retain a notarized copy of the records for yourself or have your attorney do so. Important documents can easily become lost or misplaced as they travel through the legal system.

Case 6–30: Arnold and Anita Abuser were being treated in marital therapy by Samuel Silent, Ph.D., when their child died, apparently of inflicted injuries. Prosecutors subpoenaed Dr. Silent to appear before a grand jury investigating the child's death and questioned him about the content of his sessions with the Abusers as the district attorney sought incriminating evidence about the couple. Dr. Silent asked for a judicial determination on privilege. He noted that, as a legally mandated reporter of suspected child abuse, he would have made an official report had he suspected anything. A judge ruled that the prosecutors should have adequate latitude to investigate, and because the case involved alleged child abuse, he would order the therapist to testify or face jail for contempt of court. Mr. and Mrs. Abuser did not wish Dr. Silent to discuss any material from their sessions before the grand jury.

Dr. Silent felt caught in a particularly difficult situation. If he bowed to the court order and testified, he would violate his clients' confidentiality against their instructions. If the Abusers are guilty and the therapist's silence precludes prosecution, he may protect his clients to the detriment of the victim and society as a whole. In addition, if the Abusers had given Dr. Silent reason to suspect abuse, and he did not report it, he could face prosecution.

If Dr. Silent does not comply with a judge's order to testify, he faces fines or jail for contempt of court and may thereby stand accused of breaking the law. This situation is a prime example of a point at which ethical behavior may at times seem at variance with legal requirements. If Dr. Silent believes he should not testify, the best advice would involve resisting disclosure of confidential material using all legitimate legal avenues. If such avenues become exhausted or fail, Dr. Silent's colleagues would not likely sustain an ethical infraction against him for ultimately disclosing the confidential material (APA: 4.05; ACA: C.1; NASW: 1.07.j). When conflicts between its ethics code and the law occur, the APA advises psychologists to attempt a responsible resolution, but note that "if the conflict is irresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing authority in keeping with basic principles of human rights" (APA: Introduction).

If Silent knew of abuse and chose to disclose details from the outset under mandated reporting laws, he would also have behaved ethically. If Silent had known of abuse and had failed to report it, he could possibly decline to testify, citing his Fifth Amendment right under the U.S. Constitution against self-incrimination, although such a claim affords no protection from the ethical impropriety of not reporting the abuse.

Case 6-31: John Spleen, L.M.F.T., filed for divorce from his wife, Sandra, under less-than-amicable circumstances. John practices privately as a licensed marriage and family therapist, and Sandra believed that he lied about his income in the process of reaching a negotiated financial settlement. She sought a court order for her spouse to disclose the names, addresses, and billing records of his clients so that she and her attorney could verify the actual annual income from his practice.

Dr. Spleen stands in a difficult position, even assuming that he has nothing to hide in his personal financial affairs. Disclosing the names and addresses of his clients could certainly prove embarrassing and stressful to the clients. Perhaps he could arrange for an independent

audit of his records in confidence by a bonded professional, without the need to contact clients individually or otherwise disclose their names. In any event, the Spleens' dispute involves a civil matter, and courts will be less likely to pursue disclosure for civil matters than for a criminal case. In a similar case, a California appellate court protected the confidentiality of the therapist's records from the spouse, noting that public disclosure of client status itself might prove harmful to a client.

Case 6-32: Cindy Weisbeck was treated by James Hess, Ph.D., from November 1986 to June 1987 at South Dakota's Mountain Plains Counseling Center. In September 1987, he hired her as a part-time secretary at the center, of which he was the sole owner. Some 20 months after he stopped counseling Ms. Weisbeck, Dr. Hess allegedly initiated a sexual relationship with her. Cindy's husband, James Weisbeck, sued. In seeking to show that Hess had a history of taking advantage of vulnerable female clients, Mr. Weisbeck sought access to a list of Hess's patients going back 7 years and the right to depose Hess's personal therapist, a social worker named Tom Terry (*Weisbeck v. Hess*, 1994).

In the case involving Dr. Hess, the South Dakota Supreme Court denied the request for access to client records and the right to depose Hess's therapist, although the court did not cite privacy of the clients as the primary rationale. Rather, the court noted that the APA ethics code in force at that time did not establish Hess's behavior as a "harmful act."

Records and Cyberconfidentiality

Rapid changes in the ways we store, retrieve, and transmit data, including sensitive clinical and financial material, raise many new types of confidentiality concerns. Vast amounts of information can now be stored in small, easily transported electronic, magnetic, or optical devices that can often be misused, stolen, or misplaced. Use of the Internet for communications provides great convenience as well as considerable unresolved confusion and controversy related to

rights and obligations of users (see, e.g., Barnett & Scheetz, 2003; Behnke, 2007; Fisher & Fried, 2003; Fisher, 2013; Hsiung, 2002; Kanani & Regehr, 2003; Luepker, 2012; Reamer, 2013; U.S. Department of Health and Human Services, 2014). Mental health professionals making use of new technology must remain thoughtful and cautious about the hazards to confidentiality that result.

Case 6–33: Lydia Laptop, Psy.D. industriously caught up on her record keeping, typing on her portable computer as she flew home from a professional meeting. She had nearly finished the treatment summary on a new client when a familiar message came over the public address system: “In preparation for landing, please return your seatbacks to the full upright position, turn off your larger electrical devices, and stow any items you removed for use during the flight.” Dr. Laptop saved the file to her hard disk, carefully backed it up on a USB flash drive, and placed the drive on the seat as she packed up her computer. The aircraft experienced a bit of turbulence as she zipped up the travel bag and slipped it under the seat. Dr. Laptop walked off the plane 10 minutes later, leaving the memory chip full of confidential client information on her seat. As soon as she got home, she realized what had happened and called the airline. Airline personnel never recovered the chip.

Case 6–34: Hugh-Jim Bissel, M.S.W., received a faxed HIPAA-compliant release of information form from a therapist in another city. One of Bissel’s former clients had relocated and sought treatment in his new locale. The new therapist, in turn, sought information on the previous therapy. Bissel noted an e-mail address listed on the new therapist’s letterhead and went online to transmit the requested files. Unfortunately, Bissel became distracted by a phone call as he attempted this task, and he lapsed into an oft-repeated pattern of keystrokes, accidentally posting the confidential material to 3,500 subscribers on the International Poodle Fanciers list server.

With a bit of luck Dr. Laptop clients’ privacy may have remained intact if the memory chip

ended up in the trash as the airline cleaning crew went through the cabin. Things could have been more complicated if her laptop with hundreds of client files were stolen from the coffee shop when she turned her back to get a refill. We have no idea how many people may have seen the confidential records of Dr. Bissel’s client before he realized his error and got the International Poodle Fanciers’ webmaster to delete them. Only our imaginations limit the extent of these and other horror stories on “virtual” privacy violations.

News stories of client records stored on stolen portable computers abound. Potentially confidential material routinely flows over the Internet and public Wi-Fi networks to our smartphones, tablet computers, and cloud storage. USB flash drives have become transportable conduits for terabytes of data, and new operating systems offer free and upgradable cloud storage backup. Any practitioner making use of such technology for professional practice should take basic steps to ensure data security with special attention to strong passwords, backup, and encryption.

The most secure passwords involve combinations of upper- and lowercase letters, numbers, and symbols; are changed periodically; and are not taped to your computer monitor. Inconvenient as it may be, use a locking code for cell phones and tablets and set your desktop computer to autolock if idle for a period of time. If your portable device will routinely have confidential material stored on it, consider a software program or application that includes device finding/wiping software to help you track the computer or give a command to erase the stored data remotely in the event of theft.

Encryption software converts data into a scrambled format using a mathematical algorithm or key. Such programs range in cost from free to hundreds of dollars, but vary in security by the strength of the algorithm, with federal Advanced Encryption Standards typically using 128-, 192-, or 256-bit keys. Some devices come with their own built-in encryption that uses a changeable password or biometric key (e.g., fingerprint scanner). Encryption can be used to secure single files or documents, a virtual disk (or container) on a larger drive, or an entire

disk, rendering the contents opaque to potential data thieves. The degree of encryption protection warranted depends on the sensitivity of the data stored. Some programs will encrypt data for transmission and require that the recipient have the password to decrypt the file on arrival. The HIPAA security rule recommends, but does not require, encryption of electronically transmitted PHI data.

Most readers of this chapter will likely have experienced a device or power failure that cost them some valued data. Important data should be backed up at least daily with secured storage at more than one location in case of theft or site damage. Cloud storage has appeal because it allows off-site storage, sharing, and backup of files while allowing remote access via any Internet connection. The prime concern in using cloud storage involves the location and security of the storage servers that function as the cloud. When choosing to use such storage for confidential materials, read the service agreement carefully. For example, does the purveyor of the cloud serve have the right to scan your files for commercial purposes? Does the agreement provide assurance of HIPAA compliance? If you want the convenience of cloud services with lower risk, consider uploading only encrypted files, a cloud service that provides encryption, or a personal cloud server (i.e., a password-protected hard drive connected to a home or office network and accessible via the Internet).

If Dr. Laptop (Case 6-33) had used commonly available encryption technology for her confidential files, her lost USB drive would pose no hazard to her clients. Before transmitting any confidential material by e-mail, fax, or other electronic means, Dr. Bissel (Case 6-34) should have carefully confirmed the security and accuracy of the intended recipient address. Technology will continue to evolve, but the ethical principles remain constant: Therapists are ultimately responsible for safeguarding the privacy of material entrusted to them in confidence. Understand the technology you are using and seek reviews of the products and systems to assess the relative strengths and weaknesses. If you do not believe that a particular

new technology will adequately protect client privacy, stick with safer modes of communication to protect the client's welfare. (See material also related to cybertherapy in Chapter 4.)

Third-Party Access: Insurers and Managed Care

We address the ethics involved in dealing with so-called third-party payers from the business and financial perspective in Chapter 12. We mention these issues here because clients may sometimes authorize the release of information to third parties without fully understanding the implications. When clients decide to submit a claim for mental health benefits to an insurance company (or authorize a clinician to do so on their behalf), they may not realize that, in so doing, the provider of services will share certain information (e.g., diagnosis, type of service offered, dates services took place, duration of treatment, etc.). In some circumstances, insurers or companies designated to manage mental health benefits may have authorization to seek detailed information from case files, including a client's current symptom status, details of a treatment plan, or other sensitive material. HIPAA regulations address many of these concerns, but once information leaves a practitioner's office, it lies beyond the practitioner's control, and insurance companies may not exercise the same caution and responsibility as the individual practitioner. Some insurance companies, for example, participate in rating bureaus or similar reporting services that may become accessible to other entities at some future date. One public account described the case of a business executive denied an individual disability insurance policy because he had sought psychotherapy for family and work-related stresses. Disability underwriters described this denial as a nearly universal practice, and some insurers may use a history of therapy as an exclusionary criterion for individual disability or life insurance policies (Bass, 1995). Although the Affordable Care Act did away with preexisting condition restrictions on health insurance, some mental health conditions lead to categorization of current and

former patients as part of an adverse selection group and prove a barrier for obtaining competitively priced life or disability coverage.

Despite HIPAA-mandated notices, requirements for secure transmission of claims and e-PHI, and other restrictions (U.S. Department of Health and Human Services, 2015), clients do not always read or understand the forms put in front of them to sign. This yields an interesting problem when it comes to informing clients about the implications of their using insurance coverage to pay for therapy and counseling services.

Case 6–35: In addition to the standard HIPAA notice, Victor Vigilant, Ph.D., routinely informs his clients about the issue of disclosure to insurance companies in the following manner: He tells clients who have coverage, “If you choose to use your coverage, I shall have to provide the company with information about the dates we met and what services I performed (i.e., psychotherapy, consultation, or evaluation). I will also have to formulate a diagnosis and advise the company of that. The company is supposed to provide you with a copy of their privacy policies, although I have no control over the information once it leaves this office. If you have questions about this, you may wish to check with the company providing your coverage. You may certainly choose to pay for my services out of pocket and avoid the use of insurance altogether, if you wish.”

Dr. Vigilant seems a bit sarcastic and ominous, but most clients have little choice. Refusing to authorize release of information will result in the insurer refusing to pay the claim. Some clients may not care about the issue. A parent whose child is being seen for an assessment of learning disabilities and attention deficit disorder, for example, may feel unconcerned. On the other hand, clients holding a sensitive public office or position might very well wish to avoid informing any third party that they sought mental health services. In some cases, the matter becomes further complicated by the fact that some employers use self-insurance programs that occasionally send aggregate reports or data back through company

headquarters in a manner that might become accessible to management. This may not constitute a significant threat in a post-HIPAA and post–Patient Protection and Accountable Care Act (Public Law 111-148, 2010) era, but for certain clients and some diagnoses, it might prove best to avoid any type of disclosure without first checking on the channels through which the information will flow.

Case 6–36: In the spring of 2007, Blue Cross and Blue Shield of Massachusetts (BCBSMA) announced plans to introduce an outcomes measurement program using the BHL TOP (Behavioral Health Laboratories Treatment Outcomes Package) for voluntary use with all of their subscribers seeking mental health services. Clients would be asked by their therapists to voluntarily complete the form at the start of treatment and periodically thereafter. The forms would then be transmitted electronically to BHL for scoring and data storage, with feedback reports to the therapist and to BCBSMA. Promises of data security were made, and therapists were informed that they would receive higher reimbursement rates if significant numbers of their clients completed the voluntary forms. Questions on the forms asked, among other things, sexual orientation, family income, religion, and detailed usage patterns for alcohol, cocaine, crack, PCP (phencyclidine), heroin, and other illegal substances. Other questions asked about arrest and incarceration histories.

Several professional organizations raised significant ethical questions. Therapists would find themselves in the uncomfortable position of asking clients to voluntarily compromise their privacy by completing the forms, while the therapists faced a financial incentive to secure the data. Clients' data would ultimately be stored in electronic databases with no clear parameters on its future use for their benefit or detriment. Despite claims of data storage security, major breaches by private institutions and federal agencies in recent years (see, e.g., <http://www.privacyrights.org/> and <http://www.epic.org/privacy/>) also raised legitimate concerns. Given the sensitive and personal nature of the data collection plan, including requests to

delineate illegal behaviors, the BCBSMA plan seemed to pose serious potential risks to clients. The forms would become a part of therapists' records, leaving the content open to discovery under some legal proceedings. BCBSMA initially did not plan to provide any warnings or cautions about such hazards to their subscribers and provided each practitioner sample text of a self-serving nature. After substantial advocacy by professional organizations, BCBSMA backed away from the instrument, and litigation between BHL and BCBSMA ensued. The BHL TOP is now marketed by a new company, led by the founder of BHL.

Peer review groups, such as professional association ethics committees, constitute a different type of third party with which the matter of disclosing confidential material occasionally becomes an issue. Members of professional associations must respond to inquiries from such duly constituted bodies, although they must also observe the basic principle of confidentiality. When asked by an ethics committee to respond, the therapist should first determine whether the complaining party has signed an appropriate waiver of duty of confidentiality due them. No ethics committee can press an inquiry about a client unless it first obtains a signed release from the client regarding the therapist's obligation of confidentiality. The same holds true of complaints to licensing boards or other regulatory bodies. The therapist cannot defend his or her case without the freedom to discuss the content of the relationship in question openly.

Case 6–37: Roger Control filed an ethics complaint against a psychotherapist who allegedly "made my problems worse instead of better." Mr. Control complained about one session in particular that "caused me strong mental anguish and insomnia for several weeks." Mr. Control asserted that the dozen prior sessions with the therapist were irrelevant and would only agree to allow the therapist to talk about the one "traumatic session" he had cited.

The ethics committee, noting that this limitation would not permit a sufficient response

by the therapist to their inquiry, declined to investigate the case without a broader authorization, which Roger did not accept. (We discuss suggestions for how to deal with licensing board and ethics committee complaints in greater detail in Chapters 13 and 18.)

ACCESSING INFORMATION ABOUT CLIENTS ON THE INTERNET

Googling the term *death of privacy* yielded nearly 300 million hits in March 2015. One respected commentator recently summed up the problem by noting: "The Facebook feed is a bit like a sausage. Everyone eats it, even though nobody knows how it is made" (Hidalgo, 2014). Although most people understand at some level of consciousness that nothing posted on the Internet is truly private, the actual depth of what is known or can be found is poorly understood by most users, even if they set "privacy" controls effectively on social media sites. For example, signing up for a G-mail account or searching with Google allows the automated review of e-mail and search contents that will ultimately influence advertising displayed on subsequent searches. One can readily find massive amounts of information on anyone using free or fee-based search utilities, including past and present addresses, telephone numbers, names of relatives, home property values, court records, NPI (National Provider Identifier; numbers of health and mental health care professionals), and Social Security numbers.

In its most malevolent form, some people and organizations practice *doxing*, a term derived from documents or "docs," sometimes spelled as "doxxing." This refers to the practice of investigating and revealing a target individual's personally identifiable information, such as home address, workplace information, and credit card numbers, without their consent. Searches of platforms such Facebook, Twitter, Tumblr, and LinkedIn provide a wealth of private information because many users indiscriminately self-disclose (i.e., share their photos, place of employment, phone number, e-mail

address) with low levels of security. One can also extrapolate a person's name and home address from a cell-phone number through such services as reverse phone lookup. Readily available software products enable the capture of IP (Internet Protocol) addresses that can be used to track location, identify a particular computer, and allow malevolent users to masquerade as another user. Most mental health professionals will not find themselves malevolently targeted; however, we should assume that our clients will look for information about us and stay mindful of issues such as how we present ourselves and what we disclose, as described more fully in Chapters 8 and 11.

None of the ethics codes for health or mental health professions specifically addresses the behavior of mental health practitioners as clinicians, trainers, teachers, or employers when they wish to obtain information via the Internet. Searches using public records are lawful and not ethically proscribed. However, we must be prepared to deal with the consequences of information we discover when not provided to us by our clients. We routinely gather information on clients as part of assessment or intake procedures and over the course of our work with them. Traditionally, clients have controlled disclosure of such information except for stories that might attract attention through mainstream media, but times are changing.

One physician has argued that googling has taught him valuable things about patients that do not come up during the routine history taking and the usual physician–patient interactions. He described learning that one of his patients had been an Olympic gold medalist and world-record holder in the 1960s and expressed the belief that knowing more about his patients as people helps him to build empathy (Warraich, 2014). The article describes the case of a 26-year-old woman seeking a prophylactic double mastectomy, citing an extensive history of cancer in her family, but unwilling to undergo any workup. When her medical team noted inconsistencies in her story, they searched online and discovered multiple Facebook accounts fraudulently soliciting donations for

malignancies she never had. One Facebook page showed her with her head shaved, as if she had already undergone chemotherapy.

A recent study of psychology graduate students found that 33% had used the Internet to find out information about a client, 19.5% using social networking websites to obtain information and 29% using a search. Of those who conducted an online search, 21% did so occasionally to very frequently. Of those who conducted a social network search, 25% did so occasionally to very frequently (S. E. Harris & Robinson-Kurpius, 2014).

Another study found that most trainees have changed and monitored their online presence since beginning graduate school. A quarter of respondents had googled clients, and almost half had googled supervisors. A small number indicated that both clients and supervisors had reported googling the trainee (Asay & Lal, 2014).

Kaslow, Patterson, and Gottlieb (2011) described three major categories of information available on the Internet. Their first category includes professional websites, blogs, business networking sites such as LinkedIn, newspapers, and other publicly accessible or sponsored sites containing information that individuals intentionally post for others to see. Their second category involves information retrievable through search engines such as Bing, Google, and Yahoo. Finally, they cited a third category that includes search engines with the *option* of paying for more detailed public record or other specially compiled data. They did not address the nuances of using such sites but made several recommendations that flow generally from the notion that although Internet searches may be legal, one should treat others as they wish to be treated. They also suggested that explicit policies regarding Internet searches of clients, trainees, students, and employees should be made clear at the outset of the relationship through written contracts, informed consent forms, agency policies, and verbal statements or documents. We admire the principle-laden views they espoused, but also note that no existing codes specifically address these issues.

Others will certainly disagree with the concept of advance disclosure that one intends to search for information on someone in the context of providing mental health services. For example, Chapter 13 describes the role of invisible forensic experts who consult to attorneys. When conducting such analyses as an undisclosed expert, one would never provide advance notice of the investigative techniques employed. Similarly, when investigating a licensing board complaint, checking for suspected fraudulent representations, or in a law enforcement context, the investigating individual would not routinely disclose the databases to be searched, or even the initial phase of the investigation. Of course, as with any data source, one must also recognize that not everything one finds through Internet searches is correct or fully accurate.

The key ethical challenge involves how we handle the data that we may discover if we search for information on current clients. Some examples appear in Chapter 11 (Cases 11–41 to 11–43); however, the following cases are drawn from examples provided by Zur (2010):

Case 6–38: Helen Hunter, M.S.W., treats clients in a home office and thinks it wise to conduct searches on new clients who call for appointments to reassure herself about their identities and any potential threats to her safety.

Case 6–39: After a few months of treating a self-described “web entrepreneur,” Carla Quest, L.M.H.C., googles him and discovers that he has an active and violent porn website, which he has not mentioned during psychotherapy even though treatment has focused on issues of intimacy and sexuality.

Case 6–40: Dan Delver, M.D., an openly gay psychiatrist, performs a web search on a new client and discovers he is a member of Eastboro Bible Church, an organization well known for promoting outrageous public protests against members of the LGBT (lesbian, gay, bisexual, transgender) community.

We do not know why Ms. Hunter is worried about safety issues, but knowing referral sources and focusing on particular patient categories may reduce risk of harm from patients (normally a low-incidence hazard in a normal outpatient

population). Depending on the nature of the searches she conducts, Ms. Hunter may well be deluding herself. Her identity checks may not reveal information useful in assessing the relative safety or risk presented by potential clients.

Ms. Quest and Dr. Delver face very different issues. They now know something potentially relevant or problematic about their patients that the patient has not shared. How they use this information or disclose it to their patient becomes a clinical and ethical matter. The issue becomes clinical in the sense that they will want to take note of the information as part of a treatment plan or decision to transfer/terminate the case. The matter has ethical ramifications in the sense that they owe the patient all relevant clinical and professional duties inherent in their role as a psychotherapist.

TAKING ADVANTAGE OF CONFIDENTIAL INFORMATION

Occasionally, psychotherapists have an opportunity to gain personally as a result of information received in confidence. One such case involved Manhattan psychiatrist Robert Willis.

Case 6–41: Robert Willis, M.D., treated Mrs. Joan Weill, wife of the board chair of Primerica Corporation. In the course of treatment, Willis learned of business events in the life of his client and her spouse that seemed likely to affect the value of Primerica stock. The information Mrs. Weill communicated during treatment was not public knowledge. Dr. Willis made strategic investment decisions based on the information and earned more than \$27,000 as a result. In a widely reported turn of events, Dr. Willis was caught, prosecuted, and fined by the Securities and Exchange Commission for “insider trading” (Rosenbaum, 1994).

It is impossible to know how often psychotherapists may benefit in some way from information they receive in the course of work with clients. The use of such information does not intrinsically constitute ethical misconduct. For example, a client who reports distress about an

unreliable automobile mechanic may lead the therapist to avoid using that business. However, that same sort of information is generally available to many people by word of mouth and would not lead to personal gain at the expense of others, as in the case of Dr. Willis.

CONFIDENTIAL MATERIAL IN THE CLASSROOM AND LABORATORY

We address ethical issues related to the classroom and social/behavioral research laboratories in Chapters 14 and 16; however, some noteworthy special issues relate to the use of confidential material in such settings. The first point involves confidential materials adapted for teaching purposes, and the second focuses on confidentiality problems involving research data.

Classroom Materials and Public Lectures or Writing

Ideally, any materials prepared for teaching that make use of sensitive or confidential material involve the full informed consent of the client. When adapting videotapes or audiotapes, detailed summaries of case material, or other

accounts of psychological material not otherwise in the public domain, the client or client's legal guardian should have consented to the use of the material for teaching purposes (Landrum & McCarthy, 2012). This becomes especially important when the nature of the material (e.g., visual reproductions or recognizable facts) might make it possible to identify the client. Formal consent may not be necessary if disguising the material makes identification of the client impossible. Box 6–2 contains a guide for anonymizing data consistent with HIPAA regulations.

A series of articles in a special issue of *Psychotherapy* provided an excellent discussion of ethical issues involved in clinical writing (Barnett, 2012; Blechner, 2012; Fischer, 2012; Samstag, 2012; Sieck, 2012; Woodhouse, 2012). Included are situations in which there might be some clinical contraindications to seeking the client's consent (Sieck, 2012; Woodhouse, 2012) and making a decision not to write or lecture about clients where the potential hazards to the current or former client are too great (Fischer, 2012). Similarly, another set of manuscripts published as a cluster in the *Journal of Interpersonal Violence* traced the actual consequences confronted when a client's psychotherapy became a matter of public

Box 6–2 Deidentifying Health Care Information

Properly sanitized health care information is not protected under HIPAA regulations (45 C.F.R. §164.514; LexisNexis, 2014). The following identifiers should be removed or altered when preparing material for release or discussion in public statements, teaching, or research:

- Names
- Geographic subdivisions smaller than a state (although the initial three digits of a zip code may be used)
- Any dates (except years) directly related to an individual
- Telephone, fax, Social Security, medical record, health plan, account, or medical device identification, or license numbers
- E-mail addresses, web universal resource locators (URLs), IP addresses
- Biometric identifiers, including finger- and voice prints
- Full-face photographic or comparable images
- Any other unique identifying number, characteristic, or code

discussion following a confidential case report (Brown, 2014; Cheit, 2014; Dalenberg, 2014; Kluemper, 2014; Koocher, 2014; Olafson, 2014; Putnam, 2014).

Next, we present some examples from actual cases. Some of the cases cited in this book involve actual legal decisions in the public domain and are cited as such, but we have disguised others or synthesized versions of actual situations or case material, as in the cases that follow. Although the actual people involved might recognize themselves or think that they do, this breaches no one's confidentiality.

Case 6-42: Em Barrassed entered psychotherapy with Will U. Tell, Psy.D., and was seen several times per week for nearly 2 years. During the course of these sessions, Ms. Barrassed shared a number of intimate and sensitive fantasies and life events with Dr. Tell. At the end of their work together, both felt that she had made impressive progress. Dr. Tell asked whether Ms. Barrassed might permit him to mention some details of their work together in a book he planned to write, provided he disguised the material so that she could not be recognized. She agreed and signed a release form he had prepared. Several years later, Dr. Tell's book became a best seller, and Ms. Barrassed discovered, to her shock, that she was easily recognized in the book by those who knew her. Dr. Tell had changed some details, such as the name, city, and so on, but described her family, upbringing, occupation, and red-haired, one-eyed, amputee spouse without disguise.

We cannot be certain whether Dr. Tell's inadequate efforts to disguise the client's identity resulted from carelessness or naiveté, but he might have prevented the problem by inviting his former client to preview the text. The best-disguised cases retain only the essential attributes of the original case, while changing several other potentially identifying variables.

Case 6-43: Barbara Binjer, M.S.W., has written several books on the treatment of eating disorders and often gives public talks on the topic to community groups. At one such presentation, she described a client as having been on a "see food

diet," commenting that, "Whenever she sees food, she eats it." The line got a laugh from the audience, and Ms. Binjer then described how just 2 weeks earlier one of her clients ate a whole plate of pastries while setting up for a church picnic, explaining how unhappy family relationships contributed to that behavior. Several people in the audience attended the same church event and recognized the identity of the client. One of them also attended a Calorie Counters group with the client and told her of the "funny story."

Ms. Binjer should have considered the possibility that people in the audience might know her local client or might even be her clients. She may have complicated her professional life significantly, both by hurting her client and by conveying a message to other potential clients that she cannot be trusted to keep a confidence.

Case 6-44: Irwin Klunk, Ph.D., shared the test data obtained in an evaluation of a disturbed child with his graduate psychology class. He passed around copies of drawings, test protocols, and interpretations. All of the sheets bore the child's full name and other identifying information. One of the students in the class, a friend of the boy's mother, told her about the incident. The mother filed an ethics complaint against the professor for violating her son's confidentiality. The professor responded that, because of the child's age and because the students studied at a graduate level, he had not believed it necessary to remove identifying data.

Professor Klunk may rely on the supposed professionalism of his graduate students and hold them accountable to treat the material appropriately; however, that does not excuse him from failing to remove unnecessary identifying data. As he sadly discovered, we live in a small world, and his lack of consideration caused a loss of privacy and emotional distress to a client.

The chances of having a relative, friend, acquaintance, or colleague of a client in the audience is not as small as one might imagine, and the consequences of revealing a confidence or sharing intimate details of a client's

personal life in recognizable fashion may have devastating effects. There are times when this becomes unlikely, such as a classroom discussion of a response to the Rorschach inkblots in which the identifying data include only the client's age and sex or the use of a thoroughly blinded case history. Actual individual consent may prove unnecessary for such material. When in doubt, however, we suggest reviewing the material with a colleague to ensure that some identifying facts have not inadvertently escaped attention. Likewise, one should delete any superfluous facts that might help to identify the client while not adding meaningful detail to the example.

Research Data

We address the confidentiality of research data in Chapters 14 and 16, but sometimes research in particularly sensitive topic areas creates special problems. Perhaps the best example of the difficulties resulting with respect to confidential research data involves the case of Samuel Popkin.

Case 6–45: On November 21, 1972, Samuel L. Popkin, an assistant professor of government at Harvard University, found himself imprisoned under a U.S. district court order for refusing to answer several questions before a federal grand jury investigating the publication of the "Pentagon Papers." Popkin asserted a First Amendment right to refuse to provide the information collected as part of his scholarly research on Vietnam and the U.S. involvement in that country. For failing to testify, the court ordered him confined for the duration of the grand jury's service. He won release from jail after 7 days when the grand jury's term ended. The U.S. Supreme Court later refused to review the order that led to his confinement (Carroll, 1973).

Popkin taught as a political scientist, but he might just as easily have had a background in another social/behavioral science, researching the personality structure of paramilitary groups or urban street gangs. Despite the fact that such research cannot usually take place without

some pledge of confidentiality to respondents, "national security interests" led the courts to overrule any claim of privilege or assertion of confidentiality. Sometimes pledges of confidentiality prove impossible to uphold.

Case 6–46: Between 2001 and 2006, researchers at Boston College recorded interviews with militia groups that had clashed during "The Troubles" of Northern Ireland. The 46 interviewees included 26 former IRA (Irish Republican Army) members and 20 former members of the Ulster Volunteer Force, a British loyalist paramilitary group. An extended skirmish amid claims of confidentiality and academic freedom began after British authorities approached the U. S. Justice Department when it became clear that the interviews contained information about at least one murder case that might lead to prosecution of living persons. Boston College recently announced that it will release the original recordings to participants who request them, an action that could protect the interviewees from the authorities currently investigating open cases or past crimes (Schwartz, 2014).

On some occasions, even naturalistic study data can put people at risk. Consider the case that follows:

Case 6–47: Seb Terfuge, Ph.D., conducted a field study of homosexual encounters in a public men's lavatory. Using a set of unobtrusive timing devices and a perisopic videotape apparatus, Dr. Terfuge concealed himself in a toilet stall and recorded a variety of casual homosexual encounters over a period of several months. When he published an account of his findings in a professional journal, the local district attorney attempted, by using a state law against "child abuse," to subpoena his videotapes to prosecute any of the men who may have interacted with underage youth.

Dr. Terfuge should have anticipated such difficulties, given the sensitive nature of the matters he studied, and attempted to determine whether he might collect the data in any other fashion. Assuming that alternatives proved ineffective, and assuming that the potential hazards to the people under study did not

warrant cancellation of the project, he should have taken steps to protect their anonymity, including seeking a federal confidentiality certificate (Fisher, 2013; National Institutes of Health, 2014). Dr. Terfuge did not simply conduct a field study, but rather actually put his intended research participants at some risk to themselves without their knowledge or consent. One could argue that a police officer present on the scene where the behavior took place might have made arrests, but Terfuge was not a police officer and had an obligation to consider the welfare of those he studied in the course of his research. There are additional problems with such research, such as the dubious benefits and privacy invasion. (See Chapter 16 for additional discussion.)

Not all confidential data become so threatening, and in fact, at times the revelation of sensitive or confidential research data provides enormous social benefit (Gordis & Gold, 1980). Epidemiological research presents a good example. The studies of diethylstilbestrol (DES) and its association with vaginal cancers a generation later, studies of occupational cancers with long dormancy intervals, and late-effects studies of long-term use of contraceptive or arthritis medications are but three examples. In each type of study cited here, it would become necessary to locate and track an identifiable individual over time to establish data of meaningful long-term risk to clients as individuals and society as a whole (Gordis & Gold, 1980). Sometimes, unexpected findings hold legitimate interest to research participants but may not come to light until long after they had enrolled in a study with a promise of confidentiality. Safeguards are indeed needed, but one must remain prepared to seek advice and consultation from institutional review boards (IRBs) or other appropriate bodies when conducting such studies. Knerr (1982) and Boruch, Dennis, and Cecil (1996) offered considerable information and advice on what to do if one's data are ever subpoenaed. An attorney should also be consulted regarding the impact of laws such as the Freedom of Information Act. Above all, the rights of the individual participants in the research must be considered.

RECORD CONTENT RETENTION AND DISPOSITION

Content of Records

What should therapists include in clinical case records? The APA first adopted basic advisory guidelines for psychologists in 1993 and updated them in 2007 (APA, 1993, 2007). Other mental health professions also provide guidance on record contents (AAMFT: 3.5; ACA: A.1.b, B6; NASW: 3.04). They cover a wide range of topics related to keeping and managing records, but we believe that some detailed recommendations regarding the prototype mental health record content will prove useful to readers. A high-quality clinical record provides the best way to document rendering of appropriate care. A jury or ethics committee might regard poor-quality notes or inadequate history taking as sloppy practice in a malpractice suit or complaint hearing, respectively. In a legal sense, if it was not written down, it did not happen. A suggested model for a clinical case record appears in Box 6-3.

Electronic and Interoperable Medical Records

The Health Information Technology for Economic and Clinical Health (HITECH) Act and the Patient Protection and Accountable Care Act incentivize large medical practices and health care systems to develop and maintain electronic medical records (EMRs) and move toward interoperable EMRs. The term *EMR* refers to a system of accessing patient medical data electronically, while the concept of interoperability reaches across providers and systems. For example, the medical records of U.S. military personnel on active duty can follow the patient from base to base over a unified network. Medical care providers at some large hospital systems with satellite outpatient facilities often have the ability to access surgical logs, prescription records, lab test results, and office visit notes anywhere in the system. However, such systems do have many potential problems that can compromise quality and patient care.

Box 6–3 Suggested Contents of Mental Health Records**CONTENT ISSUES**

- Name, record or file number (if any), address, telephone number, sex, birth date, marital status, next of kin (or parent/guardian), school or employment status, billing and financial information.
- Date of initial client contact and referral source.
- Documentation that client has received notice related to privacy and other practice information (e.g., access to emergency coverage, fees, and limits of confidentiality) required under federal (i.e., HIPAA) and state laws.
- Relevant history and risk factors, including a detailed social, medical, educational, and vocational history. This need not necessarily be done in the very first session and need not be exhaustive. The more serious the problem, the more history you should take. Gather enough information to formulate a diagnosis and an initial treatment plan.
- Collect information on the client's medical status (i.e., When was his or her last physical exam? Does the client have a personal physician? Are there any pending medical problems or conditions?). This is especially important if the client has physical complaints or psychological problems that might be attributable to organic pathology.
- Collect information on all medications or drugs used, past and present, including licit (e.g., prescribed medications, alcohol, tobacco, and over-the-counter drugs) and illicit substances. Also note any consideration, recommendation, or referral for medication made by you or others over the course of your work with the client.
- Why is the client in your office? Include a full description of the nature of the client's condition, including the reason for referral and presenting symptoms or problem. Be sure to ask clients what brought them for help at this point in time and record the reasons.
- Include a current comprehensive functional assessment (including a mental status examination) and note any changes or alterations that occur over the course of treatment.
- Include a clinical impression and diagnostic formulation using the most current American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)* or the *International Classification of Diseases (ICD)* model. Do not underdiagnose to protect the patient. If you believe it is absolutely necessary to use a "nonstigmatizing" diagnosis as opposed to some other label, use the R/O (rule-out) model by listing diagnoses with the notation "R/O," indicating that you will rule each "in" or "out" based on data that emerge over the subsequent sessions. The diagnosis must also be consistent with the case history and facts (e.g., do not use "adjustment reaction" to describe a paranoid hallucinating client with a history of prior psychiatric hospital admissions).
- Develop a treatment plan with long- and short-term goals and a proposed schedule of therapeutic activities. This should be updated every 4 to 6 months and modified as needed.
- Note progress toward achievement of therapeutic goals. Use clear, precise, observable facts (e.g., "I observed patient ..." or "Patient agreed that ..."). Avoid theoretical speculation, reports of unconscious content, attempts at humor, or sarcasm. If you must keep theoretical or speculative notes, use a separate working notes format, but recognize that these records may be subject to subpoena in legal proceedings.
- Include documentation of each visit, noting the client's response to treatment. In hospitals or large agencies, each entry should be dated and signed or initialed by the therapist with the name printed or typed in legible form. It is not necessary to sign each entry in one's private (i.e., noninstitutional) case files.

Box 6–3 Continued

- Include documentation of follow-up for referrals or missed appointments, especially with clients who may be dangerous or seriously ill. Retain copies of all reminders, notices, or correspondence sent to clients and note substantive telephone conversations in the record.
- Include copies of consent forms for any information released to other parties.
- Include a discharge or termination summary note for all clients. In cases of planned termination, be certain that case notes prior to the end of care reflect planning and progress toward this end.

NONCONTENT ISSUES

- Mental health professionals should maintain (in their own practice) or support (in institutional practice) a system that protects the confidentiality of records. Clear procedures should be in place to preserve client confidentiality and to release records only with proper consent. The media used (e.g., paper, magnetic) is not especially important as long as utility, confidentiality, and durability are ensured.
- In multiple-client therapies (e.g., family or group treatment), records should be kept in a manner that allows for the preservation of each individual's confidentiality should the records of one party be released.
- Mental health professionals are responsible for construction and control of their records and those of people they supervise.
- Mental health professionals must be aware of and observe all federal and state laws that govern record retention. In the absence of clear regulatory guidance under law, the APA (1993, 2007) recommends maintaining complete records for 3 years after the last client contact and summaries for an additional 12 years.
- If the client is a child, some records should be maintained until at least 3 to 5 years beyond the date at which the child attains the age of majority.
- All records, active or inactive, should be stored in a safe manner, with limited access appropriate to the practice or institution.
- Outdated, obsolete, or invalid data should be managed in a way that ensures no adverse effects will result from its release. Records may be culled regularly as long as this is consistent with legal obligations. Records to be disposed should be handled in a confidential and appropriate manner.
- Mental health professionals need to make arrangements for proper management or disposal of clinical records in the event of their death or incapacity.

Some of the special cautions required when entering or converting to an EMR or interoperable EMR system are listed in Box 6–4.

For example, systems may not communicate well with each other. Notoriously, the EMR system in military hospitals is not compatible or interactive with those at the Department of Veterans Affairs. Other problems include prescribed formats that do not

apply well to mental health care, mangled data when creating or merging systems, frequent errors by clinicians using cut-and-paste reporting, and appropriate levels of access. Should a billing clerk have access to sensitive data? Should an internist have access to psychotherapy notes? All of these issues require the clinician to understand how such systems operate and ask the right questions when joining or

Box 6–4 Avoiding Errors in Institutional Electronic Records

- Take care to avoid entering or repeating incorrect information.
- When records are being converted, uploaded, or used in a hybrid record system, check your work for conversion problems.
- Guard against electronic routing failures.
- Consider how you will access data if the system becomes unusable for a period of time.
- Take great care when using prefilled forms or attempting to copy and paste text.
- When adopting or entering a new system, check to ensure that the design aligns with the clinical needs of your clients.
- Check appropriateness of access levels for the data you will enter.
- Make sure that your clients understand the nature and security of the record-keeping system, including which other practitioners will have access to their mental health records.

becoming a service provider for an entity using such EMRs.

Record Retention

How long should one keep records? The difficulty in answering this question arises because the number and type of records kept by mental health professionals, clinics, and other agencies vary widely in form, content, and purpose. The answer will vary as a function of the type of record, nature of the client's need for documentation of prior services, probability of need for future services, validity of the data in the records, and the applicable state or federal regulations. In any given legal jurisdiction, for example, the responsibilities of a mental health professional might vary widely, depending on whether the records in question qualify as business files, medical records, school records, or research data. The two key factors a therapist should consider in making a decision about retention or disposition of records are applicable legal obligations and client welfare.

Consulting with an attorney familiar with the statutes that apply to one's practice will usually provide the best guidance. Dramatic differences exist from location to location. Considering only hospital records, Massachusetts permits the destruction of records 30 years following the discharge or final

treatment of the patient. California requires retention of such hospital records for 7 years postdischarge or until the patient reaches age 21, but never less than 7 years. New York's statute is similar to the California requirement except that the time frame is 6 years. In Texas, the law specifies 10 years for general retention, whereas Pennsylvania specifies keeping the record itself for 15 years and keeping a permanent care file on each patient. Some states, such as South Dakota, specify keeping hospital records permanently.

Laws dealing with individual practitioners, as opposed to institutions or agencies, often give less-specific retention times or require shorter retention spans for client files. Many state laws do not specifically mention mental health professionals in laws governing case records, although licensing boards may have applicable regulations. In general, the best recommendation we can offer has two prongs. First, check your legal obligations based on state law with respect to any statute of limitations on business and medical records. Second, we note that the APA (2007) recommended a minimum of 7 years' retention for the full record and keeping some summary of the record much longer. The APA also recommended that when the client is a minor, the time frame should be extended until at least 3 years past the age of majority. We recommend the APA standard as a minimum, even if your state permits shorter periods. The

retention clock should start ticking at the end of the final professional service to the client.

The U.S. Internal Revenue Service (IRS) imposes yet another type of obligation on virtually all professionals with its 7-year record-keeping requirement. Although these obligations refer to business and financial records, one would obviously need some ability to access client names and payments made. A client facing an IRS audit might have to seek confirmation of payments made to the therapist, or the practitioner might have to document certain financial data regarding his or her practice to the IRS.

Client welfare concerns come up with respect to the matter of record retention in two ways. First, you must consider the client's need and the benefit to the client of such records. Second, you must consider the risks and hazards of such records to clients, especially when they contain obsolete or potentially harmful data and may pass beyond the originating mental health professional's control. Records benefit the client in a variety of ways, including their potential to assist in the continuity of care across providers and over time. Even long after a client has improved and left the therapist's care, a need might arise to document a period of treatment or that a disability had occurred. Records do, after all, have the potential to recall events better than, and even outlive, the provider who prepared them. This last fact contributes to a potential hazard with respect to disposition of records, discussed in a separate section.

Potential problems with records, aside from the access issues mentioned in this chapter, often arise as the result of invalid or obsolete information. Determining a definition of *obsolete* can pose a problem, however. Resist the temptation, inherent in research training, to save any potentially analyzable data indefinitely. Attempt to balance this urge with an understanding of the reliability and validity of old data.

Case 6–48: A state agency serving children maintained its clinical files, including psychological test data, indefinitely. A request for information, validly executed, was received from a government

agency, requesting copies of reports for purposes of security clearance on Warren Peace, a now 40-year-old job applicant, who had been seen at the agency 30 years earlier. The request raises the question of whether the IQ and other test or psychological information has current validity.

In the face of a valid waiver form, the agency must release the information on Mr. Peace requested under the circumstances cited because the files exist, and the former client has agreed. On the other hand, one should legitimately question the appropriateness of keeping full test data and detailed notes this long, thus rendering them available for such requests. The IQ data obtained at age 10 will have no bearing on Mr. Peace's current employability, and any treatment or personality test data from that era also retain questionable likely validity. If the agency had destroyed obsolete information or purged its files of data no longer of any clinical value, little danger would exist to the former client that such information could return from the past and prove embarrassing or harmful. Likewise, facts of interest to treatment team members may rate as mere gossip years later (e.g., "paternal aunt suffered from melancholia," "intense sibling rivalry is present," "parents have difficulty with sexual intimacy").

Disposition

The era of optical, magnetic, and cloud storage have pushed traditional file cabinets down the road toward obsolescence. Still, when disposing of records or obsolete contents culled from them, their confidential nature demands respect and precautions. With paper records, therapists can shred, incinerate, recycle, or take other destructive action themselves or contract for such services. Actual responsibility for the proper destruction rests with the practitioner or agency head in charge of the material.

Case 6–49: Eurippides Upp, the administrator of a mental health agency planned to dispose of many outdated clinical records. He ordered the files piled into plastic trash bags, tied up, and inserted in an outdoor dumpster to await trash pickup.

Neighborhood dogs, in quest of food scraps, tore several bags open, and the wind blew out many reports and notes bearing client names and other identifying material. Many of the clients whose records flew around in the streets still resided in the same community.

Case 6–50: Tara Byte purchased a dozen upgraded desktop computers for the clinic she managed and donated the older office computers to a local community center. She took care to delete all of the word-processing and billing files she could locate before handing over the old equipment.

Mr. Upp evidently took little care to see to the proper disposal of sensitive records. He should have had the material shredded or stored securely until pickup by a responsible disposal agent. Ms. Byte may or may not have done an adequate job of protecting records stored in the computer. Simply deleting files on a hard drive does not permanently remove the data. In some cases, even reformatting a drive may not prevent recovery of some data.

Under provisions of HIPAA and the HITECH Act, substantial penalties ranging from \$100 to \$50,000 per violation up to \$1.5 million per year can result. Using the U.S. Department of Health and Human Services weblink (<http://www.hhs.gov/ocr/privacy/hipaa/enforcement/examples>) will provide many examples, including a multimillion-dollar judgment against a corporation that failed to wipe hard drives of old copying machines when trading up. Yes, high-end photocopiers do have the capacity to store copied documents. We recommend obtaining consultation from experts before disposing of computer, copying, or other equipment used to scan or store client data.

The death of a mental health practitioner can also raise a complex set of problems with respect to individual client records. In some cases, a surviving spouse or executor has simply destroyed records. In other cases, they have retained records but made no arrangements for the orderly processing and screening of requests to access information from them. Although we know of no complaints or litigation against the

estates of dead mental health professionals for record-keeping infractions, failure to safeguard records following the death of a clinician could conceivably lead to filing suit against a therapist's estate. For this reason, as well as client welfare, we stress the importance of creating a will or other instructions addressing record disposition. One alternative could involve an arrangement with a professionally responsible colleague for the care and management of the records. Other alternatives would be to instruct one's spouse or executor on how to seek advice from others on record management or to ask a professional association to assist in managing the files for a period of time after the death.

WHAT TO DO

- Learn about the laws and regulations that govern confidentiality and privilege in the jurisdiction where you practice.
- Inform clients about the limits of confidentiality as early as possible in the professional relationship, document this notification in writing, and remind them as appropriate.
- When releasing records, require an appropriate form and keep a copy.
- Consider clients' best interests and foreseeable adverse events by taking the recipient's need to know and any vulnerabilities of the client into account when releasing information.
- Keep adequate clinical records and retain them in a manner that conforms to good practice and the law.
- Have a plan for records management if you become incapacitated.

WHAT TO WATCH FOR

- Learn about the laws and regulations that govern confidentiality and privilege in the jurisdiction where you practice.
- Understand the technology you use to manage sensitive data in your practice well enough to preserve confidentiality in storage, transportation, and transmission of records.

- When using case materials for teaching or public lecture purposes, take care to secure proper permission and to disguise material sufficiently to protect the client.
- If you decide to search for information about a client on the Internet, be prepared to deal with surprising information that you may need to address in the professional context.

WHAT NOT TO DO

- Do not release information about clients without an appropriate release or court order.
- Do not dispose of records or sensitive information casually. Ensure appropriate and complete destruction.

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7

Psychological Assessment *Testing Tribulations*

One gets the impression that the major purpose . . .
was not to beat a dead horse but to administer
massive doses of statistics in the effort to bring the
unfortunate animal back to life.

Ann Anastasi

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Imagine these headlines in your morning newspaper or podcast:

Psychologist Devises a “Toss and Catch the Child” Test for Use in Making Postdivorce Custody Decisions

Firefighter Applicant Challenges Use of Inkblot Test as a Measure of Fitness to Fight Fires

Confidential Psychological Tests Available for Sale to the Highest Bidder on eBay

High School Students Sue the Educational Testing Service for Failing to Correct Errors in Their Scholastic Aptitude Test Scores

Strange, but true: All of these headlines are accurate. Psychological tests and psychodiagnostic assessments can have powerful effects, both good and bad, on peoples' lives. Those who plan to use such instruments with ethical integrity will need a thorough background in psychometrics, along with training in test administration and interpretation. Those most likely to obtain such education and training include clinical, counseling, and school psychologists; however, even among those specialty groups, the depth and breadth of assessment skills will vary widely.

Many professions have studied human behavior and capabilities, but in the realm of psychodiagnostic assessment or testing, the contributions of psychology remain unique. The use of small samples of human behavior, collected in standardized fashion and scientifically evaluated to categorize, diagnose, evaluate, or predict behavior, certainly stands as one of the most noteworthy accomplishments of behavioral scientists. Such tests provide powerful tools for advancing human welfare. Occasionally, great concern about the real, imagined, or potential misuses of tests have become key public policy issues. At other times, misunderstanding of technical subtleties, such as those critiqued by Anastasi (1975, p. 356) in the opening quotation for this chapter, give the false impression that the ability to quantify human behavior imparts some sort of intrinsic truth or merit.

One of the earliest and most striking public commentaries reflective of such misconceptions

came from a then 24-year-old journalist named Walter Lippman in a series of six articles on “The Mental Age of Americans” and “Mr. Binet’s Test,” published between October 25 and November 29, 1922, in *The New Republic*. Lippman stressed the potential misunderstanding and “great mischief” that might follow if parents and school authorities became confused about the nature and validity of the assessment techniques devised by Binet in France and later revised by Terman in the United States. He noted:

If, for example, the impression takes root that these tests really measure intelligence, that they constitute a sort of last judgment on the child's capacity, that they reveal “scientifically” his pre-destined ability, then it would be a thousand times better if all the intelligence testers and all their questionnaires were sunk without warning in the Sargasso Sea. (Lippman, 1922, p. 297)

One cannot underestimate the political and social significance psychological testing has come to have in America and around the world and the converse impact of public attitudes on the field of psychometrics. W. Haney (1981) traced debates over the meaning of IQ, the social functions that tests serve, and the appropriate use of personality tests, beginning with Terman’s development of the Stanford-Binet scales in 1916 and the Army Alpha test during World War I. He provided a strong illustrative case demonstrating how social attitudes and values affect even professional writings on testing and affect issues that appear to be strictly technical on the surface. In the same vein, many scholarly authors (Laosa, 1984; Kaplan & Saccuzzo, 2014; Ridley, Hill, & Wiese, 2001; Zapf & Grisso, 2012) have documented the historic misuse of psychological assessment in forging social policies against immigrants and people of color.

The ethical problems growing out of the use and potential misuse of psychological tests and assessment techniques remain as varied as the many different types of instruments, users of them, purposes for which people use them, and consequences to those tested. For purposes of general definition, we consider as a psychological test

any questionnaire, examination, or similar sample of behavior collected in a prescribed or standardized fashion for the purposes of describing, classifying, diagnosing, evaluating, or predicting behavior. We must add the additional caveat that we refer only to those techniques devised and routinely employed by psychologists and other qualified mental health professionals in the course of their professional work. We intend to exclude, for example, scientific anthropological or sociological survey and measurement techniques, as well as astral charts, tea leaf readings, biorhythms, or fondling the viscera of certain animals as a means to predict future events.

JOINT TECHNICAL STANDARDS

Good psychological assessment involves both art and science. The empirical foundations of testing remain critical for producing reliable and valid data. The ability to integrate these data with individual case factors to yield competent assessment, however, involves the art of clinical interpretation in addition to psychometric science (Cates, 1999). In an effort to clearly articulate the fundamentals of the assessment science, the three major professional organizations involved developed the *Standards for Educational and Psychological Testing*, sometimes referred to as the Joint Technical Standards in earlier iterations (American Educational Research Association, American Psychological Association [APA], & National Council on Measurement in Education, 2014). This key reference document addresses expectations regarding validity, reliability, errors of measurement, scales, norms, development and revision criteria, and required supporting documents. It also explains fundamentals of fair testing, the rights and responsibilities of both users and takers of tests, and assessing individuals with disabilities and diverse language backgrounds. The standards also address assessment for employment and credentialing, as well as legal, public policy, and evolving technology issues. In so doing, the document provides the consensual foundation of ethical psychological and educational assessment.

VARIETIES OF TESTS

One can classify test instruments across a number of dimensions, including the purpose for designing them, the population used to standardize them, the nature of their administration, the mode of interpretation, and their psychometric properties. Types of tests, listed according to intended use, are listed next. Within each of the following general categories, one can specify still types of tests that are more specific based on intended function:

- personnel selection, promotion, or classification;
- professional licensure or certification;
- educational admission and placement;
- certification testing in elementary and secondary schools;
- ability and achievement testing in schools;
- special education testing (including instruments designed for use with the blind, hearing impaired, and other people with disabilities);
- clinical assessment (including cognitive, neuropsychological, and personality testing);
- counseling and guidance (including vocational interest inventories);
- specialized instruments designed for program evaluation and programmatic decision making; and
- research instruments intended to draw inferences about the true or absolute standing of a group or individual on some hypothetical or investigative psychological dimension.

In terms of standardization samples, some tests are designed only for use with literate, English-speaking adults. Others may focus on children under the age of 7 or individuals with advanced typing skills. Without specific knowledge of the intended subject population or group used to establish norms, test scores become meaningless. This assumes, of course, that the test has norms available and that it has undergone proper validation, as discussed in the following material.

Test administration may occur in large groups of test takers or individually, with one examiner

assessing one client. The format may employ timed or untimed items; involve paper-and-pencil, oral, or computer-based administration using a range of desktop and handheld platforms; and require forced-choice or open-ended responses. Some tests require a skilled administrator, whereas others use self-administration methods using an electronic device or monitored by a person without psychological training. Many tests are administered, scored, and partially interpreted solely based on the client's interaction with an electronic interface.

Similarly, test interpretation or data use may also vary widely. Some tests may be administered, scored, and interpreted quite simply by mechanical means or a person with little or no formal training (e.g., tests of typing speed and accuracy). Other tests may not require skilled administrators but demand sophisticated clinical training for proper interpretation (e.g., personality inventories or achievement tests). Still other tests may require high levels of skill, scientific knowledge, and detailed understanding of complex scoring systems for proper administration and interpretation (e.g., neuropsychological assessment instruments or projective personality assessment techniques such as the Rorschach inkblots).

KEY CONCEPTS IN TESTS AND MEASUREMENTS

Many important technical concepts necessarily come into play when attempting to understand the proper use of psychological tests for the purpose of psychological assessment (Gregory, 2010; Hersen, 2004; Meyer et al., 2001; Rey-Casserly & Koocher, 2012). While we do not intend this chapter as a substitute for formal course work in test construction and measurement statistics, we summarize here the key terms important to understanding ethical test use. Portions of this chapter may seem rather basic to some readers, especially those who have a thorough familiarity with concepts related to tests and measurements. Unfortunately, however, such basics too often lie at the heart of ethical complaints related to testing or assessment. These include the concepts

of reliability, validity, sources of error, and standard error of measurement.

Reliability

Reliability refers to the property of repeatable results. Will the test dependably measure whatever it measures over time and across populations? Tests of relatively stable phenomena, for example, should have high test-retest reliability. If a person earns a certain score on a mathematics achievement test on Monday, that same person should earn a similar score on readministration of the same test several days later, assuming no special studying or additional teaching occurred during the interval. Likewise, the test should yield similar scores for people of relatively equal ability when these people take the test under similar conditions, whether or not they differ on the basis of other extraneous characteristics (e.g., age, sex, race, etc.). If the test does not measure something reliably, it becomes useless because we would never know whether differences in scores resulted from changes in the skill or trait being measured or from the unreliability of the instrument.

Validity

Validity refers to the concept of whether a reliable test actually measures what its proponents claim. Such claims may represent different types of validity as described in the following paragraphs. A test cannot possibly constitute a valid measure of anything unless it has good reliability. At the same time, a test may yield reliable scores yet not be a valid indicator of what it purports to measure. Test developers have an ethical responsibility to demonstrate that their tests have appropriate validity for any recommended applications.

Content and *construct validity* refer to whether the test samples behavior representative of the skill, trait, or other characteristic we want to measure. Content validity indicates the degree to which the items in the test come from the domain of behavior of interest. This addresses the question: Do the test questions or tasks relate to the performance ability

we wish to gauge? The degree to which test scores may help us to infer how well any given construct describes individual differences is the key factor in construct validity (Cureton, Cronbach, Meehl, Ebel, & Ward, 1996; Maher & Gottesman, 2005; McKelvie, 2005; Strauss & Smith, 2009; Waller & Meehl, 2002).

Cronbach (1980) claimed, "All validation is one, and in a sense all is construct validation" (p. 99), and the joint technical standards (American Educational Research Association et al., 2014) stress the centrality of construct validation. The existence or operational definitions of many hypothetical constructs (e.g., ego-strength, happiness, or even intelligence) may prove controversial, with the result that tests predicated on these constructs become open to question. For example, a test predicated on psychoanalytic concepts (e.g., the *Blacky Test*, in which illustrations depicting a dog named Blacky acting out or witnessing scenes depicting various Freudian concepts such as oral gratification, anal rage, or castration anxiety) would doubtless lead to ridicule from a behaviorally inclined clinician whose theoretical perspective focuses on directly

observable behaviors rather than constructs familiar to the psychoanalytic community. Similarly, an operant behaviorist who argues that nonobservable intrapsychic events do not exist or lack clinical significance would likely seem naive to most experienced clinicians. The responsibility for establishing whether the test measures the construct or reflects the content of interest becomes the ethical burden of both the test developers and the test publishers.

Another interesting twist on content validity was illustrated by Bertram Forer (1949). He crafted a bogus personality test, administered it to a group of students, and produced an analysis drawn from the astrology column of Los Angeles newspapers. The students thought they were getting individualized reports; in reality, each received exactly the same "personality analysis." Asked to rate the accuracy of the document on a 1-to-5 scale (5 being the most accurate), they rated the accuracy as 4.26. Paul Meehl later referred to this apparent validity as the "Barnum effect" in recognition of showman P. T. Barnum's claim that he offered "something for everyone." Box 7-1 contains Forer's items.

Box 7-1 The Forer Effect

- You have a great need for other people to like and admire you.
- You have a tendency to be critical of yourself.
- You have a great deal of unused capacity that you have not turned to your advantage.
- While you have some personality weaknesses, you are generally able to compensate for them.
- Your sexual adjustment has presented problems for you.
- Disciplined and self-controlled outside, you tend to be worrisome and insecure inside.
- At times you have serious doubts regarding whether you have made the right decision or done the right thing.
- You prefer a certain amount of change and variety and become dissatisfied when hemmed in by restrictions and limitations.
- You pride yourself as an independent thinker and do not accept others' statements without satisfactory proof.
- You have found it unwise to be too frank in revealing yourself to others.
- At times you are extroverted, affable, and sociable, while at other times you are introverted, wary, reserved.
- Some of your aspirations tend to be pretty unrealistic.
- Security is one of your major goals in life.

Criterion-related validity (sometimes referred to as *predictive validity*) addresses whether a given test's outcome relates to other criteria in predictive or concurrent fashion. For example, the admissions committees of graduate programs have a clear interest in which data will best predict success in graduate school. The admissions offices collect test scores, undergraduate grades, reference letters, and other data thought to predict (and thereby better select) those applicants who have the highest likelihood to do well in, and successfully complete, the degree program. Adequate demonstration of this type of relationship also becomes the responsibility of the test developers and publishers. Individual test users also have a responsibility to use test data in ways that reflect well-established predictive or criterion-related relationships or to sample a particular content domain.

Interestingly, even supposedly sophisticated users sometimes use techniques of questionable predictive value because of face value or even laziness. Consider the use of the Graduate Record Examination as a factor in admitting students to doctoral programs in psychology. The profession has long known that, while the scores do reflect the ability of some students to demonstrate some level of ability and content mastery in standardized fashion, the scores have much less predictive validity when it comes to presaging successful degree completion or a successful career in psychology. The scores tell us little about motivation, persistence, interpersonal skills, or other factors beyond test performance that are critical to completion of a doctoral program or successful career (<http://news.vanderbilt.edu/2014/06/grit-better-than-gre/>). Nonetheless, many graduate schools require the scores as part of the admission process without stating any cogent rationale. We suspect that one reason may be lethargy or a quest for a simpler applicant screening system. For admissions committees faced with selecting a small number of finalists from a large applicant pool, using such scores as a sieve to identify a subset for final scrutiny or elimination seems a no-brainer. Such strategies will eliminate many people with the ability to succeed, but it will also take less time and

some would argue lower the risk of accepting riskier students.

A similar situation comes up frequently in human resources or consulting situations, when someone (seldom a well-trained psychologist) pulls out the Myers-Briggs Type Indicator (MBTI) personality inventory (Briggs & Myers, 1998; <http://www.myersbriggs.org/my-mbti-personality-type/mbti-basics/>). A recent *New York Times* article captured the essence of this test, designed by a mother and daughter with no particular psychometric expertise, with the headline, "Why Myers-Briggs Is Totally Useless—But Wildly Popular" (North, 2014). The instrument relies on the theories of C. G. Jung (1921/1971) with no attempts at construct validation. In fact, the data at times contradict the supposed underlying theory. For example, the test-retest reliability of the instrument is lower than one would expect, given the theory that the trait types assessed are stable and enduring (Pittenger, 2005). Similarly, the basic psychometrics of the tool raise a plethora of questions, and the predictive validity of the tool is nonexistent (Pittenger, 2005). The tool does have intuitive face validity appeal and great marketing, and training is sold as a means of certifying examiners (no professional degree required), who can then readily market themselves as career coaches or consultants without a license. The tool has been estimated as generating \$20 million dollars in revenues annually (North, 2014).

Sources of error constitute a critical consideration when evaluating test scores. A person may feel more motivated to perform on one occasion than another. Another person may have a better ability to make educated guesses relative to peers. Still a third might feel ill, hungry, or anxious or have greater familiarity with specific test items on one particular form of a test instrument. The importance of any particular source of error depends on the specific use of the test in the context of the specific individual who took it. The goal of reliability studies focuses on establishing estimates of the magnitude of the errors of measurement from assorted sources. Any given test has many types of standard errors. The test user has responsibility for becoming familiar with these and for making

appropriate selections depending on the comparisons they wish to make. A standard error of measurement is a score interval that, given certain assumptions, has a given probability of including any individual's true score.

Consider some cases related to these concepts as ethical issues (APA: 9.01, 9.05, 9.08; ACA [American Counseling Association]: E.2, E.6, and E.9):

Case 7-1: Norma Skew, Ph.D., developed a detailed interview schedule that one can score in objective fashion, yielding a set of numbers she describes as a "leadership quotient," a "motivation index," and a "likelihood-of-success rating." She selected the items from a variety of existing personality assessment tools and questionnaires. Dr. Skew proceeded to advertise this instrument for use in "selecting executive talent," although as yet she has collected no validity data and simply presumes reliability "because the items are all based on questions asked in other reliable instruments."

Psychologists sophisticated in testing standards or who have familiarity with assessment and measurement theory will no doubt wince at the prospect that any practitioner could behave in this manner, but these types of problems prove all too common. Dr. Skew may have demonstrated "creative innovation" in designing her assessment instrument, but she has not bothered to validate it. We give her the benefit of one doubt and assume that she has secured permission to use any copyrighted material. The fact that she has used items of known validity related to other instruments, however, does not mean that these items will prove valid for the uses she ascribes to them in this new context. On the other hand, unless she has specific validity data to show that her items measure the constructs of leadership, motivation, and likelihood of success and that the scores her instruments yield predict some meaningful criterion of success in selecting talented executives, she has misused psychological tests.

Case 7-2: Marge N. O'Vera, Psy.D., retested a child who had taken the Wechsler Intelligence

Scale for Children—Fifth Edition (WISC-V) by another examiner a few months earlier. The youngster, described as mildly mentally retarded, earned IQ scores 3 to 5 points higher when O'Vera tested him, O'Vera then told the child's parents, "This shows that he could have intellectual progress potential."

Dr. O'Vera represents one of the most frightening kinds of practitioners because she has offered illusory grains of hope to the family of a child with a significant disability, perhaps with the result of promoting unfortunate expectations. The "new scores" fall within the standard error of the differences for each, as described in detail in the test manual. This means that the upward shift most likely relates to practice, some chance variable, or other trivial factor rather than a sign of intellectual gain. O'Vera's naiveté about developmental disabilities and the proper use of the test manual data also hints strongly at incompetence.

Case 7-3: Lois Tess Core, Ed.D., worked as a school psychologist charged with selecting a few dozen intellectually talented youngsters from the Plainville Regional School District to receive access to a special summer enrichment program. She decided that the simplest way to select candidates would be to group administer a standardized paper-and-pencil IQ test and select students from among the high scorers.

Dr. Core's choice of a group-administered paper-and-pencil measure of intelligence as the sole selection criterion constitutes a significant error in fairness. To begin, many intellectually talented youngsters may not score well on such tests. One child, for example, may have become distracted by spitballs dispatched by a classmate, another might feel preoccupied by family stresses, and still another might have an insufficient grasp of written English to do well on the test. Still others may have impressive abilities that are not reflected in the test items. Instead of using multiple criteria suited to the nature of the program and the type of students sought (Sternberg & Renzulli, 2004), Dr. Core appears to have sought a solution requiring the

least effort on her part. She has used an instrument designed chiefly for another purpose and ignored potential drawbacks of the instrument as a valid indicator of the one variable she is actually measuring (i.e., the ability to do well on a group-administered paper-and-pencil task according to norms based on a sample that may not adequately represent some student populations). At the very least, she should not rely on a single data source.

PRIMARY REFERENCE SOURCES

The definitive reference sources for anyone with a substantial interest in the proper use of psychological tests include the *Mental Measurements Yearbook* (Carlson, Geisinger, & Jonson, 2014) and *Tests in Print* (Murphy, Geisinger, Carlson, & Spies, 2011). The Buros Center for Testing at the University of Nebraska provides online search capabilities (<http://buros.org/>). The Buros databases contain information on more than 3,500 commercially available tests, along with reviews of more than 2,800.

The APA also offers a plethora of useful information on testing for both practitioners and the public (<http://www.apa.org/science/programs/testing/index.aspx>) and Science Directorate websites. We particularly recommend the *Rights and Responsibilities of Test Takers: Guidelines and Expectations* (<http://www.apa.org/science/ttrr.html>), the Testing Information Clearinghouse (<http://www.apa.org/science/programs/testing/>), and the section on how to locate detailed information on psychological tests (<http://www.apa.org/science/programs/testing/>). We also recommend the APA's casebook, *Responsible Test Use* (Eyde, Robertson, & Krug, 2010) as an excellent supplement, including 85 training cases that are fully indexed by topics and fully cross-referenced.

The October 1981 issue of the *American Psychologist* is an additional historical reference work that will interest many readers. It addresses "Testing: Concepts, Policy, Practice, and Research" and contains 20 invited articles, including overviews and discussion of then-current controversies, and represents an

excellent collection of basic concepts, historical information, and opinions from psychologists with expertise in assessment. Although somewhat dated, most of the papers have significant conceptual and historic value.

TEST ADEQUACY

Most readers will recognize by now that the question of whether any given psychological assessment instrument constitutes a "good test" or a "bad test" is complex. A test characterized as reliable, valid, and useful for one purpose may prove useless or inappropriate for another. An instrument adequate for its intended use in the hands of a trained examiner could be subject to substantial misuse in the hands of less qualified users. The next section of this chapter focuses solely on the adequacy of particular instruments themselves and the factors that contribute to, or detract from, the appropriateness of the test.

Before moving ahead, however, it is important to note that techniques used in some forms of clinical assessment at times come to masquerade as psychological tests. The best example of this phenomenon involves the use of anatomically detailed dolls (occasionally referred to inaccurately as "anatomically correct dolls") in the assessment of children thought to be victims of sexual abuse. In a comprehensive overview of the scientific basis for using such dolls, Koocher and his colleagues (Koocher et al., 1995) noted that assuming such dolls constitute some form of psychological test (i.e., a formal instrument with demonstrated potential for detecting child sexual abuse or for stating with a degree of certainty that sexual abuse occurred) is unfounded and dangerous.

As noted, psychological tests provide standardized procedures for the presentation of common stimuli, rules for recording responses, and rules for then assigning quantitative features (i.e., a score) to the elicited responses. The range of anatomically detailed dolls offered in the marketplace does not meet any of these requirements. Such dolls appear in many shapes, sizes, and colors, even with varying

genital and related characteristics that may affect a child's precepts and responses. No uniform set of questions to elicit responses, method of presentation, or quantifiable means of evaluating responses exist. Although a number of suggested protocols for use of anatomically detailed dolls have appeared in print, many have not undergone validation studies or rigorous peer review (see, e.g., Boat & Everson, 1986; Friedemann & Morgan, 1985; Levy, Kalinowski, Markovic, Pittman, & Ahart, 1991). Sadly, some may assume that such dolls are appropriately labeled if called a "projective test" or "projective instrument." However, even projective techniques have a standard set of stimulus materials and specific rules of inquiry, and most have a set of scoring criteria. Anatomically detailed dolls have none of these attributes and do not properly fit any validated projective hypotheses.

If not a test, what should we call anatomically detailed dolls? Koocher and his colleagues (1995) noted that such dolls are best considered a diverse set of stimuli that can function as communication and memory aids to children and other individuals who have immature language, cognitive, or emotional development or who have impaired communication skills. They are simply intended to assist in the communication process, allowing children and others to demonstrate acts for which they have limited verbal descriptions, with which they have limited familiarity in life, or about which they are too embarrassed to speak. Other commentators have supported selective use of such dolls as communication aids (Faller, 2005), with caveats that individuals who use them bear the burden of proving that dolls constitute the best alternative for eliciting information about personally experienced events from children (Dickinson, Poole, & Bruck, 2005).

Unfortunately, police, child protective service workers, and even some therapists who do not understand the appropriate use or limitations can readily purchase such dolls. In fact, significant ethical complaints have grown from evaluations conducted with these dolls. In some cases, for example, clinicians have too quickly assigned diagnoses of PTSD (post-traumatic

stress disorder), "validating" child sexual abuse on the basis of observing repetitive anatomical doll play. Such presumed indications of PTSD may actually result from repeated investigatory interviews by law enforcement or child protection investigators (Fisher, 1996). Others have criticized the minimal generalizability of existing research to actual forensic practice (Dickinson et al., 2005; Everson & Boat, 1997). The problems described here illustrate how an evaluative approach with apparent content or face validity, but no reliable measurement system and no predictive validity, can take on the aura of a psychological test. More dangerous still, some tools of this sort often become readily available for misuse by individuals with no sophistication in psychometrics.

The Test Manual

Each psychological assessment instrument should have a test manual that contains detailed information for potential users, including the following:

- the development and purpose of the test,
- information on the standard administration conditions and scoring,
- data on the sample population used to standardize the test,
- information on its reliability and measurement error,
- documentation of its validation, and
- any other information needed to enable a qualified user or reviewer to evaluate its appropriateness and adequacy for its intended use.

The manual may have supplemental sections addressing particular issues or audiences (e.g., a technical measurement section or a section written in lay terms to help test takers understand the meaning of their scores). Optional versus mandatory components of a test manual will vary as a function of the intended applications of the tool. The manual must include sufficient detail to permit the user to determine the test's appropriateness for a specific population and assessment goal. The

manual should also include references for all relevant published research on the instrument. Publication or distribution of a test without making such documentation available would constitute an ethical breach, as doing so omits critical information, violates accepted professional standards, and invites misuse.

Test manuals should also include data on potential biases, along with cautions to users regarding improper or unvalidated test applications. In advertising the test to professional or public audiences, the publisher must take care to avoid any suggestion that the instrument has greater utility or validity than the existing research base warrants. Implying that any given test satisfies federal guidelines or requirements without qualification, for example, would raise ethical concerns because even tests that have earned some type of official recognition or approval are limited to certain specific contexts (Bersoff, 1981; Novick, 1981). The following three cases involve tests that may have utility or validity, although presented or dealt with in a potentially unethical fashion.

Case 7–4: Guy Grand, Ph.D., developed a personnel selection instrument that proved to have some validity for selecting middle-level managers of a large consumer goods manufacturing company. In that context, the use of the test later won recognition as appropriate by the Equal Employment Opportunity Commission and the U.S. Department of Labor. Dr. Grand subsequently touted the ruling in advertising for the test sent to personnel officers of several other large corporations.

Dr. Grand's advertising may lead to unwarranted generalization regarding the meaning of "governmental approval" of the test. The most likely recipients of his announcements (e.g., corporate executives or human resource officers) will typically not have sufficient knowledge of tests and measurements to conceptualize the issues needed to evaluate his claims intelligently or to discriminate between the "recognized" and potential unrecognized uses of the test.

Case 7–5: The manual for the *Omnibus Achievement Test* gives the numbers, grade levels, and ages of the schoolchildren in the standardization sample. It fails to mention, however, primary language, ethnic/racial composition, geographic diversity, socioeconomic status, or similar demographic variables of the sample population.

The *Omnibus Achievement Test* severely handicaps any potential user by omitting crucial demographic data on the basic population sampled. This omission effectively undercuts any potential application of the test, valid and reliable though it might be, because the users have no basis to conclude that the population to be tested resembles the population for which norms exist. By omitting such critical data from the manual, users of this test would employ it at their peril because they could not draw generalizable conclusions. Marketing such a test with an incomplete manual would constitute a shared unethical act because it might lead an unsophisticated potential user to think that it has some appropriate application. We describe this as a shared violation because qualified test users should know better than to rely on defective instruments.

Case 7–6: Joyce Nerd, Ph.D., is the primary author of the *National Nonsequitor Personality Inventory-3* (NNPI-3), which has won wide acceptance as a personality-screening instrument. In revising the test manual, Dr. Nerd omits references to several articles published in peer-reviewed journals that criticize the NNPI-3's stated uses and validity studies. She reasons that the "overwhelming body of data over many years" documents the utility of the test, whereas the "few polemic studies" critical of the test are not worthy of mention.

Dr. Nerd may be letting her personal bias and investment in her work cloud her competence. She should not intentionally delete questions about the instrument raised in scholarly publications. Citing all relevant research, including critiques, allows the informed test user to make an independent decision. Dr. Nerd can certainly attempt to rebut such citations in her manual, but the conscious omission of

this information represents an act of deception and misrepresentation, regardless of Nerd's rationalization.

Test Administration

One of the important scientific values of a psychological assessment technique grows from the fact that it provides a means for assessing a standard slice of human behavior. This implies a specific test ecology, adherence to administration rules, and specific scoring criteria. Consider these examples of variations in administration of certain tests:

Case 7-7: Erika, age 6, had become bored in first grade. Her parents called Mr. Blitz, the school principal, to request a conference regarding their daughter's progress and possible promotion. In a hurry to obtain some data before the parent conference, Mr. Blitz had Erika sent to a third-grade classroom one morning, without prior notice, to take paper-and-pencil intelligence and achievement tests scheduled for administration to the third graders. When comparing her scores to first-grade norms, they seem low, so Blitz concludes that the data prove her basic abilities are limited.

When Mr. Blitz removed Erika without warning from her first-grade class and put her with a strange group of older children to take a test that was not explained to her, he put her at a substantial emotional disadvantage. Even if we assume that the tests have validity for the intended purpose, one cannot base a conclusion about the child's ability solely on paper-and-pencil tests without considering such other factors as teacher reports, individual stresses on the child, and so on. The chief difficulty in this case, however, is the error of altering the child's ecology during the sampling of her behavior while not making any effort to assist her adjustment. It would have been much more appropriate to provide the child with an explanation and to schedule testing with a group of peers or with an individual examiner who could establish rapport with Erika and make individual observations of her work during the test.

Case 7-8: Sidney Mute, a deaf, nonverbal adult, was arrested as a criminal suspect. Because of questions about his mental competence, Alice Stanine, Ph.D., was asked to undertake a psychological assessment. She discovered that Mr. Mute could read and write at an elementary school level, so she administered a test battery using intelligence and personality tests intended for hearing/speaking clients by providing Mr. Mute with cards she had specially prepared containing the test questions or instructions. Her behavioral observations note that "Mr. Mute engaged in considerable hand-waving and finger-twitching tic-like behaviors suggestive of Tourette syndrome."

Dr. Stanine certainly attempted a creative approach to evaluate Mr. Mute. However, in so doing she deviated significantly from the test administration conditions prescribed in the manual. From an ethical perspective, she must make note of that in any report of results. More important, she has used a test on an individual for whom it had not been validated. Some of the data she collects may prove useful, although clearly not in the same fashion as if the client had the ability to hear and speak. More troubling, however, is the fact that Dr. Stanine seems clueless about the legal mandates of the Americans with Disabilities Act and did not attempt to use one or more of the specific tests designed for use with the hearing impaired (e.g., the Hiskey-Nebraska Test of Learning Aptitude) or refer the case to an examiner familiar with assessment of deaf clients. She apparently did not consult anyone knowledgeable about assessing deaf clients and seems to have overlooked attempts by Mr. Mute to use sign language, misinterpreting these as suggestive of psychopathology. While this case has major implications regarding Dr. Stanine's competence, it also illustrates the problem of applying a standardized test instrument in a nonstandard fashion and of failure to recognize one's own lack of competence in a specific domain of expertise (APA: 9.02; ACA: E8).

Another ethical concern regarding test administration involves the issue of supervising clients taking multiple-choice instruments. In April 1993, the APA Ethics Committee issued a

policy statement in response to an inquiry about whether it is a *per se* ethics violation to send a Minnesota Multiphasic Personality Inventory (MMPI) home with a client for completion (APA Ethics Committee, 1993). The committee noted the importance of considering each such circumstance on a case-by-case basis and would involve any similar types of assessment, not simply the MMPI. Concerns focused on violations of test security, failure to supervise the testing adequately (with resulting potential validity problems), and impairment of client welfare. Debate ensued regarding whether there are ever any appropriate circumstances for which it might be reasonable and appropriate to allow administration of such a test away from a professional setting. In such cases, the psychologist would bear the burden of justifying why the client's welfare or other extenuating circumstances necessitated unmonitored administration. The psychologist would need to ensure that test security was maintained and that the correct person completed the test. In addition, any reports resulting from data collected in a nonstandard manner should address that issue in terms of reliability and validity of the results under nonstandard conditions.

Finally, checking to confirm scoring accuracy constitutes a critical professional obligation, even when using the clear-cut scoring criteria or so-called objective test instruments. In one study, for example, scoring errors were detected in 53% of personality inventories that had been hand scored by trained clinic personnel at an "unnamed metropolitan outpatient mental health clinic" (Allard, Butler, Faust, & Shea, 1995). Fully 19% of the hand-scored test protocols in question contained errors sufficient to alter clinical diagnoses. The same tests scored by computer program were free of errors.

Test Bias

The problem of test bias has received intense scientific and public scrutiny over the years, generating considerable scholarly and public debate (Flaugh, 1978; Frederiksen, 1984; Helms, 2006; Kaplan & Saccuzzo, 2014; Rey-Casserly & Koocher, 2012; Teresi & Jones, 2013). Even

the definition of the term *test bias* consists of many disparate facets (Flaugh, 1978). Bias may manifest itself as a function of the skill or trait being tested, as a statistical phenomenon, as a selection model, as test content problems, as an overinterpretation issue, as in the use of wrong criteria, or even as test atmosphere or test ecology issues (APA: 9.05–9.06; ACA: E.2–E.8). When discussing ethical problems related to the matter of test bias, it therefore becomes critical to consider what sort of definition and which cluster of issues one has in mind.

Frederiksen (1984) noted increasing evidence that economical multiple-choice tests in academic settings have driven other testing procedures out of school evaluation programs, to the detriment of students. He argued that such testing has led to teacher and student behavior changes less conducive to practice with feedback and the development of higher level cognitive skills. He termed the adverse influence of testing itself on teaching and learning the "real bias" in psychological testing programs.

Cole (1981) presented an excellent historical overview of research on test bias and included analyses of subtle differences in the content of test items to which individuals react differently. She argued that the basic issue regarding test bias should more properly focus on validity. She made a careful distinction between whether a test has validity for some potential use and whether it should be used (even if valid). For example, a single test may predict success in a particular educational setting for some groups, but not others. In such a situation, that test should not constitute the single selection criterion because it does not recognize the "others" who have the ability to succeed, despite a low score on that test. She noted that tests have often served as a kind of lightning rod or focal point of anger related to difficult social policy questions that seldom lend themselves to solution by test data (Laosa, 1984).

Cole (1981) cited several examples of social policy problems. In selecting for employment or promotion, for example, how can we best meet current employer needs while compensating for past wrongs and current individual rights? What role should selective admissions play in higher

education, and how should broad opportunities be provided? What form should education for children with disabilities take? How should we deal with people for whom English is not a native language? We agree with Cole's assertion that the bias issues fundamentally boil down to questions of validity. The ethical problems are more clearly linked to the test developers and test users, who hold ultimate responsibility for remaining sensitive to the proper and improper application of the instruments they devise and employ, respectively. Mental health professionals should certainly speak out on major public policy issues, both as individual citizens and as scientists who may have data to assist in resolving problems beneficially, but the solution to complex social policy problems will rarely be found through a psychological test.

Case 7-9: Amena Afghani, orphaned in Afghanistan and relocated in the United States, where she was adopted at age 14 by an American couple, found herself referred for psychological evaluation as she prepared to enroll in an American high school. Amena spoke passable English, and the examiner tested her using, among other instruments, the current version of the Wechsler Adult Intelligence Scale-IV (WAIS-IV) and the Rorschach inkblots. On the basis of IQ scores in the 60–70 range and unelaborated “explosion” or “fire” responses on the Rorschach, the psychologist described Sara as “most likely mildly retarded and prone to violent acting out.”

Once again, the issue is not clear cut in terms of testing problems. One could argue, as in the case of Dr. Stanine (Case 7-8), that this seems a user competence problem. However, it is also evident that a test standardized on and designed for adult, native English-speaking Americans is not the ideal instrument to use for ability testing of a recent immigrant with limited English language experience. In fact, Amena proved to be a very bright youngster whose receptive and expressive language skills were limited in English. She believed she must not complain or question authorities and should behave in a compliant manner. As a result, she did not ask for clarification or protest her lack

of understanding of instructions and test questions. All of Amena's family had been killed during a Taliban attack on their village, and she still suffered nightmares of that episode. In that context, her “explosion” responses to the Rorschach seem less subject to the usual interpretation. If the psychologist who saw Amena had given careful thought to these issues, or at least had included adequate cautionary statements in discussing the test data, the use of the tests might have been at least partially justified. In the context of Amena's situation, the evaluation and tests certainly created cultural and linguistic bias.

The importance of both linguistic and cultural sensitivity in testing is critical. For example, the English word *peach* (i.e., a fruit) has two common translations in Spanish. *Durazno* is the word children from Mexico would use to name the fruit, whereas children from Puerto Rico would call it *melocoton*. A vocabulary test in Spanish would have significant flaws unless both uses of the word are scored as correct. Similarly, in teaching reading comprehension, programs in the United States stress the concept of the main idea. Schools in Israel, on the other hand, often stress the moral lesson of a given story. It is easy to see how tests keyed with one emphasis or the other could seriously underrate a person from a different cultural or linguistic background (APA, 1990).

Subgroup Norming

During the 1980s, the U.S. Employment Service (USES) determined that an aptitude test used for referring job applicants to employers was having an adverse impact on the candidacy of members of ethnic minority groups, especially African Americans and Hispanics (Brown, 1994). In an effort to reduce the unfavorable impact of such testing on these groups, the USES made a decision to use within-group scoring, also known as subgroup norming. This practice resulted in percentile scores based on ethnic group membership. The practice has remained controversial among psychologists, civil rights activists, and legislators. In the context of so-called reverse discrimination, matters

culminated with passage of the Civil Rights Act of 1991, by which the 102nd Congress banned any form of score adjustment predicated on race, color, religion, sex, or national origin (Public Law 102-166, Section 106).

A special section of the *American Psychologist* focused on this issue (Brown, 1994; Gottfredson, 1994; Sackett & Wilk, 1994). The articles trace the agony of behavioral scientists and psychometrists who find themselves drawn into public policy debates that alternately cast them as social advocates and as threats to the compromise of personnel selection science. From our perspective, however, this debate is not a matter of test bias so much as an attempt to use psychological assessment methods to resolve social and political problems. Some would argue that testing contributed to the origin of the problem, but one need look only to Matarazzo's (1990) distinction between psychological *testing* and psychological *assessment* to understand that the problem is not the tests. Rather, the difficulty lies with users who focus on easily gathered test scores instead of comprehensive assessments. As is too often the case, society would like inexpensive and easy solutions to complex assessment problems and will find those willing to deliver services that fit the demand.

Classic Test Case Litigation

Because major litigation has revolved about the issue of test bias, it seems reasonable to summarize some of the key cases here. We focus on major cases in which issues of test bias were raised.

Griggs v. Duke Power Company. This case (*Griggs v. Duke Power Company*, 1971) became the first major challenge to employment tests (Bersoff, 1981) and grew from an objection to the legality of using general ability tests to hire and promote employees in a private company. Employees of African American ancestry cited the 1964 Civil Rights Act, claiming that the practice of test usage constituted a form of racial discrimination. While the employer acknowledged that few people of color were employed or promoted and that the test may have had a prejudicial impact, the company claimed no

intent to discriminate. A unanimous Supreme Court decision held that discriminatory practices were actionable regardless of whether the form is fair as long as the result is discriminatory. When statistical data were produced showing the disproportionate impact on Black workers, the court faulted the company for using broad and general testing devices (Bersoff, 1981). The court introduced the concept of "job relatedness" as critical to the valid use of personnel testing. That is, the human attributes measured by the test must be clearly relevant to the duties performed in the particular job.

Larry P. v. Riles. In this class action law suit (*Larry P. v. Riles*, 1979), the federal courts prohibited the use of standardized intelligence tests as a means of identifying educable mentally retarded (EMR) Black children or for placing such children in EMR classes. This case began because Black children had become disproportionately overrepresented in such classes, and the primary basis for such placement in California (at that time) focused on such tests (Lambert, 1981; Powers, Hagans-Murillo, & Restori, 2004). Attorneys for the children argued that the test items originated from White, middle-class culture, that Whites had more advantages and opportunities than children of color, and that language used by Black or Latino children may not correspond to that used in the test. In addition, they noted that the motivation of some ethnic minority children to perform on the tests may have been adversely influenced by the race of the examiners, who were mostly White, and that the number of children of color in the standardization sample was low.

The type of problem demonstrated in the *Larry P.* case is essentially a validity issue. That is, the test was being used for making a type of discrimination or judgment for which it was neither intended nor validated. Use of a single psychometric instrument as the sole or primary criterion in making critical educational or other life decisions fails to consider each individual as a whole being in a specific life context. Such lack of comprehensive assessment is a frequent type of test misuse (Moreland, Eyde, Robertson, Primoff, & Most, 1995).

PASE v. Hannon. In this case (*PASE v. Hannon*, 1980), a federal court in Illinois reached the opposite decision from its West Coast counterpart in the *Larry P.* case. The court permitted continued use of psychological tests in special education placement decision making. This contrast is of interest because many of the same psychological experts testified in both cases, both cases were under active judicial review simultaneously, and the outcomes were quite different. One might be tempted to read these cases as contrast or contradiction in the legal system. We believe the contrasting opinions are best viewed as context specific. That is, the court was most likely convinced that use of the psychometric tools in Illinois was more appropriate to the context than was the use of the same instruments by the psychologists in the San Francisco school district. The fact that two different judges and sets of facts were involved, however, makes a definitive conclusion on the legal merits impossible. The point is that the clinician who becomes involved in testing to be used for critical decision making bears an especially heavy ethical burden to ensure the data are applied in an appropriate scientific context that does not unfairly discriminate against any individual being assessed. (As an aside, it is somewhat ironic that the judge in the *PASE* case permitted the standard questions and keyed answers to the intelligence tests used to become a part of the public record of the trial. The court clearly had little concern for the matter of test security.)

The use of psychological tests for the educational classification and tracking of children in cases such as these was unethical in our judgment for three reasons: (a) the tests were not well suited for the sort of fair differentiation needed; (b) scores were being used inappropriately as paramount criteria for complex decisions affecting the lives of people; and (c) psychologists were not sufficiently sensitive to the flaws in their instruments and the manner in which these flaws could adversely affect the lives of others. There was little recognition of the tests' contribution to broader repressive social policies. It is incumbent on the psychometrician who uses intelligence tests to be

sensitive to these issues and take steps to ensure that the assessment is not used to the detriment of the person tested.

Atkins v. Virginia. Around midnight on August 16, 1996, Daryl Renard Atkins and William Jones abducted Eric Nesbitt. They took his money and drove him to an automated teller machine in his pickup truck; cameras recorded them withdrawing additional cash. They then took him to an isolated location, where he was shot eight times and killed (*Atkins v. Virginia*, 2002).

After trial and conviction for capital murder, the defense relied on one witness during the penalty phase of the trial: Evan Nelson, Ph.D., a forensic psychologist. Dr. Nelson had evaluated Atkins before trial and concluded that he was "mildly mentally retarded." Dr. Nelson based his conclusion on interviews with people who knew Atkins, a review of school and court records, and the scores from a Wechsler intelligence test indicating that Atkins had a full-scale IQ of 59.

The jury sentenced Atkins to death, but the Virginia Supreme Court ordered a second sentencing hearing because the trial court had used a misleading verdict form. At the resentencing, Dr. Nelson testified again. The state presented an expert rebuttal witness, Stanton Samenow, Ph.D., who expressed the opinion that Atkins was not mentally retarded, but rather had "average intelligence, at least," and offered a diagnosis of antisocial personality disorder. Samenow noted that Atkins's vocabulary, general knowledge, and behavior suggested that he possessed at least average intelligence. As a result, the jury again sentenced Atkins to death and the Virginia Supreme Court upheld the sentence.

In a 6-to-3 decision, the U.S. Supreme Court overturned the decision, noting two reasons consistent with the general legislative consensus that mentally retarded persons should be categorically excluded from execution. The court noted that the primary justifications for imposing the death penalty remain retribution and deterrence of capital crimes by prospective offenders. The court found that executing the mentally retarded violates the Eighth

Amendment's ban on cruel and unusual punishments. The APA had filed an amicus brief with the court (see <http://www.apa.org/about/offices/ogc/amicus/atkins.aspx>) addressing a range of issues, including established procedures for evaluating the presence of mental retardation and the attributes of such conditions that relate to criminal sentencing.

Ironically, although Atkins's case and ruling may have saved other mentally retarded inmates from the death penalty, a jury in Virginia subsequently decided in July 2005 that he was intelligent enough to be executed because the constant contact he had with his lawyers had intellectually stimulated him and raised his IQ above 70, making him competent for execution under Virginia law. The prosecution had argued that the cause of his poor school performance originated with his use of alcohol and drugs, and that his lower scores in earlier IQ tests were not accurate representations of his true ability. His execution date was set for December 2, 2005, but the Virginia Supreme Court ultimately reversed his death sentence again on procedural grounds. On the one hand, this case raises significant ethical issues by placing psychological test data at the core of a life-or-death decision (Brodsky & Galloway, 2003; Koocher, 2003). On the other hand, the case raises the more ironic question about whether interacting with one's attorney can increase a person's IQ.

USER COMPETENCE

Although we have thus far focused chiefly on basic concepts in testing and issues in test adequacy, many of the examples we have cited raise issues of test user competency or, more accurately, incompetence on the part of some test users. Clearly, appropriate utilization of psychological tests involves much more than simply recording responses and totaling the score (Rey-Casserly & Koocher, 2012). Moreland and his colleagues (1995) described 86 test user competencies and 7 factors accounting for most test misuse. Examples of the 86 competencies include the following:

- Avoiding errors in scoring
- Keeping scoring keys and test materials secure
- Making certain that examinees follow directions
- Refraining from coaching or training individuals on test items
- Establishing rapport with examinees to obtain accurate scores
- Using settings and conditions that allow for optimum test performance

The seven most common misuse factors noted by Moreland and his colleagues were

- Lack of a comprehensive assessment,
- Improper test use,
- Lack of psychometric knowledge.
- Failure to maintain integrity of test results,
- Inaccurate scoring,
- Inappropriate use of norms, and
- Inadequate interpretive feedback.

The APA has also weighed in on the issue with a comprehensive report on test user qualifications (Turner, DeMers, Fox, Roberts, & Reed, 2001). The competence issues, discussed in Chapter 2, are generally related to this point; however, testing also involves a special subset of competence problems. Many standardized psychological instruments seem deceptively easy to administer and score, requiring little or no formal training. However, the accurate interpretation and application of these instruments, as well as placing the test data in the context of the individual's life, becomes a much more complex matter entirely. In addition to training issues, we next raise a number of special ethical problems related to diagnosis, test security, and sale of tests to unqualified users.

Training Issues

How much and what types of training should the profession require as a prerequisite for designation as a "qualified" user of psychological tests (Bartram, 2001; Ekstrom, Elmore, Schafer, & Dillon, 1997; Koene, 1997; Rupert, Kozlowski, Hoffman, Daniels, & Piette, 1999; Turner et al.,

2001)? At times individuals who do not meet appropriate standards as qualified users have asserted claims of their ability to offer assessment services to the public (Clawson, 1997). The APA and state psychological associations have historically supported legislation that would allow only licensed psychologists to use most psychological tests (APA: 9.07). At times, they have been opposed by school psychologists or counselors with master's degrees; however, the ACA code, particularly Section E and Subsection E2, addresses similar concerns regarding assessment ethics and competence. The National Association of School Psychologists makes similar points in its Principle II (National Association of School Psychologists, 2010).

The answer to the qualified user question becomes complicated when one considers the type of test, the use to which it is put, and the setting in which it is applied. For example, at present psychologists can successfully complete an APA-approved doctoral program in clinical psychology without ever having administered a projective personality assessment technique (e.g., the Rorschach inkblots, Roberts Apperception Test, or Thematic Apperception Test). Some would argue that mandatory course work in statistics, individual differences, personality theory, abnormal psychology, and cognitive processes should precede undertaking comprehensive psychological assessments. If the evaluator intends to practice in organizational or industrial settings, course work in organizational behavior, personnel law, and similar fields might be necessary prerequisites. If a school setting is to be the primary workplace, a psychologist may need additional course work in curriculum planning and educational theory prior to undertaking assessments. Few standards currently exist to specify the minimum competence needed to perform each assessment task adequately, and psychologists are generally left to address this matter on the basis of their own awareness of their competencies and limitations. Sometimes, this is an effective means of control, but at other times it is not.

Case 7-10: Dinah Saur, Psy.D., hired Mary Smurf to work in her private practice. Ms. Smurf had a

B.A. degree in psychology, and Dr. Saur gave her a few hours of training in the administration of the Wechsler tests, Thematic Apperception Test, and Rorschach inkblots. Dr. Saur would interview referred clients for about 10 minutes and then send them to Ms. Smurf, who would administer the tests Dr. Saur prescribed. Dr. Saur would then prepare and sign evaluation reports based on the data Smurf collected.

Dr. Saur provided only minimal supervision and training to her relatively unqualified assistant. She then based her reports on a superficial interview and data collected by a person not sufficiently trained to administer complex tests or to note the subtler aspects of meaningful variations in test behavior. The reactions of the client to certain test stimuli may go unrecorded; the nuance of a response, which may tend to suggest one meaning or interpretation over another, could be lost; and Dr. Saur made no apparent effort to ensure quality control of the process. In some ways, Dr. Saur is actually offering an impersonal service and giving the impression that she has conducted an evaluation when she has actually had only minimal direct contact with the client.

Case 7-11: Dexter Dendrite, Psy.D., had a busy neuropsychology assessment practice. He hired Sandra Synapse, M.Ed., who had worked for many years as a school psychologist, to assist him. In addition to her master's degree in education, Ms. Synapse had taken many continuing professional education courses to learn new assessment tools, and Dr. Dendrite has trained and observed her in the administration of several neuropsychological instruments. Dendrite would meet with each client, review the client's history, speak with the referral source, and develop an assessment plan with Ms. Synapse. She would then administer the tests and score them, as well as provide her clinical observations. Dr. Dendrite would check the scoring and integrate the test data and other information into a single report, which both he and Ms. Synapse would sign.

Some psychologists have questioned the use of individuals without a psychology license to

administer psychological tests. However, few state laws regulate the use of specific tests, leaving that to professional licensing boards that may disagree with each other's rules. For example, a psychology board may object to a physician's use of psychological tests, but the medical licensing board may not agree. The controversy has become fodder for discussion among clinicians, professional organizations, state and provincial boards of psychology, state governments, departments of education, and third-party health care insurers (Hall, Howerton, & Bolin, 2005). Unlike Dr. Saur in Case 7–10, Dr. Dendrite has taken a number of steps to ensure the quality of his work by hiring a skilled assistant, staying closely involved with her training, carefully monitoring her work, and jointly owning responsibility for the final product.

Case 7–12: Sandra Toddler, Ph.D., had specialized in clinical child psychology, although her course work and practica had always involved school-age children and their families. When she began to receive referrals for assessment of developmentally delayed infants and children under age 4, she ordered copies of several developmental instruments (e.g., Bayley Scales of Infant Development, etc.), read the manuals, and began using them in her practice.

Dr. Toddler may be bright and sensitive enough to learn the administration of new instruments from their manuals rather quickly. Is she qualified, however, to assess the meaning of the data and integrate it with other information to produce a valid and useful assessment? We really cannot tell from the information provided. If Toddler were more attentive to her ethical responsibilities, she probably would have sought some consultation, supervision, training, or any combination of these from a colleague with expertise in infant assessment. Toddler could then, with a meaningful basis of comparison, be able to gauge her own competence and weakness on the tasks at hand.

Case 7–13: Norris Nemo, Ph.D., earned his degree in counseling psychology, and his doctoral

program included supervised course work in the use of intelligence, personality, and vocational guidance assessment tools. He approached several large companies to offer "placement and exit counseling" services to their personnel offices.

Dr. Nemo seems rather naive. We cannot know with certainty what he means by placement and exit counseling, and we do not know whether he has any background in personnel assessment or organizational consultation. He may not even recognize that he may well lack the typical qualifications expected of practitioners offering such services. On the other hand, he may indeed have the competence to offer the services he proposes, but these might not align with the needs of potential client companies. Perhaps Nemo mistakenly assumes that vocational preference and IQ are the most important factors in successful job functioning. All we know for certain is that Nemo seems to have reached out to offer assessment in areas for which his training has not adequately prepared him.

Each of the last four cases cited demonstrates a need for awareness of adequate or necessary training across a variety of assessment activities. Although we would like to believe that there are few grounds for concern of this sort in day-to-day practice, a study by Smith and Dumont (1995) provided little reassurance. They found a group of psychologists all too willing to offer interpretive statements based on casual use of a poorly validated instrument for which they had little or no training. The clinicians tended to use the data at hand to find support for initial diagnoses (i.e., confirmatory bias) with an embarrassing lack of scientific rigor.

A recent survey of clinical psychology programs (Ready & Veague, 2014) revealed that only 60%–70% of programs paid significant attention to teaching the conduct of psychological assessment in a manner sensitive to the many forms of diversity that clinicians encounter. They also noted a decline in the teaching of projective assessment techniques, observing that more academically oriented faculty members in clinical psychology programs hold unfavorable attitudes toward projective personality

tests, and that newer faculty seem disinclined and unprepared to teach projective tests as older faculty members who had greater familiarity with such tools retire. This trend seems to flow from the zeitgeist of evidence-based practice, with criticism of scoring systems for various projective tools. Considerable evidence does exist in the literature to support the validity of some projective tools, but some evaluators seek to draw inferences from projective data without reference to rigorous norms. This seems to happen more often with projective tests than with objective inventories.

Diagnosis

Assigning a diagnostic label can have serious consequences for a client. We address this issue in our discussion of confidentiality (Chapter 6), but the point is well illustrated in Hobbs's (Hobbs, 1975) classic books on issues in the classification of children, in which issues such as the adverse consequences of labeling and self-fulfilling prophecies are discussed. Other classic works by Szasz (1970) and Goffman (1961) highlight the labeling problem for mentally ill adults, whereas Mercer (1973) documented similar adverse consequences for those labeled mentally retarded. Because psychological test data at least occasionally become the basis for applying diagnostic labels, it seems critical that those using tests for that purpose remain appropriately cautious and sensitive to potential alternatives.

Case 7-14: Kevin Bartley, age 15, arrived at a psychiatric facility accompanied by his mother, who demanded hospitalization for him. She felt overwhelmed by her life situation, including a divorce in progress and other young children at home. Kevin's truancy and problem behavior at home had become too much for her. Because Kevin was a minor, the psychiatrist on duty admitted Kevin over Kevin's objections and in the process assigned a psychiatric diagnosis. Several months later, the courts ordered Kevin's discharge (*Bartley v. Kremens*, 1975). Some time after his 18th birthday, Kevin was denied a municipal job because of his "history of psychiatric illness."

The case of Kevin Bartley has particular significance because his hospitalization arose as much because of his family situation as from any psychopathology he may have had. He was "diagnosed," and that diagnosis had very real adverse consequences for him when he later sought employment. This occurred in spite of a federal court decision, which suggested that he ought not to have been hospitalized in the first place.

Case 7-15: Carla Split sought the services of Jack Label, Ph.D., to assist her in coping more effectively with a variety of emotional issues. Dr. Label asked her to complete some paper-and-pencil personality inventories and then offered her his diagnostic impression. Ms. Split, according to Dr. Label, was "a psychopath from the waist down and schizoid from the waist up." Ms. Split felt very upset by these rather unusual diagnoses. She had never heard of them, could not find reference to them in books she consulted, and began to believe that she had a major mental illness view of the "serious diagnoses."

Dr. Label seems a proponent of the creative school of diagnostic psychopathology. It appears that he offered a rather rapid diagnosis of Ms. Split, but failed to explain it adequately. In addition, he used an idiosyncratic, jargon-laden term that struck the client as more frightening than helpful. Even if a diagnosis based on valid data and a legitimate classification system properly applies, the terms should not be tossed off lightly to clients. In Dr. Label's case, one wonders how much thought he gave to the actual assessment, as well as to the capricious and demeaning terminology.

Case 7-16: Ivan Meek, age 7, transferred to the Rocky Coast School when his family moved to town from another part of the country. Ivan, shy and socially withdrawn, could not establish much rapport with Helen Rush, Ph.D., the school psychologist asked to assist in placing him in the proper class. Dr. Rush, very busy with the start of the new school year, recommended placing Ivan in a special education class on the basis of a 15-minute interview, during which she administered

some “screening tests.” Ivan spent 3 years in classes with mildly-to-moderately delayed youngsters before a full evaluation revealed him to have average intellectual ability. During the 3 years, the school system made no effort to assess his potential or to investigate the emotional issues that contributed to his shyness and withdrawal because most of the personnel simply assumed significant developmental delay by virtue of the placement Dr. Rush had suggested.

The situation in the case of Ivan Meek and Dr. Rush illustrated two major problems with labels and diagnoses. One can acquire either easily or by inference, and they may stick for a long time, much to the client’s detriment. If we assume that Dr. Rush felt overworked, we might excuse some initial haste and misjudgment. Apparently, however, she forgot about Ivan, failed to check with his prior school, did not order any follow-up evaluation, and did not apply any of a number of standardized assessment tools that might have proved more accurate than her quick judgment. Teachers and parents will often defer to professional judgment, and in Ivan’s case, it took 3 years for meaningful recognition of his needs and correction of the initial misclassification.

The last few cases provide additional examples of the risks of misdiagnosis based on psychological test data. A discussion of actuarial prediction and automated test-scoring programs presented in the following material illustrates an extension of this hazard. This type of problem seems most likely to occur when assessment fails to consider all relevant evidence, including nontest data, such as data learned in history taking or with other interview techniques. Certainly, any mental health professional who intends to use psychological test instruments for psychodiagnostic purposes should have completed formal studies related to these issues.

Strange as it may seem, in some circumstances a diagnostic label may become desirable or even sought by a particular client. For example, some learning disability diagnoses might result in the ability to obtain special educational services or unique consideration at

college examination time. In some court-related circumstances (*Atkins v. Virginia*, 2002; Brodsky & Galloway, 2003), certain diagnoses may suggest a lack of criminal responsibility or mitigating factors, leading to a reduced sentence. Some diagnoses might result in the ability to obtain disability insurance payments, while other diagnoses would not. Regardless of the client’s preference, a diagnostic assessment should never be offered without adequate supporting data. The value of psychological assessment arises from the examiners’ integrity, as well as from their clinical skills.

Test Security

Well-conceptualized and carefully standardized assessment tools require considerable development effort and expense. The validity and utility of many such instruments could suffer serious compromise if their security were violated (APA: 9.11; ACA: E.10). Some tests also have substantial potential for abuse in the hands of untrained individuals, and publishers therefore restrict access to individuals trained in their use and application. Such security is not always easy to maintain, and any persistent person can obtain substantial “secure” test information by accessing journals, textbooks in major university libraries, or Internet sources (LoBello & Zachar, 2007; Rey-Casserly & Koocher, 2012; Ruiz, Drake, Glass, Marcotte, & van Gorp, 2002). Ample proof exists to show that as far back as the 1970s a moderately clever nonprofessional could easily obtain copies of secure test materials (Oles & Davis, 1977). So-called truth-in-testing statutes enacted during the 1980s in some states mandated public access to certain types of group-administered educational placement, achievement, and admissions tests (e.g., Scholastic Aptitude Tests [SATs] and Graduate Record Examinations [GREs]), along with the correct answers. Consider some cases for which the security of specialized clinical instruments was violated:

Case 7-17: A reporter working on a story about IQ testing sought an interview with Turner Loose, Ph.D. During the course of the interview,

Dr. Loose showed the reporter a test manual and many items from the WAIS-III. Subsequently, the reporter wrote an article for a national magazine, "How to Score High on IQ Tests." In the article, the reporter revealed 70%–80% of the verbal questions on the test, along with practice hints and other clues linked to the items he had seen.

Dr. Loose felt outraged and embarrassed when he saw the reporter's article, but there was little he could do. In attempting to be "open and candid with a member of the press," he had inappropriately shared material he should have treated as confidential. The impact of the article in terms of inflated and invalid scores is obviously unknown. (See also Chapter 11 for more about interactions with journalists and media staff.)

Case 7-18: Adolph Snitler, Psy.D., wrote a book popular with the public about notorious criminals. The book included reduced black-and-white reproductions of the Rorschach inkblots (half of which include color) along with lists of common responses to the same stimuli.

For his book on notorious criminals, Dr. Snitler had sought and been granted permission by the publisher to reprint copies of the Rorschach plates in achromatic reduced-size format. Many clinicians would assert that in doing so and listing common responses represents a serious unethical act. Others would note that one could easily find more detailed Rorschach textbooks available in public areas of many university libraries and suggest that the impact of reading such a book on potential test takers' subsequent performance is questionable. While a psychologically well-adjusted individual with above-average intellect might have the ability to fake a disturbed Rorschach protocol, it seems most unlikely that a troubled client could muster the psychological resources to simulate a psychologically sound protocol no matter what information was available in the public domain. Again, the impact of this disclosure remains unknown, although the author certainly used questionable professional judgment.

Case 7-19: An executive of a large corporation qualified as one of a group of candidates for promotion to a major position in that organization. The company required all candidates to take some psychological tests administered by a psychologist as part of the selection process. The executive arranged a confidential consultation with Kent Hoyt, Ph.D., a psychologist with training in personnel selection, to help him prepare for the tests. Dr. Hoyt discussed a number of the potential test instruments and even suggested response styles that might help the executive to seem most appealing in the final assessment.

Dr. Hoyt regarded himself as helpful to his client, the executive. Consulting on the general matter of how to "look good" in a specific type of interview situation does not necessarily constitute ethical misconduct. However, Hoyt's apparent willingness to reveal suggested responses to confidential test items to the client crosses the ethical threshold. In so doing, Hoyt may invalidate an instrument in secret, with the intent of undermining the objective ethical work of any colleagues who subsequently attempt to assess the candidate, unaware of his coaching.

Wetter and Corrigan (1995) surveyed a group of lawyers and law students and found nearly half of attorneys and fully a third of law students believed that clients referred for testing should be informed about the existence of validity scales for some psychological tests. Some lawyers also believe that it is appropriate to coach clients prior to such testing. Cooperation with such coaching by a psychologist would clearly qualify as unethical because such conduct would undermine the validity of the instrument. At the same time, it is not inappropriate for a practitioner to advise an assessment client that some test scales may reveal atypical responses, unusual defensiveness, or other such response styles.

One can help prepare people for assessment and reduce anxiety by giving information that will not compromise the integrity of the assessment. Consider the following case:

Case 7-20: Tran Quility, Psy.D., routinely takes time to establish rapport with clients prior to

beginning data collection during psychological assessment. This includes asking clients whether they have undergone testing previously and if they understand the purpose of the assessment. When administering the Minnesota Multiphasic Personality Inventory 2 (MMPI-2), Dr. Quility explains that psychologists use the instrument with a wide range of people, including those with serious mental illness and normal folks. He notes that, as a result of the range of personality factors covered, some questions may seem odd or unrelated to the client. He urges them to simply respond as honestly as possible and not to feel rushed.

Dr. Quility's comments and attitude will go a long way to put many clients at ease, while not betraying any confidential data or engaging in coaching.

A related area of conflict in professional opinion involves the question of whether third parties (e.g., a child client's parents or a client's attorney) should be allowed to sit in on testing sessions (National Academy of Neuropsychology [NAN], 2000b). In general, we do not recommend permitting the presence of third parties as this could compromise test security and potentially lead to some response bias. However, we recognize that some forensic circumstances or situations involving clients with communication difficulties may necessitate the involvement of third parties. Another potential solution might include recording the assessment session so that opposing experts would have the ability to carefully check the administration and scoring.

High-Stakes Testing

The term *high-stakes tests* refers to instruments designed to assess knowledge, skill, and ability with the intent of making decisions regarding employment, academic admission, graduation, or licensing. For a number of public policy and political reasons, these testing programs face considerable scrutiny and criticism (W. M. Haney, Madaus, & Lyons, 1993; Kaplan & Saccuzzo, 2014; Rey-Casserly & Koocher, 2012; Sackett, Schmitt, Ellingson, & Kabin, 2001).

Such testing includes the SAT, GRE, state examinations that establish graduation requirements, and professional or job entry examinations. Such tests not only can prove useful but also are subject to misuse and a degree of tyranny in the sense that individuals' rights and welfare are easily lost in the face of corporate advantage and political struggles about accountability in education.

In May 2001, the APA issued a statement on such testing, *Appropriate Use of High Stakes Testing in Our Nation's Schools* (see <http://www.apa.org/pubs/info/brochures/testing.aspx>). The statement noted that the measurement of learning and achievement are important and that tests, when used properly, are among the most sound and objective ways to measure student performance. However, when test results are used inappropriately, they can have highly damaging unintended consequences. High-stakes decisions such as high school graduation or college admissions should not be made on the basis of a single set of test scores that only provide an isolated snapshot of student achievement. Such scores may not accurately reflect a student's progress and achievement and do not provide much insight into other critical components of future success, such as motivation and character. The APA statement recommends that any decision about a student's continued education, retention in grade, tracking, or graduation should *not* be based on the results of a single test.

The APA statement noted:

- When test results substantially contribute to decisions made about student promotion or graduation, there should be evidence that the test addresses only the specific or generalized content and skills that students have had an opportunity to learn.
- When a school district, state, or some other authority mandates a test, the ways in which the test results are intended to be used should be clearly described. It is also the responsibility of those who mandate the test to monitor its impact, particularly on racial and ethnic-minority students or students of lower socioeconomic status, and to identify

- and minimize potential negative consequences of such testing.
- In some cases, special accommodations for students with limited English proficiency may be necessary to obtain valid test scores. If students with limited English skills are to be tested in English, their test scores should be interpreted in light of their limited English skills. For example, when a student lacks proficiency in the language in which the test is given (students for whom English is a second language for example), the test could become a measure of their ability to communicate in English rather than a measure of other skills.
 - Likewise, special accommodations may be needed to ensure that test scores are valid for students with disabilities. Not enough is currently known about how particular test modifications may affect the test scores of students with disabilities; more research is needed. As a first step, test developers should include students with disabilities in field testing of pilot tests and document the impact of particular modifications (if any) for test users.
 - Test results should also be reported by sex, race/ethnicity, income level, disability status, and degree of English proficiency for evaluation purposes.

One adverse consequence of high-stakes testing is that some schools will almost certainly focus primarily on “teaching to the test” skills acquisition or even attempting to manipulate test scores after the fact (Jarvie, 2014). Students prepared in this way may do well on the test but find it difficult to generalize their learning beyond that context and may find themselves unprepared for critical and analytic thinking in their subsequent learning environments. Some testing companies, such as the Educational Testing Service (ETS), developers of the SAT, at one time claimed at coaching or “teaching to the test” would have little meaningful impact and still publicly attempt to minimize the potential effect of coaching or teaching to the test. Amusingly, while maintaining that stance in public statements, ETS simultaneously

offered and continues to market test preparation books for sale at a profit.

Perhaps the best rebuttal to such assertions is the career of Stanley H. Kaplan. An article in *The New Yorker* (Gladwell, 2001) documented not only Kaplan’s long career as an entrepreneurial educator, but also the fragility of “test security” and the ability to teach strategies that significantly improve test scores in exactly the way the industry claimed was impossible. When Kaplan began coaching students on the SAT in the 1950s and holding posttest pizza parties to debrief the students and learn about what was being asked, he was considered a kind of subverter of the system. Because the designers of the SAT viewed their work as developing a measure of enduring abilities (such as IQ), they assumed that coaching would do little to alter scores. Test designers seem to have given little thought to the notion that people are affected by what they learn, and that what they learn is affected by what they are taught (Gladwell, 2001). In addition, school curricula undergo change because of pressures from educators and parents. They typically respond to high-stakes testing by supporting curricula and teaching aimed at yielding higher scores. Kaplan’s methods have helped many students improve their test scores, notwithstanding the cautions of the test developers.

THE TESTING INDUSTRY

As the prior discussion of high-stakes testing illustrates, psychological testing has become big business. Apart from publishers who develop and revise test kits and computerized assessment tools, many large and small corporations develop and market assessment tools for mass-testing markets. In fact, because many managed mental health benefit programs require special approval before agreeing to pay for individualized testing, psychologists are doing less of it, and the profitability of some expensive test kits palls by comparison with the profit margins of entities conducting large-group testing programs. Finding accurate numbers regarding corporate revenues related

to the testing industry has become complicated because of corporate buyouts and consolidated revenue reports. One account from the 1970s (Kohn, 1975) noted that American school systems spent in excess of \$24 million annually in the early 1970s on testing secondary and elementary schoolchildren. Inflation alone would have grown that number to over \$1.5 billion annually by 2014.

Despite secretiveness about income related directly to testing services, Haney and his colleagues (Haney et al., 1993; National Board on Educational Testing and Public Policy, 2014) estimated their annual profits in the hundreds of millions of dollars. The actual revenues from testing most likely reach much higher numbers, given the increased number of people taking the tests and the increased number of test instruments for sale, particularly following the significant increase in high-stakes testing mandated under recent changes in state and federal law. The testing industry's "Big Four" Harcourt Educational Management, CTB McGraw-Hill, Riverside Publishing (Houghton Mifflin), and NCS Pearson write 96% of state-level competency exams, and NCS Pearson is the largest scorer of standardized tests (PBS, 2002). As one example of profitability, note that on February 28, 2014, Pearson reported a net operating profit of £458 million, equal to \$733 million (Pearson, 2014).

The spread of consumerism in America has seen increasing assaults on the testing industry (Haney et al., 1993; Kaplan, 1982; National Board on Educational Testing and Public Policy, 2014) and well-reasoned papers on test ethics from within the industry itself (Eyde et al., 2010; Messick, 1980; Reckase, 1998). Most of the ethical complaints leveled at the larger companies fall into the categories of marketing, sales to unauthorized users (Dattilio, Tresco, & Siegel, 2007; LoBello & Zachar, 2007; Rey-Casserly & Koocher, 2012), and the problem of so-called impersonal services. Publishers claim that they do make good-faith efforts to police sales so that only qualified users obtain tests. They note that they cannot control the behavior of individuals

in institutions to which tests are sent, and one could argue that documented episodes of improper sales (Oles & Davis, 1977) involved at least a modicum of deception (Turner et al., 2001). Because test publishers must advertise in the media provided by organized psychology to influence their prime market, most major firms are also especially responsive to letters of concern from psychologists and committees of the APA. The use of automated testing services, however, raised a number of potential ethical issues that led to frequent inquiries (Dattilio et al., 2007).

Automated Testing Services

The advent of the computer age made possible the bulk scoring and analysis of test data, creation of new profile systems, and generation by computer of reports that spring from the printer untouched by human hand or comment. As this period dawned, psychologists argued about the advantages of clinical versus actuarial prediction (Dawes, Faust, & Meehl, 2002; Garb, 2005; Grove, Zald, Lebow, Snitz, & Nelson, 2000; Holt, 1970; Meehl, 1954, 1997). That is, can a computer-generated, statistically driven, actuarial diagnosis or prediction be more accurate and useful than predictions by clinicians in practice? We do not take sides in that debate but simply note more recent developments (APA: 9.09; ACA: E.9).

Automated testing services and software can be a major boon to assessment practices and significantly enhance the accuracy and sophistication of diagnostic decision making, but there are important caveats to observe. Those who offer assessment or scoring services to other professionals should accurately describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use. Those who use such scoring and interpretation services should select them based on evidence of the validity of the program and analytic procedures. In every case, ethical practitioners 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 (APA: 9.09; ACA: E9).

Computerization clearly presents a wide assortment of clinical and ethical challenges for those conducting clinical assessments. Several large testing corporations offer test-scoring services to mental health professionals with nearly instant results based on scanned or faxed score sheets or on responses entered by a client from a range of desktop, laptop, or handheld devices. Users may have the ability to obtain test scores or interpretive report services. In the latter circumstance, the software can generate narrative paragraphs or simple statements describing the client diagnostically in terms of personality traits, vocational interests, or any of a number of other declarative or predictive ways.

Such applications have significant ethical implications for clinicians, client/responders, and those who construct or administer assessment systems. A lack of sophistication regarding hardware- or software-related issues may undermine clinicians' ability to ethically perform computerized psychological assessments. Both graduate students and practicing clinicians need exposure to ethical concerns, potential judgment errors, and pitfalls in evaluating computer-generated reports (Bersoff & Hofer, 2008; Rapp, 2006; Schulenberg & Yutrzenka, 2004). For example, the effects of computerization on item response theory, test designs, and emerging new item types on assessment practices demand attention (Hambleton, Bartram, & Hambleton, 2006). A comprehensive set of international guidelines on computer-based and Internet-delivered testing exists but remains mostly unknown to American practitioners and graduate students (Lievens, 2006). Special ethical concerns also come into play around computer-based testing for professional licensing (Melnick, Clauer, Bartram, & Hambleton, 2006) and school-based use of computerized psychological assessment measures (Knauss, 2001).

Although one can expect that computer programs will become increasingly important for psychological assessment, many automated assessment programs and statistical prediction rules offer limited value. For example, validity

may not be clearly established for many automated assessment programs. Statistical prediction rules may have limited value because they typically originate with sample populations or models that flow from limited information without significant statistical power. Garb (2000) offered significant recommendations for ethically building, evaluating, and applying new computerized assessment programs.

Many assessment instruments originally developed for research have increasingly found their way into clinical practice as outcome measures or assessment tools. It seems reasonable to expect that innovative clinicians will increasingly seek to adapt such tools for computerized administration and interpretation. Garb (2007) attempted to assist psychologists in deciding on the appropriateness of adapting interviews and rating scales for routine administration using computers. He focused on comparison of structured and unstructured assessment instruments, advantages and disadvantages of computer administration, and the validity and utility of computer-administered instruments.

One particular difficulty in the use of automated testing is the aura of validity conveyed by the adjective *computerized* and its synonyms. Aside from the long-standing debate within psychology about the merits of actuarial versus clinical prediction noted previously, some people display a kind of magical faith that numbers and graphs generated by a computer program somehow equate with increased validity of some sort. Too often, skilled clinicians do not fully educate themselves about the underpinnings of various analytic models. Even when a clinician is so inclined, the copyright holders of the analytic program may be reluctant to share too much information lest they compromise their property rights.

In the end, the most reasonable approach involves recognizing that automated scoring and interpretive services comprise but one component of an evaluation and to carefully probe any apparently discrepant findings. This suggestion will not surprise most competent psychologists, but unfortunately they are not the only users of these tools. Many users of such tests are nonpsychologists with little understanding

of the interpretive subtleties. Some will take the computer-generated reports as valid on their face, without considering important factors that make their client unique. A few users are simply looking for a quick-and-dirty source of data to help them make or justify a decision in the absence of clinical acumen. Other users inflate the actual cost of the tests and scoring services to enhance their own billing. When making use of such tools, psychologists should have a well-reasoned strategy for incorporating them in the assessment and interpret them with well-informed caution.

One obvious hazard involves lazy or incompetent practitioners, psychologists and nonpsychologists alike, who rely on artificial intelligence and programmers' skills. One mailing brought us news of a new office system available to psychologists who wish to find "improved patient care, increased interaction time, and cost efficiency" by administering and interpreting some 20 different scales, indices, checklists, surveys, inventories, and schedules. Areas covered include intelligence, child development, personality, vocational preference, somatic problems, symptoms, and a measure of "depression and hopelessness." Can a commercial enterprise ignore a marketplace expansion opportunity for the sake of ethics, even if it is unregulated by government? Consider the following cases:

Case 7-21: A firm providing computer-generated MMPI-2 interpretive reports ran an advertisement in the *APA Monitor* promoting a "sample kit" and everything one needs to use their service for a \$50 trial offer. The coupon stated that one must be a qualified user but did not specify what this means and sought no evidence from responders. Subsequently, the same company solicited psychiatrists in a direct-mail invitation to use the service.

Case 7-22: Ann O. Vation, M.S.W., licensed social worker, makes use of computer-generated vocational guidance interest reports to offer career counseling to her clients in an effort to expand her practice.

Both of these cases illustrate the reach of the automated testing services to professionals outside psychology, as well as an emphasis on

attracting new clients with little attention to the nuance of qualifications. The companies would argue that this is a clinician-to-clinician service, and the practitioner holds responsibility for use of the material. Representatives of such companies would also note that their interpretive reports are replete with cautions and warnings about the use of data. They might also argue that psychiatrists (or other physicians), social workers, marriage and family counselors, and other licensed mental health professionals have a right to such services. On the other hand, given that so many psychologists lack training to use certain complex psychometric tools, we must wonder how many nonpsychologist mental health service providers understand the complexities and proper use of these instruments. Such sales represent a serious ethical problem.

Case 7-23: An urban police department planned a civil service examination for new recruits and recognized the need to screen out psychologically troubled individuals. Because they could not afford to provide individual in-depth interviews for several hundred candidates, the department decided to use a computer-scored personality inventory as a sieve. Those candidates with deviant scores were selected for personal screening interviews to rule out serious psychopathology.

This case represents a fairly appropriate use of the instrument, but something interesting happened. A substantial portion of the applicants obtained "grossly deviant" scores. It seems that the hundreds of true-false items on the personality inventory came at the end of a daylong exam. Many of the candidates felt exhausted and found the items "silly" or "stupid." The purpose of the test was not explained by the civil service clerks administering the examination, so many candidates left most of the items blank, responded randomly, or "checked off the weird answers to gross out the administrators of the program."

Tyranny in the Marketplace

When a commercial testing company dominates a niche of the marketplace, a degree of tyranny can occasionally lead to abuses of

the consumer. The fact that the companies involved were founded and are managed by psychologists may offer little reassurance. The following case examples use the actual names of the testing companies involved:

Case 7-24: A high school student took the SAT on two separate occasions. The student's scores improved significantly between the two administrations, but the ETS, which owns and administers the SAT, refused to release the newer, higher score to colleges to which the student had applied. ETS personnel expressed the belief that the student cheated, citing mysterious statistical analyses they declined to make public. When the student threatened litigation and produced expert psychometric support, ETS offered a substantial settlement without admitting wrongdoing and requiring the student to keep the terms of the settlement confidential (Haney, 1993a, 1993b; Haney et al., 1993)

Case 7-25: The Professional Examination Service (PES) collaborates with the Association of State and Provincial Psychology Boards (ASPPB) to produce and administer the Examination for the Professional Practice in Psychology (EPPP), a multiple-choice examination used nationally in the licensing of psychologists. When state licensing board members previewed a draft copy of the EPPP, they discovered errors on several questions and notified PES. The testing company declined to make appropriate corrections and included three erroneous items in the next version of the EPPP administered nationally. The members of one state licensing board, who knew of the errors, granted licenses to three candidates who had "failed" the exam by virtue of making an "error" on one or more of the faulty questions, and one member of the licensing board wrote a journal article describing the entire incident. When leaders of PES and ASPPB were offered the opportunity to reply to the manuscript, they attempted unsuccessfully to block publication and ceased allowing state licensing boards to preview the draft examinations from that date forward. Representatives of ASPPB subsequently wrote a response that ignored the key issues and avoided mentioning their attempt to stifle publication of the information (Koocher, 1989a, 1989b; Rosen, Reaves, & Hill, 1989).

These cases illustrate that professional ethical codes do not necessarily ensure that psychologically sophisticated testing companies and the psychologists who manage them will act in the best interests of individual consumers, especially when the company holds a complete monopoly (as in the case of PES and ASPPB with respect to psychologists' licensing examinations) or dominates the marketplace (as ETS does with respect to college admissions testing).

USE OF TEST RESULTS

From the discussion in this chapter, it is evident that a "good test" may be ill-used, either by inappropriate application or by misuses of the resulting scores. In this section, we raise special questions about access to test results and the potential use or misuse that can result.

Problems of Consent

The issue of informed consent is discussed several times in this book as it involves important decision making by clients of mental health professionals. Insofar as assessment is concerned, clients have a right to know the purpose of the evaluation and the use that will be made of the results. They are also entitled to know who will likely have access to the information they provide to the evaluator. Such use and consent problems often arise when the individual who conducts the assessment does so as an agent of an institution or organization. Chapter 15 includes a detailed discussion of ethical dilemmas in special work settings, such as prisons, schools, and industry. Consent as an issue is also discussed in the chapters on psychotherapy, confidentiality, and research (Chapters 3, 4, 6, and 16, respectively). We raise it here to illustrate some of the special consent problems associated with psychological testing.

Consent implies three separate aspects: *knowledge*, *voluntariness*, and *capacity*. The person seeking the consent must disclose sufficient information for the person granting consent to understand fully what is being asked. It is not necessary to disclose every potential aspect

of the situation, only those facts a reasonable person might need to formulate a decision. Voluntariness refers to the absence of coercion, duress, misrepresentation, or undue inducement. Capacity refers to legal competence to give consent. Although all adults are deemed competent to grant consent unless they are found to be incompetent in a court proceeding, children are presumed to be incompetent to grant consent under the law.

Case 7–26: Testa Battery, Ph.D., was hired to consult with the Central City Fire Department. She put together a series of tests, including the MMPI, Rorschach inkblots, Thematic Apperception Test, Draw-a-Person, and a sentence completion series (i.e., all personality assessment tools) for administration to potential firefighters along with the standard civil service examination. Several of the firefighters protested that such tests constituted an invasion of their privacy.

A complaint by the prospective firefighters seems appropriate. Requests that job applicants reveal personal information that is not clearly relevant to the job in question constitutes an invasion of privacy (Lefkowitz, 2003; Lowman, 2006). Unless Dr. Battery has some basis for documenting the validity of the personality assessment techniques as firefighter selection tools, she appears to have committed an ethics violation.

Case 7–27: Patricia Popquiz, Psy.D., works as a school psychologist for the Central City School Department. She scheduled and supervised the administration of standardized achievement testing and IQ testing for all students in Grades 3, 5, 7, and 9, as has routinely occurred over the years. Much to her surprise, several parents complain that their children have been tested without their consent. She responds by saying, “But it was only routine testing!”

Dr. Popquiz sees no problem in continuing what has been the routine practice of the school system for many years. The fact that no one has complained previously does not immunize Popquiz from her responsibility to

solicit appropriate consent and to remove from the routine-testing program any child whose parents or guardians refuse to give consent. Permission may not be required for some systems or statewide testing related to specific school curricula, but it certainly is required for intelligence testing. Even routinely collected intelligence test data can have a lasting impact on a child’s education and life (Hobbs, 1975). If parents do not know that their child has been tested, they might never know that the scores exist. Inappropriate or erroneous data could not be challenged. While courts have ruled that the right of parents to veto testing is not absolute (Pryzwansky & Bersoff, 1978), failing to notify them at all is unquestionably unethical. Seeking cooperative consent is certainly good psychological practice, even if inconvenient. (We invite readers to skip ahead to Chapter 13 and Case 13–16 to see how the same principle applied to James P. Grigson, M.D., when he conducted a psychiatric assessment without adequate notice in a capital murder case.)

Obsolete Scores

Mental health professionals cannot ethically base their assessments, intervention decisions, or recommendations on outdated data or test results. We also do not base decisions or recommendations on obsolete tests and measures not useful for the current purpose (APA: 9.08; ACA: E.11). Determining the precise definition of obsolescence can sometimes prove a challenge.

Case 7–28: Helen Duration began working for General Tool and Power Company 8 years ago. She had taken some paper-and-pencil general ability tests during the hiring period. She has recently applied for a higher level opening within the company, but the personnel department is not seriously considering her because the test scores of 8 years earlier fall below those required for the new position.

The case of Helen Duration illustrates the problem of obsolescence. Test scores should be maintained in a client’s file only as long as they

serve a valid and useful purpose and continue to reflect the status of that client. Occasionally, some instruments do yield data that may be valid predictors some 8 or more years after they were collected, but that is a rare exception. The consulting psychologist who supervised the testing program at General Tool and Power Company should have cautioned the personnel department that Ms. Duration's scores should not form a basis for promotion decisions years later. In fact, efforts to ensure removal of obsolete test data from all employee files should occur as a matter of routine. Unlike testing done for employment purposes, clinicians and agencies must treat clinical test data differently and should generally manage it in compliance with HIPAA (Health Insurance Portability and Accountability Act) regulations as described in Chapter 6.

One survey of professional psychologists (Berndt, 1984) provided a "good news–bad news story." The good news: Most of the psychologists responding seemed to manage their testing practices in keeping with established ethical principles. They also seemed willing to give appropriate feedback on test results to clients. The bad news: Few of those surveyed had taken any steps to deal with the problem of obsolete data. The results also suggested that 76% expressed a willingness to release old test information to agencies with the consent of the client. This implied little recognition that such old records could be inaccurate or harmful.

It is difficult to formulate firm rules regarding when a given set of data is no longer useful; however, the APA *Record Keeping Guidelines* (APA, 2007) offer general guidance, and the *Standards for Educational and Psychological Testing* (American Educational Research Association, APA, & National Council on Measurement in Education, 2014) give some helpful examples. Broad test scores used for initial employment screening have little usefulness if more detailed evaluation follows and are certainly of no value after a year or more of employment. Likewise, college placement test scores have little value after the college course work is completed. Retention of such data (particularly low scores) could have a long-term

stigmatizing effect on test-takers. It is certainly possible to code data for use in long-term archival research, when indicated, while removing all traces of the same data from individual files.

Access to Test Data

Fairly uniform agreement among professionals holds that clients have the right of access to information about themselves and that parents have similar access to information about their minor children. The specific nature of the information, however, has sometimes been raised as a question. While this topic is addressed Chapter 6, test data present some special difficulties because they seldom stand alone for interpretation. The test scores themselves may well prove meaningless or be misinterpreted by a layperson. One way of handling this is to frame reports in plain language, keeping in mind that the reports are likely to be read by the people about whom they are written. Likewise, those who work with children must frame their reports with the parents' right of access in mind. At the same time, HIPAA and state laws (as described in Chapter 6) clearly do consider test data (APA: 9.04) as medical records, accessible to the client (or parents of a child client). The ethics code of the ACA uses language more akin to earlier APA codes by stating that: "Such data are released only to persons recognized by counselors as qualified to interpret the data" (ACA: E.4). That element of the ACA code runs counter to the legal requirements of both HIPAA and FERPA (Family Educational Rights and Privacy Act), as described in Chapter 6, in the sense that parents do have a legal right to such data but most parents are not "qualified to interpret" the data without professional help.

Mental health practitioners who conduct assessments of individuals involved in litigation must expect that they will have to provide raw data (i.e., scores, observations, and client responses to test stimuli) to nonexperts in response to court orders or releases signed by the client (Committee on Legal Issues of the American Psychological Association, 2006). Although ethics codes have traditionally discouraged

release of raw data to unqualified persons (ACA: E.4; older APA codes), we must clearly provide such data in response to a client release, to the client/patient or others identified in the release (APA: 9.04). We may seek to refrain from releasing test data not only to protect a client or others from substantial harm, misuse, OR misrepresentation but also must also recognize and obey the law (APA: 9.04).

In general, the best strategy in such circumstances is preventive (see Chapter 6 for a discussion of responding to subpoenas). Records should be kept with the understanding that they may ultimately be released to the client or to a court. We should write test reports with a directness and clarity that makes it possible to give copies of the report to the client. Ideally, the practitioner will review the report together with the client and address any questions that come up (APA: 9.10; ACA: E.3.a). If asked for test manuals, printed record forms, or other copyrighted test materials, the psychologist may decline to provide them and refer those making the request to the published source (APA: 9.11; ACA: E.10). Actually, a considerable amount of test material is readily available in the public domain.

Case 7–29: As part of a diagnostic evaluation, Dr. Ira Median administered intellectual and personality assessment tools to Victor Vector, age 8. Victor's parents felt dissatisfied with Dr. Median's evaluation and recommendation that Victor needed psychotherapy. They demanded a copy of all the tests and the answers that Victor gave, along with a copy of Dr. Median's report, as they prepared to seek a second opinion.

If Victor Vector's test protocols, for example, include themes that some might call "murderous rage," "Oedipal anger," or similar psychodynamic concepts, one would hope that Dr. Median will deal with the meaning or basic issues, as opposed to something like "Victor told stories in which an angry boy persistently kills evil father figures." Rather, Dr. Median might write: "Victor's test data suggest that he has difficulty dealing with angry feelings, especially in his relationship with his father or

authority figures." This sort of writing can convey all appropriate meaning, while avoiding jargon, which may be misunderstood or upsetting to the client.

Case 7–30: The Detroit Edison Company posted notice of six vacancies for the job classification "Instrument Man B" at a new power plant. All 10 employees who applied for the openings failed to achieve the acceptable cutoff score the company had set on a battery of psychological aptitude tests, so the vacancies were filled by promoting employees with less seniority who had scored at or above the recommended cutoffs. A union grievance was filed, and the union sought copies of the tests, employees' answer sheets, scores, and other related data, claiming that this was essential for arbitration (Eberlein, 1980).

The case involving Detroit Edison went to the Supreme Court, with the APA filing an amicus brief in support of withholding the requested information (*Detroit Edison Company v. National Labor Relations Board*, 1979). By a 5–4 vote, the court agreed that the "undisputed and important interests in test secrecy" justified refusing to turn over the tests and answer sheets directly to the union. The court noted that retaining test security represented a greater benefit to the public than would open disclosure of the test contents. By a 6–3 vote, the court also ruled that the union's need for information was not so great that it required breaching the promise of confidentiality to the examinees or breaching of the psychologists' code of ethics and resulting potential embarrassment to the examinees.

Teaching Psychological Testing

Psychologists who teach assessment have a unique opportunity to shape their students' professionalism and approach to ethics by modeling the active integration of professional ethics into the practice of assessment (Kaplan & Saccuzzo, 2014; Rey-Casserly & Koocher, 2012; Yalof & Brabender, 2001). Ethical standards in the areas of education and training are relevant: "Psychologists responsible for education

and training programs must ensure that the programs offered will provide the appropriate knowledge and proper experiences, and to meet the requirements for licensure, certification, or other goals for which claims are made by the program" (APA: 7.01). Other professions engaged in assessment agree that primary responsibility involves ensuring competence in assessment practice by providing the requisite education and training (ACA: F.6).

We must continually ask ourselves whether our educational programs provide adequate breadth and depth of assessment experience using a competence-based approach (Kaplan & Saccuzzo, 2014; Rey-Casserly & Koocher, 2012). One review of studies evaluating the competence of graduate students and practicing psychologists in administration and scoring of cognitive tests demonstrated that errors occur frequently at all levels of training (Alfonso & Pratt, 1997). The review also noted that relying only on practice assessments as a teaching methodology does not ensure competent practice. The authors concluded that teaching programs that include behavioral objectives and focus on evaluating specific competencies are generally more effective.

Multiple-role problems also frequently complicate courses in psychological assessment. One example involves the common practice of using children of friends or relatives and students' classmates as "practice" subjects in psychological testing courses (Rupert et al., 1999). Imagine the complications when testing the child of a friend and the outcome does not yield "good results," whatever that means to them or their family. The potential for violations of privacy can prove significant if graduate students are required to take personality tests or "practice" assessing their peers. Yalof and Brabender (2001) argued that students' introduction to ethical decision making in personality assessment occurs in assessment courses with practice components. They recommended that instructors demonstrate, highlight, and explore ethical principles with their students. They focused on four particular concerns: students' role in procuring personal experience with personality testing, identification of participants

to practice on, development of informed consent procedures for assessment participants, and classroom presentations. Their discussion offered good illustrations of the relevant ethical principles.

One interesting solution involves asking students to role-play test subjects with different cognitive or emotional issues. By assigning client roles with details about particular styles and personalities, the student can both follow the assigned script and attempt improvisation based on their own research into the problems being assessed and instruments to be used.

DIY (DO-IT-YOURSELF) TESTS

It should come as no surprise that people are fascinated about do-it-yourself (DIY) psychological testing, particularly now that the Internet has automated what was once the province of popular magazines (e.g., to answer the question, "How good a [insert the noun of your choice: lover, parent, student] are you?"). Executing a Google search on psychological testing in 2007 yielded more than 1 million hits. Seven years later, an identical search on Bing yielded 26.7 million hits. When addressing psychological testing on the Internet, most members of the psychological community will think first about matters of data integrity, validity, security, or similar professional issues (Barak & English, 2002; Naglieri et al., 2004; Rapp, 2006). Others have expressed worries about the test security after finding sales of obsolete and unwanted test materials on Internet auctions (LoBello & Zachar, 2007). During one 3-month interval of monitoring eBay, Lobello and Zachar (2007) found 82 tests or partial tests for sale. A quick scan of eBay in October 2014 easily turned up a range of psychological test kits and materials for sale to anyone, as well as T-shirts and coffee mugs emblazoned with accurate reproductions of the Rorschach inkblots.

Members of the public have increasingly become fascinated with DIY tests available online. As noted in Chapter 11, many such self-care products put the public face of the

mental health profession in a confusing situation. Tests have circulated on the Internet for years, purporting to assess physical conditions (e.g., risk for assorted diseases, genetic conditions, and HIV testing). Increasingly, one can find psychological mass-screening tools (e.g., attention deficit disorder, early Alzheimer disease, depression) or actual claims of valid online DIY IQ and personality assessment. Often, the tests appear on websites associated with the advertisement of services for the problem purporting to be assessed. The ethical issues regarding DIY tests mirror criticisms of some self-help books. These include insufficient regulation or professional oversight of test validity, potential for misuse and errors in interpretation, and absence of in-person support counseling (Kier & Molinari, 2004).

Some of the online instruments seemed grounded in meaningful research, while others present more ambiguous constructs. For example, one site apparently based at the University of Pennsylvania under the auspices of a former APA president purported to assist participants in determining whether they have authentic happiness, leading to the question of whether inauthentic happiness represents delusional thinking. That site required a personalized log on and appeared intended for data collection and marketing related to other authentic happiness products. Another site with no clear expert connections offered a wide range of online testing opportunities. One fascinating site offered a personality assessment based on color preferences and described the task as follows:

ColorQuiz is a free five minute personality test based on decades of research by color psychologists around the world. There are no complicated questions to answer, you simply choose colors with a click of the mouse! Your test results are completely confidential and we do not keep the results. Take the test now.

This test is based on the work of Dr. Max Lüscher and is used worldwide, most notably in Europe, by psychologists, doctors, government agencies, and universities to screen their candidates. Since the 1950s, the test has been given

to hundreds of thousands of people. Sadly, the site neglected to provide any specifics related to validity, although later text essentially acknowledged no reliability because “human moods change.” Americans were also warned that they may not fully grasp the concept of the test because of its European origins.

While most such tests may prove analogous to self-help books, one seems particularly noteworthy because of its potential to inflict distress. The Implicit Association Test (IAT) is a cognitive task ostensibly helping diagnose implicit preferences the test taker possesses but does not consciously recognize. According to information on the website, more than three quarters of the people who take a given test discover that they demonstrate implicit preferences for Whites over Blacks or for the young over older adults or that they subtly endorse gender stereotypes about relative abilities of men and women (Blanton & Jaccard, 2006; Blanton, Jaccard, Gonzales, & Christie, 2006). Of course, feedback of this sort can be disconcerting and distressing to people who believed, prior to taking the IAT, that they did not have such prejudices. The website offers advice for these individuals (Blanton & Jaccard, 2006; Blanton et al., 2006).

A website funded by the National Science Foundation and National Institute of Mental Health presents the public with an opportunity to take the IAT, and thousands have done so, often at the recommendations of people in the corporate world who promote or sell “diversity training” of various sorts. Blanton and his colleagues (Blanton & Jaccard, 2006; Blanton et al., 2006) cited the IAT as a prime example of inappropriate use of arbitrary metrics in psychology. They noted that many psychological tests have arbitrary metrics but remain appropriate for testing psychological theories. Metric arbitrariness becomes a much more significant concern when researchers wish to draw inferences about the true, absolute standing of a group or individual on the psychological dimension being measured. In the IAT, this ostensibly happens based on the milliseconds required to alternate between keystrokes at a computer keyboard in response to photographs or words flashed on the terminal screen.

The social psychologists who designed and promoted (or continue to promote) the IAT do so with many good intentions and clinically unsophisticated caveats to those who stumble onto or are directed to the site. Sadly, those directing others to the site often have little understanding of the underlying problems intrinsic to the whole exercise (Arkes & Tetlock, 2004; Azar, 2008; Tierney, 2008). To the extent that people sitting alone at a computer terminal taking the IAT depart feeling somehow diminished by the experience, the developers have inflicted harm. Have they done so with informed consent? Possibly. Have they done so with scientific rigor, accuracy, and concern for the welfare of those who feel hurt? Absolutely not.

WHAT TO DO

- Take care to understand and apply basic knowledge in psychometrics.
- When developing a test or assessment technique, prepare a manual that provides all relevant instructions for administration and scoring, as well as the psychometric foundations (e.g., sample, norms, reliability, and validity data).
- Use assessment tools that are well validated and for which you have the necessary education and training.
- Select each instrument or technique with an understanding of its strengths and limitations with respect to the referral questions you hope to answer.
- Clients should be informed in understandable terms of the purpose and intended use of the tests and test data.
- Provide feedback because clients have a right to know the results of an evaluation and a right to have test data kept confidential within the limits promised when consent is obtained.

WHAT TO WATCH FOR

- Make sure that the assessment tools you use are appropriate in terms of norms and

validity for the clients you plan to test and for the conclusions you hope to reach.

- Understand the limits of the tools you use.
- Follow the test manual administration and scoring standards carefully.
- Remain aware of potential test bias or client characteristics that might reduce the validity of the instrument for that client in that context.
- Report specific cautions along with test data in any situations in which bias or other problems with validity are suspected.
- The validity and confidence of test results often relies on the security of certain test information or items; protect this secure information carefully.
- Automated testing services create a hazard to the extent that they may generate inaccurate data or produce valid results that are subsequently misused by individuals who do not fully understand the instruments or apply the same stringent safeguards required with manually administered tests.

WHAT NOT TO DO

- No test user is competent to use every standardized assessment tool. Do not be tempted to use new instruments without appropriate training.
- Do not employ assistants to administer tests unless they have appropriate training and supervision.
- Do not neglect informed consent. Clients (or their parents or legal guardians) must be given full informed consent about the nature of the evaluation, payment for services, access to results, and other relevant data prior to initiating the evaluation.

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8

Nonsexual Multiple-Role Relationships

Good habits result from resisting temptation.

Ancient proverb

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Ethics complaints based on sexual and nonsexual role blurring comprise the most frequent type of complaint brought to the ethics committee of the American Psychological Association (APA; Knapp, Bennett, & VandeCreek, 2012) and a common category of licensing board actions (Bader, 1994; Knapp, Younggren, VandeCreek, Harris, & Martin, 2013; Montgomery & Cupit, 1999; Neukrug, Milliken, & Walden, 2001; Sonne, 1994).

Sexual intimacies with current clients are considered unethical under any circumstances. However, ethics codes reveal relaxed admonitions from earlier mandates that essentially forbade virtually any boundary crossing with psychotherapy clients (APA: 3.05, 7.04; American Association for Marriage and Family Therapy [AAMFT]: 1.3, 1.7, 4.6; American Counseling Association [ACA]: A.6; National Association of Social Workers [NASW]: 1.06, 3.01). Debates do continue regarding the point at which a boundary crossing becomes a boundary violation. Views continue to remain divergent, ranging from avoiding interactions or discourse falling outside therapeutic issues to treatment orientations that almost obliterate the difference between “therapist” and “good buddy.” The addition of individual clients’ tolerance for a boundary crossing further complicates the matter, as seen in the first case.

Case 8-1: Melvin Chatty, Ph.D., maintained a therapy style that involves frequent revelations about his own life struggles and triumphs that paralleled those of a client, believing such sharing deepened the therapeutic alliance and proved to clients that such issues can be successfully resolved. Charlie Splitup found the story of Dr. Chatty’s divorce helpful in managing his own quest to become happily single again. Alice Fears found his recollections of moving from a small town to a large city reassuring and comforting. Dr. Chatty’s personal stories about his own problem with alcohol in his youth made Gin Jumpy uncomfortable, and Buck Waste quit therapy with Dr. Chatty after three sessions because he talked too much about himself.

A too rigid stance with regard to boundaries may deprive clients in ways that are counter

to their treatment needs (Barnett, 2014). However, when a client experiences a boundary crossing as uncomfortable or unwanted, it is probably a boundary violation. If it causes an individual client harm, it is definitely a boundary violation (Barnett, Lazarus, Vasquez, Moorehead-Slaughter, & Johnson, 2007). This means that considerable demands are placed on competent, individualized decision making for each treatment dyad (Gottleib & Younggren, 2009).

It is instructive to point out how entering into a complex multiple-role relationship can feel so right at the time, with no hint of how it could eventually unravel like a cheap sweater. As an example, writer Susan Shapiro and her long-time, greatly admired psychotherapist decided to create a book together. He would supply the material, and she would do the writing. She was not paid for her service, and he did not charge his usual \$200 a session for therapy. Royalties would be split 50/50, and the authorship would have his name first followed by “with Susan Shapiro.” It seemed like a win-win proposition at the time. However, as Shapiro began to learn more of her therapist’s very private life, she came to believe he was sabotaging the project, perhaps because of his own issue with a parent resulting in a fear of success. On confronting him—almost as a therapist would confront a client—the relationship began to stall and dissolve. Shapiro experienced feelings of rejection and abandonment. After a series of back-and-forth jousting, the book was ultimately published. But, the psychological costs seemed higher than any monetary benefit (Shapiro, 2011).

BOUNDARIES AND MULTIPLE ROLES

Boundaries can range from crisp to fuzzy. Boundary blurring can be formed intentionally or arise unexpectedly and can readily involve conflicts of interest (Ebert, 2006). Some boundary crossings prove beneficial to clients and do not even necessarily create a multiple-role relationship. Limited or inconsequential contacts

growing out of chance meetups with clients would not normally fall under the definition or cause any ethical concerns, although we illustrate how unexpected encounters can be awkward and may require some fast decision making. Other boundary breaks are extremely harmful, depending largely on the context intent of the therapist.

Multiple-role relationships with clients and students are viewed as unethical when objectivity is compromised, competence degrades, effectiveness in performing professional functions could become impaired, or if a risk of exploitation might result (APA: 3.05; AAMFT: 1.3, 4.1; ACA: A.6; NASW: 1.06, 3.01, 3.02). The APA defines multiple-role relationships as occurring when a therapist is already in a professional role with a person while in another role with the same person, is in a relationship with someone closely associated with or related to the person, or makes promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

To qualify under the APA definition, the initial relationship typically requires an established connectedness between the parties. The primary role is usually with an ongoing therapy client, although it could be with another significant individual, such as a client's family member or close relation. Nonsexual consecutive role relationships with *ex*-clients do not fall under any specific prohibitions. However, based on the posttherapy incidents we describe, caution is advised even after a natural termination of the professional role (see NASW 1.06.c).

Some boundary crossings are difficult to define and evaluate. For example, just as some dentists may sell electric toothbrushes or audiologists sell hearing aids to their patients, mental health professionals may have books, tapes, videos, or other therapeutic aids available for clients to purchase. Such products may be beneficial, but clients may find it difficult to resist a sales pitch from their therapist/vendor, especially for those promoting products created by the therapist. Although not strictly forbidden, the slope is slippery, and the related ethical issues can be debated (Sommers-Flanagan, 2012).

DIFFERING VIEWS ON NONSEXUAL BOUNDARIES

Those mental health professionals who decry the concept of boundaries argue that maintaining rigid roles promotes psychotherapy as a mechanical application rather than relating to clients as unique persons. Such rigid, cold, and aloof "cookbook therapy," they say, harms the formation of empathy and stunts the natural process of psychotherapy. Instead, acting as a fully human therapist provides the most constructive way to enhance personal connectedness and honesty in therapeutic relationships (Hedges, 1993) and may even improve professional judgment (Tomm, 1993). Lazarus (1994) put it bluntly: "Practitioners who hide behind rigid boundaries, whose sense of ethics is uncompromising, will, in my opinion, fail to really help many of the clients who are unfortunate enough to consult them" (p. 253). Those who criticize drawing firm boundaries further assert that role complexities are inevitable, and attempting to control them by invoking authority (e.g., through ethics codes) oversimplifies the ramifications inherent in the psychotherapy process and creates the practice of defensive therapy (Bogrand, 1993; Clarkson, 1994; Lazarus & Zur, 2002; Ryder & Hepworth, 1990).

Because ethics codes now specify fewer specific restrictions, mental health professionals may feel empowered to make role-blending judgments based on the *likelihood* that exploitation or harm reasonably might or might not occur. Such decisions emerge from the context of the therapy, not a list of rules (Zur, 2014). Although we certainly agree that careful consideration must precede softening of boundaries, accurate outcome predictions are hardly guaranteed. Furthermore, boundaries that are more lax might place the unaware therapist at far greater risk than earlier, stricter rules. Why? "Exploitation" and "harm" are general terms, somewhat vague, and open to interpretation. Therefore, any client who claims exploitation or harm when roles became complicated could be difficult to challenge and refute. Ethics committees, licensing boards, and juries will make those findings on a case-by-case basis. The

takeaway message here is that any boundary crossing or multiple-role formation should be documented regarding what was decided and why should it ever become necessary to explain a deviation from a relationship focused strictly and objectively on the client (see ACA: A.6.c).

Our stand on role blending is somewhat conservative given the harms ill-conceived decisions can cause clients as well as therapists. We do recognize the impossibility of avoiding all nonprofessional interactions with clients and acknowledge the futility of setting firm boundaries appropriate for every client under every circumstance. However, we agree with Pope's (1991) contention that the therapeutic relationship should be secured within a reliable set of boundaries that both therapists and clients can depend on. Similarly, Knapp and VandeCreek (2006) asserted that boundaries create a safe atmosphere that allows a relationship to develop without worrying about the needs of the therapist. Borys (1994) noted that clear and consistent boundaries may constitute a curative factor in and of itself. In short, the therapy relationship should remain a sanctuary in which clients can focus on themselves and their needs while receiving clean feedback and guidance.

All intentional decisions to blur roles require sound clinical judgment indicating clearheaded self-awareness of one's motives, an assessment of how the client would benefit, and any foreseeable consequences. A consideration of cultural differences is also essential. Pack-Brown and Williams (2003) suggested multiple-role relationships, as proscribed in professional ethics codes, reveal Eurocentric values (e.g., distance over closeness, detachment over attachment, and objectivity over influence), which results in a "cultural bias toward bounded rather than fluid relationships" (p. 148). We would not suggest that therapists violate ethical codes because a client's culture would find adding another role acceptable or even desirable, but a full understanding of cultural differences, how they manifest themselves, and the ability to communicate effectively with clients are essential groundings for a successful therapeutic alliance (see Chapter 5).

For therapists already predisposed to blend roles, rationalization processes are probably well under way, thus subverting the accuracy of any personal risk assessment. One can even rationalize inappropriate role blending as benevolent or therapeutic. As Gabbard (1994) concluded: "Because the needs of the psychotherapist often get in the way of the therapy, the mental health professions have established guidelines . . . that are designed to minimize the opportunity for therapists to use their patients for their own gratification" (p. 283).

We must face an unfortunate reality: Psychotherapy provides an almost-ideal climate—a "perfect storm" if you will—for emotionally or morally precarious mental health professionals to seek to gratify their personal needs. The settings are private and intimate. The authority falls on the side of the therapist. And, if things turn sour, the therapist can eliminate the relationship by unilaterally terminating it. While reviewing the cases in this chapter, do note the pervasive incidence of harm perpetrated by therapists who were, themselves, out of touch with the impact of their judgments about those they were supposed to be helping.

CAUTIONS

Perhaps the most difficult message for us to convey in writing is how *right* it might feel at the time to slip into a more complex role with clients. Our brief case stories summarize situations that often take weeks and months to unfold. One needs to pay attention to warning signs. (See Chapter 17 for a detailed list of red flags.)

We also need to stress the importance of assessing how venturing into crossing a boundary is perceived by clients. The exact same content may elicit exceedingly different interpretations (Pope & Keith-Spiegel, 2008). The intent of one party and the impact on another are not always congruent. For example, a male therapist in his 40s says to a young female client who enters the office for her second session, "My, my. Don't you look gorgeous today!" A client could construe what was meant as a simple compliment as flirtatious, maybe embarrassing,

or even harassing. But, if the therapist is a married 68-year-old proud grandfather of six who has been seeing the client for 6 months, it is unlikely that the same remark would come across as anything other than benign or supportive.

Risky Therapists

Therapists with underdeveloped competencies or poor training can sometimes be more prone to improper role blending. However, even those with excellent training and high levels of competence may relate unacceptably to those with whom they work because their own boundaries are not firm or they feel a need for adoration, power, or social connection.

Self-Disclosing Therapists

Therapists cannot help but disclose some personal information. Choices, such as mode of dress, office décor, preferences for how clients should address them, speech mannerisms (e.g., the use of profanity), and scores of other visual and vocal clues will inform clients beyond the more obvious age, gender, voice characteristics, and professional credentials. Most of the time, more purposeful disclosing has no clear ethical implications, although Knapp, VandeCreek, et al. (2013) discussed how what they call “behaviors on the ethical rim” may unintentionally interfere with client expectations for successful therapy and perceptions of competence.

How much, what, and under what circumstances therapists should disclose personal information about themselves has been a heated topic of interest (e.g., Bloomgarden & Mennuti, 2009; Bridges, 2001; Cristelle, 2011; Farber, 2006; Goldstein, 1997; Striker & Fisher, 1990; Zur, 2007). Some hold the position that therapists should share only professionally related information. But, most mental health professionals apparently do knowingly self-disclose, at least on occasion (C. E. Hill & Knox, 2001; Pope, Tabachnik, & Keith-Spiegel, 1987; Yeh & Hayes, 2011). The question, then, is not related to if but to how, when, why, and what.

Self-disclosures can be benign and helpful (Knapp & VandeCreek, 2006), and many

studies have examined the role played by self-disclosure in the process of therapy (e.g., Davis, 2002; Farber, Berano, & Capobianco, 2004; Kim et al., 2003; Z. D. Peterson, 2002). Therapist visibility can increase the connection with the client and affords marginalized clients more power in the relationship (Vasquez, 2007). However, those who engage in considerable and revealing self-referencing stand at greater risk for forming problematic relationships with clients. Whereas well-considered illustrations from the therapist’s life may help make a point or signal empathy, absorbing therapy time with extended renditions of one’s own personal history and family issues is not typically justifiable.

Case 8–2: Harvard Strutter, Ph.D., looked forward to sessions with Lois Teem, a young client struggling with the demands of college life, feeling insecure and unprepared. Strutter relished telling his own stories of success as an undergraduate, thinking they would inspire Ms. Teem. Strutter was taken aback when Ms. Teem complained to the counseling center director about his “bragging” taking up most of every session and making her feel even more deficient.

Those favoring appropriate self-disclosures in therapy assert that more authentic alliances can be created, that clients can better understand how everyone has failings and insecurities, and that therapeutic engagements can be strengthened. Furthermore, new insights and perspectives may free clients to disclose difficult and shameful material (Bridges, 2001; Curtis & Hodge, 1994; Z. D. Peterson, 2002; Williams, 2009; Zur, 2007). But, such disclosures can go only so far,

Case 8–3: Matt Dillinger, M.D., decided to share his fantasy with a client who was feeling anxious about the extent of her rage toward her ex-husband. Dillinger revealed his intense dislike of a colleague and how he enjoyed imagining himself “tracking him down and shooting him in the street like a dirty dog.” The client was stunned by Dr. Dillinger’s bizarre fantasy and never returned.

Concerns center on intentional self-disclosures for the purpose of gratifying the

needs or desires of the therapist, that burden or confuse clients, or are excessive or unwelcomed (C. E. Hill & Knox, 2001; Keith-Spiegel, 2014; Zur, 2007). Contextual issues are important; these include the therapist's theoretical orientation and treatment approaches as well as client factors, such as culture, gender, mental health history, current treatment needs, and agreed-on goals. However, even though becoming too relaxed when sharing one's own personal life (or ignoring unexpected client reactions to disclosures) may not result in a formal ethics charge, effective psychotherapy can be compromised (Barnett, 2011).

Clients, of course, may instigate inquiries into their therapists' personal lives. It seems reasonable to expect they would want to know about the person in whom they are placing considerable trust. So, we agree with Lazarus's (1994) contention that it feels demeaning to have an inquisitive client's question dismissed by responding with another question: "Do you have children, Dr. Shell?" "Why do you ask me, Maurice?" Not all clients' questions should be answered, of course, and it may prove wise to explore the intent of a client who is too curious. Skillful therapists can respond without demeaning their clients while reserving the right to consider their own level of comfort (Barnett, 2011; Goldstein, 1997).

Of course, clients can obtain answers to at least some of their questions without ever asking directly. Internet searches can turn up highly personal information, even when therapists are careful not to participate in social media and actively attempt to keep a low profile on the Internet. (More about these issues, including therapists trolling for information about clients, is discussed in Chapters 6 and 11.)

Case 8-4: Bernard Public, Ph.D., accepts any friendship offer on Facebook. His family as well as his clients have been "friended" and can view his entire wall. He posts photos of his children, wife, home, and office and shares stories about his travels and hobbies. When a client entered an irrelevant comment complaining about something Dr. Public said during a session, everyone else chimed in, mostly to defend Dr. Public and accuse

the poster of being mean and "a loser." The client felt humiliated and attempted to press an ethics complaint. Dr. Public maintained that he never discussed psychotherapy or his clients and only wanted his clients to see him as a normal human being just like themselves. He had not anticipated getting into this kind of pickle.

Although an ethics committee did not find Dr. Public guilty of an ethics violation, they strongly suggested he rethink his Facebook privacy settings and the wisdom of giving clients that much access to his private affairs.

Professional Isolation

Professional or personal isolation conspires to cloud professional judgment and decision making (Cooper, 2009). The therapist described in the next case might elicit sympathy were it not for her ill-conceived approach to coping with her own unmet needs.

Case 8-5: Ima Lonely, Ph.D., an unhappy divorced mother of two adult children who lived hundreds of miles away, maintained her practice in the living room of her home. She often served wine and appetizers after the therapy session and sometimes invited herself along on clients' social outings. She appeared to keep a string of perennial clients to provide her with a sense of family. Eventually, a client complained about her excessive intrusion into his family's life.

During ethics committee meetings, we could not help but notice how many cases involving boundary blurring (including sexual ones) occurred among therapists who maintained solo practices, often in remote offices removed from other mental health professionals. Something about therapists either choosing to work in isolation or the isolating conditions themselves appears to cloud the maintenance of professional standards of care. Regardless of the reason, an insular practice with no provisions for ongoing professional contact diffuses professional identity, especially given that it is not difficult to find ways to engage in collegial support.

Examples include peer supervision groups, consultation, participation in professional associations, continuing professional education programs, and Internet news and chat groups.

Therapeutic Orientation and Specialty Practices

Some therapists practicing according to types of orientations are likely more vulnerable to charges of boundary violations. Simon's (1988) research, for example, revealed how therapist self-disclosure differed significantly depending on whether psychotherapy is practiced as a process working through the clients' transference or on the interconnections between client and therapist. Williams (1997) noted that adherents of humanistic and encounter group philosophies based on tearing down interpersonal boundaries often disclose a great deal about themselves, hug their clients, and insist on the use of first names. These therapists become, according to Williams, more vulnerable to ethics complaints even though they are practicing according to their training.

Some therapists who specialize with a particular clientele or in certain venues may need to exercise extra vigilance because they can be conducive to (or even require) relaxed boundaries. Sports psychologists, for example, often travel, eat, and "hang out" with a team and may be called on to fill water bottles and help out with whatever else needs doing (M. B. Anderson, Van Raalte, & Brewer, 2001). A more complex relationship exists for mental health professionals placed in military units, where quarters are close and they, unlike embedded journalists, are expected to tend to the unit's needs and even engage in combat (Johnson, Ralph, & Johnson, 2005). In such instances, murky edges may be inherent in the nature of practice rather than inappropriate.

Pastoral counseling, by which the therapist may also function as the client's religious guide, presents a particularly sensitive preexisting dual role.

Case 8-6: Mildred Devine requested counseling from her minister, Luther Pew, for what she termed

a "spiritual crisis"; Pew also held a license in marriage and family therapy. Ms. Devine relayed her uncertainties, blaming God for having forsaken her. Rev. Pew responded by disclosing his own questioning of faith and shared some crises he was coping within his own family. Miss Devine became upset by these revelations, passed them along to other parishioners, and left the church. Several weeks later, she made a suicide attempt and required hospitalization.

Reverend Pew appears to have mismanaged his parishioner's clinical depression by misjudging its intensity and his own lack of competence to treat it. He also interjected too much from his life while failing to recognize Ms. Devine's request for spiritual guidance, not her minister's confessions. Pew should have stuck to his role as a pastor and referred Ms. Devine to someone competent to treat her depression.

Risky Career Periods for Inappropriate Role Blending

Therapists who engage in inappropriate role blending are often inexperienced. Many have come from graduate programs in which students developed complex relationships with their educators and supervisors. Similarly, the internship or residency period usually involves multiple roles, including social, evaluative, and business-related activities (Slimp & Burian, 1994; see also Chapter 10). Mental health professionals new to functioning independently may have had insufficient opportunity to observe other professionals with appropriate boundaries in place. Further, some therapists have experienced appalling supervisory models, involving sexual advances and other improper behaviors, when they were students, which could misocialize them even before they begin to practice independently (Glaser & Thorpe, 1986; Pope, Levenson, & Schover, 1980).

Other early career therapists may be overly eager to do everything right and make no mistakes, which could lead to an unhealthy risk-avoidance posture. Unless such therapists can become comfortable with their role, they may become inflexible and face

difficulties engaging clients in meaningful ways (Behnke, 2009).

The midcareer period can be risky for therapists whose profession or life in general has not panned out according to the dreams of their youth. Therapy may feel less involving and more routine. Divorce or other family-based dysfunction, onset of a chronic illness, and apprehension about aging are among other midcareer difficulties that can interfere with professional judgment. The majority of therapists who engage in sexual relationships with their clients are middle-aged.

Another elevated risk period occurs at the far end of the career cycle. Sometimes, older therapists have, perhaps without full awareness, come to see themselves as evolved beyond questioning and bestow on themselves a “senior pass” to do whatever they please.

Case 8–7: Reddy Beenthere, Ph.D., just celebrated 40 years in practice. He quit trying to keep up with the professional literature long ago. Because of his professional longevity, he believed therapy just came naturally to him without putting in much thought. An ongoing client brought in a friend with whom she was experiencing significant conflicts for a joint session. The session went poorly, with loud accusations between the client and her friend. Nevertheless, Beenthere liked the friend, who shared his own interest in jazz, so he called the friend right after the contentious session to invite him to meet at a jazz bar for drinks. Additional social meetings followed. The client discovered the liaisons, felt betrayed, quit therapy, and filed a complaint.

Case 8–8: Gloria Vast, Ph.D., refers to herself as the “grand dame of psychology.” For many years, she has run encounter groups based on her long-standing best-selling book, *Touch Yourself, Touch the Universe*. Now in her late 60s, she pays several of her current clients minimum wage to assist her. Should her client-workers become disaffected, she berates them and sometimes banishes them. One client expelled from the circle successfully pressed charges of exploitation with the state licensing board.

Dr. Beenthere was unprepared for the letter from the ethics committee, wondering what

business it was of anyone’s to say with whom he could and could not consort. He seemed to have lost touch with ethical responsibilities to his client. Dr. Vast was also incensed by the charges, claiming the complainant and the members of the licensing board were jealous of her success.

Using Clients for Self-Gratification

Aside from viewing clients as an audience while talking about oneself, Knapp and VandeCreek (2006) described two additional types of self-gratifiers. The first, “psychological voyeurs,” are therapists who elicit details about clients’ lives for their entertainment value.

Case 8–9: Television aficionado Fan Atic, Ph.D., was delighted when Rolee Starlet, the actress who played a scrub nurse on Dr. Atic’s favorite TV doctor show, became his client. After 10 sessions, Ms. Starlet complained to a licensing board that Dr. Antic was exploiting her by spending much of their time trying to draw out the behind-the-scenes gossip and hardly any time on the anxiety issues that brought her into therapy.

The second type of self-gratifier, labeled the “intrusive advocate,” involves soliciting clients to support the therapist’s causes.

Case 8–10: An avid environmentalist, Keepa Tree, L.M.F.T., encouraged clients to join her local group to save a grove of redwoods; she handed out brochures, informed them of upcoming rallies, and placed a donation jar in the waiting area. Some clients worried that Ms. Tree might find fault with them if they did not accept the material, did not show up at rallies, and did not contribute to the jar.

Despite the worthiness of a cause, it was inappropriate for Ms. Tree to muster support for her own purposes, ignoring the discomfort felt by, and pressures placed on, her clients.

Risky Clients

Not every client can tolerate boundary crossings. Even Lazarus (1994), who advocated flexible boundaries, allowed that:

With some clients, anything other than a formal and clearly delineated doctor–patient relationship is inadvisable and is likely to prove counterproductive. It is usually inadvisable to disregard strict boundary limits in the presence of severe psychopathology; involving passive-aggressive, histrionic, or manipulative behaviors; borderline personality features; or manifestations of suspiciousness and undue hostility. (p. 257)

Trust issues often lie at the heart of the matter. Clients seen at social service and other outpatient community agencies may become disenfranchised due to deficits in cognition, judgment, self-care, and self-protection, as well as holding little social status and power. Such clients are at greater risk for exploitation (Walker & Clark, 1999). Clients who have experienced victimization through violent attacks or abuse resulting in difficulties with trust or ambivalence also benefit from clear boundary setting, despite their frequent testing of such boundaries (Borys, 1994).

Clients who have suffered early deprivations may seek to meet their residual needs by courting favor with a nurturing therapist. Developing a therapeutic relationship can mobilize high hopes that the therapist will be able to replace or supply that which was lost. If the therapist responds as a rescuer, an inappropriate cycle becomes established, and the client will again experience the loss because a therapist never can (and should never intend to) replace a parent or the past (Borys, 1994). In this context, we gain considerable insight into the psychodynamics behind many charges of “abandonment” brought by clients tangled in multiple-role relationships with their therapists.

The technique of positive limit setting involves placing restrictions when responding to the client’s request while reframing the response in a way that meets a legitimate underlying need. All therapists should master this skill. Essentially, therapists must ask themselves how their potential comments or interventions will likely benefit their client. The next two cases provide examples of positive limit setting.

Case 8-11: Timmy Vulnerable, age 10, was enrolled in psychotherapy with Carla Carefull, Psy.D., by a state welfare agency and the foster parents with whom Timmy had been placed following a significant physical beating by his substance-abusing mother. After several months, the agency began to plan for a reunification with the mother, who would soon graduate from a drug rehabilitation program. During a session, Timmy stated, “I thought maybe if my mom started hitting me again, I could come over to your place.” Dr. Carefull replied, “You’re right! You do need a plan for what to do if things get bad at home. I’m not always home, so it will be better if we figure how you could get help any time.” She then informed Timmy of emergency resources and how to reach them.

Dr. Carefull was moved by Timmy’s situation and his poignant analysis of her as a helper in times of crisis. She also appropriately recognized, however, that she could not meet these needs in the way the child was asking.

Case 8-12: Rita Repeata sought psychotherapy with Hy Pedestal, Ph.D., following a breakup with the man she had been dating for 2 months. She described a series of relationships with three different men in the past year. All followed the same pattern: casual social contacts leading to sexual intimacies by the second date and a breakup within a few weeks. Each time, Rita said she “felt like ending my life.” She began her second therapy session with Dr. Pedestal by telling him how helpful the first session had been and what an exceptional therapist he was. She then got out of her chair and sat on the floor at his feet, looking up at him adoringly. When Pedestal asked what she was doing, Rita replied, “I feel more comfortable like this.”

Dr. Pedestal acknowledged Rita’s feelings but explained how sitting on the floor in that manner would do little to break out of the pattern for which she was seeking help. Politely, but firmly, Dr. Pedestal asked her to sit in one of the office chairs and initiated a discussion of the importance of focusing on the issues bringing her into therapy.

ENTERING INTO BUSINESS RELATIONSHIPS WITH CLIENTS

Becoming Business Partners

Any business partnership is vulnerable to interpersonal conflict and financial loss. In the context of such certainties, it seems astonishing that therapists have willfully undertaken risky associations with their ongoing clients. There is no such thing as “strictly business” when one of the partners has a fiduciary duty to uphold the trust and ensure the personal welfare of the other, who in turn has no such obligations. Ventures that went awry illustrate the damage done to both therapists and their clients.

Case 8–13: C. P. Yu had been a client of Teki Grabbit, Psy.D., for almost 2 years. Dr. Grabbit was in awe of Yu’s programming skills. When Yu announced his intent to start a data management company and invited Dr. Grabbit to become an investor, she jumped at the chance. The company was formed, but things moved slowly. Yu quit therapy because, as he later stated in his complaint to a state licensing board, “During our sessions, Dr. Grabbit focused almost exclusively on the company, demanded I make certain changes in the business plan, and ignored the personal issues I needed to deal with. When I told her I resented having to pay her to talk about the business, she yelled, ‘You owe it to me.’”

Case 8–14: “You and I would make a great team,” declared cosmetic surgeon Marcel Sculpt to his counselor Barb Overhead, L.M.H.C. “My patients often need counseling, and some of your clients may be interested in my services. We could share an office suite and call ourselves, ‘Beautiful Inside and Out.’ I can get you clients.” Ms. Overhead, whose client caseload was flagging, thought the idea a bit wacky. But, the more she considered the potential benefits, the more attracted she became. Ms. Overhead did require Sculpt to continue his therapy with someone else, figuring this would defuse any mixed-role conflicts. However, the expected clientele did not materialize, and Ms. Overhead’s share of the lavish office expenses proved to be more than she could afford. Her relationship with Sculpt soured, and when they argued, she brought up content from his past counseling sessions to

use against him. The partnership was dissolved, leaving Ms. Overhead in debt. Overhead blamed Sculpt for cajoling her into such a ridiculous venture and is considering suing him.

No one goes into business to lose money, which puts immediate and complicating expectations and pressures on both clients and therapists. Greed played a large role in both Grabbit’s and Overhead’s cases, even though neither would likely admit it. As a result, they became entangled in business dealings to the detriment of their clients’ needs and ultimately to their own welfare. Both should have recognized from the outset how their objectivity and judgment could be impaired. Grabbit lost her entire investment, more than \$50,000, and was further admonished by her state licensing board. Ms. Overhead believed that because Sculpt instigated the partnership and because she terminated the therapy with him, she had no responsibility for what then transpired. On the contrary, the responsibility rested exclusively with her because her training should have enabled her to foresee the potential hitch in the plan. Terminating a client for the purpose of going into business constitutes unacceptable professional practice even if Overhead did assist Sculpt in finding a new therapist. Using material shared in confidence to berate a business partner is unethical. If Overhead goes ahead with her lawsuit, she will be in for a surprise when the tables turn on her.

Whereas strict provisions apply to entering into sexual relationships with former clients (see Chapter 9), only NASW (1.06) specifies that entering any multiple-role relationships with *former* clients is unethical if there is a risk of exploitation or harm. It appears, however, that engaging in business relationships with those once formerly treated is not uncommon (Lamb et al., 1994; Pope et al., 1987). Unfortunately, these surveys did not probe how well the ventures fared.

Professional Relationships With Employees

Some degree of relational blending occurs naturally in most work settings. Employees and

their supervisors are often friendly, care about each other's welfare, and attend some of the same social events away from the business. The workplace can also be rife with land mines—gossip, conflicts, incivility, competition for promotions and resources, and disliked coworkers—all of which contribute to the potential for volatility. Therefore, this ever-changing environment should not be further complicated by willfully appending yet another professional role to it. Employees almost always have reasonable alternatives for any needed psychotherapy services.

Case 8–15: Jan Typer worked as a data entry clerk and receptionist for a community mental health agency. Helmut Honcho, Ph.D., supervised her work. When Ms. Typer experienced personal problems, she asked Dr. Honcho if he would counsel her. He agreed. Ms. Typer later submitted an ethics complaint against Honcho for blocking her promotion based on assessments of her as a client instead of on her job performance.

It may prove impossible to unravel the true basis for any job-related decision in such situations. Valid or not, Ms. Typer can always interpret any unpleasant reactions to what happens on the job as linked to the therapy or vice versa. When a client also works as an employee, the consequences of a soured multiple-role relationship can be especially devastating because of the potentially adverse career and economic ramifications. Dr. Honcho should have known better than to take on Ms. Typer as a client.

Case 8–16: Renega Lease, M.S.W., owned an apartment building managed by Bolt Wrench, who collected the rent and performed routine repairs. Wrench and his wife asked Ms. Lease to see them for couples counseling. During the second session, Lease learned from the wife about Wrench's habitual drinking. She fired him, thus forcing him and his wife to leave their home.

Information shared in one sector of a relationship influences the entire relationship. Lease cannot be faulted for wanting sober management of her property, but she used

confidential information shared in another context to the detriment of her client.

Employing Clients

Working with people who have a variety of polished skills will inevitably lead to a temptation to consider what these clients might have to offer as employees. Moreover, clients are often financially strapped. Employing them may feel like doing a good deed. However, as with business relationships, such alliances can obliterate the professional relationship and disperse additional emotional and financial debris in their wake.

Case 8–17: Oscar Scatterbill, Ph.D., hired client Thomas Clerk as his personal secretary and bookkeeper. The relationship seemed to work well until Clerk asked for a raise. Dr. Scatterbill refused, saying he was already paying Clerk a good hourly wage. Clerk countered by reciting Scatterbill's monthly income and comparing it to his own. Dr. Scatterbill allegedly laughed and said, "A comparison between you and me is hardly meaningful." An insulted Clerk quit his job as well as his therapy and wrote to an ethics committee, claiming Dr. Scatterbill "exploited and dumped me."

Dr. Scatterbill should have known better than to employ an ongoing client, especially for such a sensitive position that gave a client access to confidential information. Different roles call for different protocols, and the roles of "therapist" and "boss" require disparate and often-conflicting styles of relating. Even if the employment is specific, time limited, and feels like a win-win situation, other unforeseen complications can arise, as the next case illustrates.

Case 8–18: Snap Shutter needed additional work to make overdue payments on a new boat. When Shutter offered to photograph his counselor's upcoming wedding at half price, Melvin Groom, L.M.F.T., reluctantly agreed. However, the bride found the photographs inferior and argued against paying Shutter. In the meantime, Shutter increased the agreed-on fee because the

bride proved demanding, causing him extra work and expense. The matter escalated into mayhem. Shutter quit therapy, told everyone he knew in town that Groom had married a witch, and successfully sued Groom in small claims court.

Spending beyond one's means may well be an issue to explore in therapy, but the primary problem was not Groom's to solve. Groom might have politely refused Shutter's offer, perhaps indicating that wedding plans had been finalized. In the meantime, Groom's reputation in the community as a skilled person to consult for marriage counseling tanked. A therapist can always choose to alter a client's fee downward, even temporarily. However, even financial dealings with clients motivated by genuine kindness can backfire. By becoming directly involved in a client's personal misfortune, the therapist in the next case unwittingly withdrew from his role as a safe, neutral haven.

Case 8–19: Barney Bigheart, Ph.D., felt sympathetic when his client Bart Busted faced foreclosure on his home. Bigheart offered to loan Busted several thousand dollars to stave off the lender. Busted gratefully accepted and signed an unsecured note with a generously low interest rate. Busted's financial situation did not improve, however, and he failed to make his loan payments to Bigheart. Even though Bigheart exerted no pressure regarding the late payments, Busted expressed considerable guilt over "letting down the only person who gives a damn about me." Busted's depression deepened, and he required hospitalization.

We can hardly question Bigheart's compassion, but we can fault his professional judgment. By attempting to solve his client's problem from a domain unrelated to therapy, he destroyed Busted's refuge by also becoming his lender. Simply remaining available as Busted's compassionate therapist, and perhaps seeing him at no cost, would have better served the client's emotional well-being.

Bartering Arrangements

There was a time when ethics codes staunchly discouraged exchanging anything other than

money for professional services, citing the potential for taking advantage of clients and distortion of the professional relationship. Except for the NASW code (1.13) that provides a list of considerations, current codes have dropped strong cautionary statements, currently admonishing only that professional judgment be used regarding any clinical contraindications and potential for exploitation (APA: 6.05; AAMFT: 8.5; ACA: A.6, A.10.e, C.6).

So, why have professional organizations transformed bartering from a forbidden practice to an almost- incidental ethical matter? Perhaps because insurance coverage for mental health services has decreased, more people seeking psychotherapy may be unable to afford it. However, clients may possess skills or objects the therapist would be willing to accept in lieu of fees (M. Hill, 1999).

On the surface, allowing bartering in hard economic times seems like a win-win situation for clients who want therapy and therapists who want clients. Lawrence (2002) asserted that as cost considerations skyrocket, bartering should become prevalent, although others (e.g., Woody, 1998) argued that bartering is fraught with risks, and it is the therapist who assumes all potential liability. We acknowledge that bartering agreements can be reasonable and even a humanitarian practice toward those who seek mental health services but are uninsured and strapped for cash. Here are a few examples of positive outcomes:

A marriage and family therapist agreed to take fresh produce as payment for three sessions with a couple who lived on a farm out of town and needed professional advice regarding the management of an elderly parent with dementia.

A counselor agreed to see a client with few means who would not accept charity. The counselor offered therapy in return for the client's carpentry work on a charitable home restoration project organized by a group the counselor supported.

A psychologist performed a child assessment in exchange for five small trees from the parent and owner of a struggling nursery service.

In each of these situations, mental health services and the clients' assets were limited.

Exploitation was not at issue. The services were of relatively short duration, the economic value of the exchanges was not excessive, and the clients' needs were specific and circumscribed and did not involve complex transference issues or open-ended demands. In all three cases, the chances of untoward results were minimal, although the marriage and family counselor accepting the fresh produce did confide to us that "being practically knee deep in 100 pounds of corn presented a bit of a challenge."

Exchanging Therapy for Services

Bartering service for service can seem like a win-win proposition. The next case suggests such an outcome, at least for now. Things could change.

Case 8-20: A gifted seamstress agreed to make clothes in exchange for counseling by Donatella Pravda, L.M.H.C. The client was satisfied because she needed counseling and had plenty of available time to sew. Pravda's elation was summarized by her giddy remark at a cocktail party, "I am most assuredly the best-dressed counselor in town."

This case illustrates the potential darker side of barter arrangements. Because the counselor openly acknowledged, with delight, her dual relationship at a social gathering, she apparently never considered the inherent risks of exploitation. What will happen when an outfit does not fit properly or does not meet the counselor's requirements? What if the client becomes displeased with the counseling and begins to feel like a one-woman sweatshop? What if the counselor remains so satisfied with this relationship that she creates within the client an unnecessary dependency to match her own? These "what-ifs" are not idle speculation when one considers incidents of bartering that have already gone awry.

Case 8-21: Kurt Court, Esq., and Leonard Dump, Ph.D., met at a mutual friend's home. Mr. Court's law practice was suffering because of what he described as "mild depression." Dr. Dump was about to embark on what promised to be a bitter

divorce. Together, they hit on the idea of swapping professional services. Dr. Dump would be Mr. Court's psychotherapy client, and Mr. Court would represent Dr. Dump in his divorce. Mr. Court proved to be far more depressed than Dr. Dump anticipated. Furthermore, Court's representation of Dump was erratic, and the likelihood of a favorable outcome looked bleak. Yet, it was Mr. Court who brought ethics charges against Dr. Dump. Court charged that the therapy he received was inferior, and that Dump spent most of the time blaming him for not getting better faster.

This case illustrates not only the potential for detrimental consequences when the follow-through phase of bartering results in unhappy clients, but also the vulnerable position in which the therapist placed himself. Dr. Dump's impatience may have been appropriate under simpler circumstances. But, because of the intertwining of nonprofessional issues, Dump was perceived as retaliatory.

Charges of exploitation are heightened when the value placed on the therapist's time and skills is set at a higher rate than those of the clients. Because the therapist's hourly rate is more likely to exceed what one would pay a client, this risk is probably present in most service-for-service exchange agreements.

Case 8-22: Elmo Brush offered to paint his therapist's office suite in exchange for counseling Brush's teenage daughter. Paul Peelpaint, D.S.W., treated the girl for six sessions and terminated the counseling. Brush complained that his end of the bargain would have brought \$1,500 in a conventional deal. Thus, it was as though he paid \$250 a session for services for which Peelpaint's other full-paying clients paid only \$100. Dr. Peelpaint argued that he had satisfactorily resolved the daughter's problems, and the arrangement was valid because task was traded for task, not dollar value for dollar.

When a service cannot be cost estimated in advance, trouble lies ahead. Brush's daughter might have required 50 sessions, valued at \$5,000, if Dr. Peelpaint was willing to conduct

as many sessions as therapeutically necessary and had been collecting his usual fee.

Case 8–23: X. Ploit, Ph.D., offered an unemployed landscaper, Sod Flower, the opportunity to design and redo his grounds in return for psychotherapy. Dr. Ploit charged \$100 an hour and credited Flower at a rate of \$15 an hour, which meant Flower worked over 6 hours for every therapy session received. Flower complained to Dr. Ploit that the amount of time he was spending on the yard prevented him from entering into full-time employment. Dr. Ploit responded that Flower could choose to terminate therapy and return when he was able to pay the full fee. Flower felt abandoned and exploited.

Dr. Ploit's case is even more complicated and bothersome. Ploit figured the amount due for an ongoing service considerably below the going rate for a skilled landscaper. The bartering contract most likely did exacerbate the client's difficulties. In the actual case, the client successfully sued the therapist for considerable damages. If service for service had been time defined—1 hour of the client's service is exchanged for a 1-hour therapy session—charges of exploitation would be minimized.

Case 8–24: Notta Rembrandt proposed painting a portrait of Gig Grump, Psy.D., in exchange for psychotherapy. Dr. Grump posed, and Rembrandt received therapy on an hour-for-hour basis. On the 11th session, Grump viewed the almost-completed canvas for the first time and expressed dissatisfaction, calling it "hideous." An insulted Rembrandt insisted the portrait was superb and "captured Grump's soul." The conversation escalated into a fervent argument. Rembrandt grabbed her canvas, stomped out, and did not return. Dr. Grump sent Rembrandt a bill for 10 sessions. Rembrandt filed an ethics complaint. Grump responded that the whole setup was the client's idea, and he was not responsible for the disputed outcome.

Possible transference and countertransference issues notwithstanding, the arrangement between Rembrandt and Grump was shaky from the beginning, given the wide variability

in artistic tastes. Rembrandt prevailed in her ethics complaint. Grump's attempt to fault the client was not a persuasive defense, but he did decide to withdraw the bill.

Exchanging Therapy for Goods.

Exchanging professional services for tangible objects may be less problematic because a fair market price can often be established by an outside, objective source. Possibly tricky non-therapy-related interactions can also be substantially reduced. However, the value of goods often depends almost entirely on what buyers are willing to pay for them. Determining the true value of some items will prove challenging, and charges of exploitation could easily arise. Therefore, we urge considerable caution when professional services are traded for objects.

Case 8–25: Decora Shod, M.S.W., was treating Lenny Couch, who owned a furniture import business. Ms. Shod casually mentioned that she was redecorating her home. Couch offered to let Shod select items from his warehouse at his cost if Shod would see him at a reduced rate. Mr. Couch reasoned they would both benefit because Shod would be receiving more for far less than she could in retail outlets, and Couch would also save money. In therapy, Shod increasingly confronted Couch in areas in which she felt the client behaved in a self-destructive and defensive manner. Couch reacted negatively and contacted an ethics committee, complaining that Ms. Shod attempted to lock him in to unnecessary treatment until her home was refurnished.

Case 8–26: When Manifold Benz, Ph.D., learned his financially strapped client's planed to sell his classic automobiles to pay outstanding therapy bills and other debts, Benz expressed an interest in one of the cars. Dr. Benz informed the client about the same model he saw at an auto show for \$19,000 and offered to credit the client with 200 hours of therapy in exchange for the car. The client stood 100 hours in arrears at the time.

Ms. Shod's confrontations may have been therapeutically justified and ethically

acceptable were they not contaminated by a superimposed arrangement. Instead, she was perceived by the client as exploitative. Benz was, in fact, exploiting his client by committing him to a specific number of future therapy sessions that the client may not need. Further, we do not know if the price Benz suggested represents fair market value, and this may be difficult to determine precisely because the item was rare, possibly unique. (That Benz allowed a client to fall 100 hours in arrears creates another ethical issue, as discussed in Chapter 12.)

Case 8–27: Flip Channel, Ph.D., allowed Penny Pinched to pay her past due therapy bill with a television set Penny described as “near new.” However, when Dr. Channel set it up in his home, the colors were faded, and the picture flickered. He told Penny that the television was not as she represented it, and she would have to take it back and figure some other method of payment. Penny angrily retorted that Dr. Channel must have broken it because it was fine when she brought it to him. When Channel insisted that the TV was defective, Penny terminated therapy and contacted an ethics committee, complaining that Channel broke both a contractual agreement and her television set.

Dr. Channel found himself in a no-win situation as a result of the television fiasco. A therapeutic relationship was also destroyed in the process. Channel could have avoided a confrontation and perhaps saved the relationship by junking the TV without mentioning anything to Ms. Pinched. But, the therapeutic alliance might have suffered anyway due to any lingering resentment that might leak out toward his client.

Additional Bartering Issues

We agree with Woody (1998) that it is difficult to confidently ascertain which clients will be well suited to a nontraditional, negotiated payment system and which should be turned down, especially near the outset of the therapeutic relationship. By definition, bartering involves a negotiation process. Is a client in distress and in need of professional services in a position to

barter on an equal footing with the therapist? Even therapists are attracted to a good deal, but how does this pervasive human motive play itself out in a bartering situation with clients?

When a bartering arrangement is suggested by the client, a therapist without a clearly understood “no-barter policy” can be placed in any of three uncomfortable positions. First, if a therapist is known to barter, which is probable in small communities, turning down an unwanted proposal could be experienced as a rejection. Second, must a therapist accept something unneeded or unwanted? Can you say to a client, “Well, I sometimes accept goods for services, but I’m allergic to potatoes and don’t need a llama rug.” Third, how does a therapist react when one bartering client refers someone who also wants to barter, but the referral clearly is not clinically suited to it? Some of these predicaments may not end up on ethics committee tables but remain sticky nonetheless, with the potential to cause the kinds of hassles therapists would certainly prefer to avoid.

Keep in mind that most professional liability insurance policies specifically *exclude* coverage involving business relationships with clients (Bennett et al., 2006; Canter, Bennett, Jones, & Nagy, 1994; Knapp, VandeCreek, et al., 2013). Liability insurance carriers may interpret bartering arrangements as business relationships and decline to defend covered therapists should bartering schemes go awry. To obscure matters even further, failure to report the monetary value of bartered services or goods constitutes tax evasion. To fully meet legal requirements (and thereby behave in an honest and ethical manner) requires detailed documentation, creating another type of interaction with the client. The therapist who declared nothing was illegal about doing therapy for free and having that client work in the therapist’s dress shop for free has set up both for charges of income tax fraud and, for the therapist, labor law violations.

Those who advise against bartering arrangements as ways of protecting both clients and therapists have been accused of giving only lip service to serving the poor (Zur, 2003). Or, “affluent guilt” was suggested by Pack-Brown and Williams (2003) as a possible factor when

financially successful therapists are faced with deciding whether to accept a request for bartering. Therapists who want to assist their clients of little means may feel pressed to accept without fully assessing the implications for the clients or themselves. Thus, given the potential for glitches, actual exploitation of clients (or the appearance of it), and unsatisfactory outcomes for both parties, we recommend bartering only after reflecting on a host of considerations. These include the client's culture, financial status, personality, and profession, among others (Zur, 2007). We advise carefully considering other special arrangements (as discussed in Chapter 12) for clients who are unable to afford psychotherapy.

Finally, should mental health professionals ever be the ones to initiate bargaining in exchange for psychotherapy?

Case 8–28: Ron and Isabel Penny informed Tyler Quickthinker, L.M.H.C., that financial considerations meant they would have to quit counseling despite a continuing need. Quickthinker suggested Isabel, a daytime sous chef at a local restaurant, could come to Quickthinker's house every Friday night and create a nice dinner for the family. Isabel was already feeling guilty about not being home with their three small children in the evenings.

We recommend avoiding the *instigation* of a bartering plan. Mrs. Penny may find it difficult to reject Mr. Quickthinker's off-the-cuff suggestion, and she may well have feelings about cooking for her therapist's family. To the extent that clients see their therapists as the more authoritative individual in the relationship and are dependent on them for emotional support, they may feel they must accept the therapist's proposal when they would prefer to refuse (Gutheil & Brodsky, 2008).

Outright Purchases of Clients' Goods

Can a therapist purchase an item outright for cash from clients? Does that not eliminate the potential negative outcomes inherent in bartering? This is not necessarily the case.

Case 8–29: When Gemmy Sparkle wanted to buy a house, she decided to start selling her mother's antique jewelry. She brought an exceptionally nice piece to show her therapist, Willa Buyit, M.S.W. Buyit asked how much Sparkle wanted for it, and Sparkle quoted her a price. Buyit bought the piece outright for the quoted amount, paying cash. Over a year later, and after the therapy relationship had successfully terminated, Sparkle learned that the piece was worth far more than Buyit paid for it. Sparkle called Buyit, asking for an additional \$2,000. A stunned Ms. Buyit refused.

In the actual case, the client took the therapist to small claims court and told everyone how the therapist had "taken her for a ride." The client did not prevail, but the local town paper carried a brief article about the lawsuit. The therapist's client base fell, and the residual effects had not softened 2 years later. Thus, even though the therapist did not elicit the sale and paid the full asking price at the time, the ex-client's distress took its toll. Here is a similar case with a different response:

Case 8–30: Ima Broke was facing financial hardship and feeling desperate. She knew her therapist, Jimmy Thoughtful, Ph.D., liked Native American décor by the paintings and items displayed in his office. She thought he would be interested in purchasing for \$200 a clay pot that belonged to her grandmother. Dr. Thoughtful gently turned her down for two reasons. First, the piece was likely far more valuable than Mrs. Broke realized. But, as important, Thoughtful ascertained that the pot had been lovingly cared for as it was passed along in the family, and even if it had to be sold, he should not be the one to take over an object with considerable sentimental value.

Dr. Thoughtful was able to put his own desires aside and realize that countertransference and other issues could contaminate the therapy process. Instead, he agreed to continue to see Ms. Broke at a reduced rate, offered her the name of a respected appraiser should she still need to sell the pottery elsewhere, and provided a referral to a community financial assistance service.

When clients have items to sell, there will rarely be any reason why their therapists should be the one to purchase them. Today, many ready markets exist, and objects can be offered for sale through Internet sites, reaching thousands of potential buyers at little or no cost to sellers.

If the client offers something of value that the therapist would very much like to have because of its special characteristics or uniqueness, proceed with caution. What are possible complications based on the client's issues and your relationship? What is the most the client could get for the item elsewhere? (Do not pay less.) At what juncture is the therapy process?

Case 8-31: Despite his client's anger issues and financial instability, Les Patriot was enamored with Danny Whittle's intricate wood carvings. He asked to purchase a large eagle and paid Whittle more than the quoted price "to be on the safe side." The therapy alliance did not hold, and Whittle contacted a licensing board with several complaints, including charges that Patriot took advantage of him by "paying almost nothing for one of my masterpieces."

Even though Dr. Patriot attempted to ensure that the purchase would not become an exploitation issue, he was remiss in not considering the patient's emotional lability and the fact that an original and unique object cannot be securely priced.

MULTIPLE ROLES WITH THOSE ONE ALREADY KNOWS

Delivery of Services to Close Friends and Family Members

Mental health professionals come to expect frequent requests for advice from friends and family. Queries can range from handling a child's biting other children to convincing a proud grandmother with short-term memory loss to move into an assisted living facility. When more than factual information or casual advice is indicated, a temptation may arise to enter into professional or quasi-professional relationships with good friends or members of one's family.

Therapists may believe themselves capable of providing especially good counsel because trust already exists. Furthermore, therapists may express a willingness to see these "clients" at bargain rates or at no cost whatsoever.

Despite the seeming advantages of offering formalized counseling to friends or family, such sustained relationships should be avoided. Close relations and psychotherapy exist in the context of intimacy, but the differences between the function and process of the two are striking. Successful personal relationships are free of charge, involve the satisfaction of mutual needs, are not necessarily goal directed, and aim to last indefinitely. Professional relationships, on the other hand, aim to serve only the emotional needs of the client, usually involve payment, and focus on specific therapeutic goals followed by a termination of the relationship. When these oppositional characteristics are superimposed, the potential for adverse consequences to all concerned increases.

Mental health associations caution therapists to refrain from undertaking a professional relationship if impairment of objectivity or effectiveness might result (APA: 3.05; AAMFT: 1.3, 3.4, 4.1, 4.6; ACA: C.2.g; NASW: 4.05). Responding to a frantic call from a friend in the middle of the night is something friends do for each other. Should the friend require more than temporary comforting, offer a referral. Otherwise, as the following cases illustrate, unexpected entanglements can occur, even when therapists have benevolent intentions.

Case 8-32: Weight-reduction specialist Stella Stern, L.M.H.C., agreed, after many requests, to work on a professional basis with her good friend Zoftig Bluto. Progress was slow, and most of Bluto's weight returned shortly after it was lost. Dr. Stern grew impatient because Bluto did not seem to be taking the program seriously. Bluto became annoyed with Dr. Stern's irritation as well as the lack of progress. Bluto expressed disappointment in Dr. Stern, whom she believed would be able to help her lose weight quickly and effortlessly.

Case 8-33: An intellectual assessment of 9-year-old Freddy was recommended by the boy's school.

Freddy's father, Paul Proud, asked his brother, Peter Proud, Ph.D., to perform it. The results revealed some low-performance areas and a full-scale IQ score of 93. Paul was very upset with his psychologist-brother for "not making the boy look good to the school."

Case 8-34: Murray X. Plode, Psy.D., accepted his sister's 17-year-old daughter as a client. During the second session, his niece revealed being sexually abused by her father, the therapist's brother-in-law. Dr. Plode stormed over to the parents' home, threatened police action in front of the entire family, and told his brother-in-law to pack his things and leave. The father, who denied ever sexually molesting his daughter and claimed the girl was a chronic liar, complained to an ethics committee that Dr. Plode had violated his rights and destroyed his life. Plode responded that this was a strictly personal matter.

Faulty expectations, mixed allegiances, role confusion, and misinterpretations of motives can lead to disappointment, anger, and sometimes a total collapse of relationships. Dr. Stern's friend could not commit to the obligations of the professional alliance but expected results anyway. Dr. Proud's brother assumed a close family member would willingly cheat. Dr. Plode was unable to separate his role as an upset uncle from his role of a therapist upholding professional decorum and utilizing established legal recourse.

In summary, therapists are free to be completely human in their friendship and family interactions and to experience all of the attendant joys and heartaches. Their skills might prove helpful by offering emotional support, information, or suggestions. When problems become more serious or require longer term attention, however, the prudent course of action is always to assist in offering competent referrals.

Accepting Acquaintances as Clients

Another ready source of potential client contacts flows through therapists' circles of acquaintances. A member of the same athletic club or

religious congregation may request professional services. Disallowing casual acquaintances to become clients would, in general, be frustrating to consumers as well as to therapists, although each request should be carefully considered (see ACA: A.6.a). This section illustrates cautions to be considered before taking on clients who base their interest in your services on the fact that they know you slightly from another context.

Case 8-35: Felina Breed, Ph.D., also raised pedigree cats. Many of her therapy clients were the "cat people" she met at shows. The small talk before and after treatment sessions was usually about cats. Clients also occasionally expressed interest in purchasing kittens from Dr. Breed. She agreed to sell them to her clients, which eventually came back to haunt her. When the therapy process was not proceeding as one client wished, he accused Dr. Breed of using him as a way to market her high-priced kittens. Another client became upset because Dr. Breed sold her a cat that never won a single prize. If the therapist raised "loser cats," the client assumed, trust in her therapy skills should be questioned as well.

Dr. Breed did not adequately meet her responsibility to suppress her acquaintance role while engaging in a professional role. This disconnection can usually occur without untoward consequences if the continuation of the former role does not require more than minimal energy or contact and avoids conflicts of interest. The risks and contingency plans for likely incidental run-ins with clients should be discussed during the initial session. In Dr. Breed's case, refraining from extended discussions of cats before or after the therapy session and abstaining from selling cats to any ongoing therapy client would have been appropriate.

So, what differences exist between a friend, who should *not* be accepted as a therapy client, and an acquaintance, who may become one? Making the distinction is not clear-cut because sociability patterns among therapists themselves vary considerably. Contextual issues, such as the potential for frequent interactions with the acquaintance in other settings, also require consideration.

Generally, friends are those you would call if you needed advice, who would visit you in the hospital if you became ill, who would include you as a guest at an important event in their lives, or who you would trust with sensitive information about your own private life. Acquaintances are more typically those whose interactions with you would involve little intimately personal content, who might send a get well e-mail or card if you became ill, but who you would not arrange to see socially on any regular basis.

A twist on the acquaintance peril involves dealing with solicitations for services by someone who also holds some influence or advantage over you. Examples include a request from the head of admissions of the local college to which your daughter has applied to work with his troubled son or a call for an appointment for marriage counseling from the banker who manages your personal finances. Unless alternative services are unavailable, we encourage therapists placed in awkward positions to explain the dilemma to prospective clients and offer to help find alternative resources.

Socializing With Current Clients

Commentators on the nature of psychotherapy have referred to it as, among other things, “the purchase of friendship” (Schofield, 1964). It is precisely the *differences* between psychotherapy and friendship that account for its potential effectiveness. Friendships should ideally begin on an equal footing, with each party capable of voluntarily agreeing to the relationship.

The various complications that can arise when clients become friends are illustrated in the cases that follow. Do take note of the therapists’ delayed awareness that anything was amiss, a common phenomenon that morphs into an unwelcome surprise.

Case 8–36: Soon after Patty Pal began counseling with Richard Chum, L.M.F.T., Patty invited Dr. Chum and his wife to spend a weekend at her family’s beach house. The outing was enjoyable for all. During the next few sessions, however, Ms. Pal became more reluctant to talk about her anxieties. Dr. Chum confronted Ms. Pal with

his impression that therapy seemed to be at an impasse. She broke down and admitted she had been experiencing considerable distress but feared if she revealed more, Chum might choose to quit socializing with her and her husband.

Patty Pal found herself in a double bind. As M. R. Peterson (1992) observed about boundary violations in general, the client is always faced with a conflict of interest. No matter what they do, they risk losing something.

Case 8–37: Jack Ace, D.S.W., and his client, King Draw, shared an affinity for poker. Ace accepted Draw’s invitations to play with Draw’s friends on Wednesday nights. One evening, Dr. Ace was the big winner. After that evening, Draw began to cancel appointments and stopped attending games. A puzzled Dr. Ace telephoned Draw, who admitted the therapy no longer felt quite right. He could not be specific, but after he lost several hundred dollars to his therapist, Ace seemed dangerous rather than someone to depend on for support.

These examples did not involve clients who pressed formal ethics charges against the therapists, but such cases do exist. In these instances, the clients felt exploited or abandoned.

Case 8–38: Will Crony, Ph.D., treated Buddy Flash for 2 years. They also invited each other to their homes. Flash gave elegant parties, often attended by influential community leaders. During one event, Flash and Dr. Crony argued over their differences regarding the upcoming mayoral race. Flash terminated therapy and contacted an ethics committee, complaining that Dr. Crony had kept him as a client for the sole purpose of capitalizing on his social status.

Case 8–39: Artist Raphael Baroque complained to an ethics committee that Janis Face, Ph.D., did not follow through with her commitments. Baroque had seen Dr. Face for over a year, during which time she praised his work, accompanied him to art shows, and promised to introduce him to a gallery contact. Baroque began to feel self-assured and terminated therapy, expecting that their mutual interest in his career would continue. However,

Dr. Face did not return his calls. Baroque became frantic. When contacted by an ethics committee, Dr. Face explained how she unconditionally supported her clients, but because Baroque was no longer a client her obligations to him were over.

Ethics committees found in favor of both Flash and Baroque. The therapists had intertwined their lives in ways that confused the clients. Baroque, especially, experienced harm as a result of Dr. Face's failure to grasp the potential consequences of the significant dependency she had nurtured in her client by making promises she never intended to keep once he was no longer a client.

Relationships With Clients After Therapy Ends

Although clients and therapists typically part ways on termination, when might more intimate social friendships or other types of relationships be formed with previous clients without the danger of multiple-role complications? Conservative critics say, "Never." An ex-client may need to reenter therapy, and a clear pathway—including the beneficial effects of continuing transference—should remain open for them. Others argue against any significant nonsexual relationships with former clients, at least for some period of time following termination (Pipes, 1997).

Shifting from a unidirectional relationship with a power differential to a shared egalitarian relationship may be difficult and even disappointing, possibly even eroding the gains from psychotherapy if the ex-client discovers the therapist-as-a-real-person is not an idealized friend or business partner. The therapists who clients believed they got to know so well may not closely resemble their professional personas in a nonprofessional context.

The ethics codes of NASW (1.06) and ACA (A.6) issue warnings for establishing nonsexual relationships with former clients, whereas the APA and AAMFT codes are silent, except for the general provision that clients should never be exploited. However, if friendship or business dealings disappoint, turn sour, or cause

confusion, issues coming up during therapy may resurface to raise new doubts in the clients. Should the ex-client need additional services, such as for a court appearance, records, or other forms of support, interactions would be awkward at best.

Case 8–40: Sue Nami, Ph.D., and her client Marsha Nullify often discussed how well they worked together and decided to become friends as soon as therapy wound down. However, after termination Nullify found Dr. Nami overbearing and controlling in casual social situations, and Nullify's other friends disliked Nami's strident demeanor. Nullify began to distance herself from the posttherapy friendship. She even suspected that she had misjudged the helpfulness of the therapy. She sought the counsel of another therapist, who encouraged her to press ethics charges against Nami.

Nullify's charges against Dr. Nami came before an ethics committee, although not exactly as Nullify expected. Incompetence could not be conclusively proven, but what became clear to both a surprised therapist and the now ex-client was the finding of a multiple-role relationship violation. The investigation revealed Nullify's active therapy status, during which Dr. Nami focused on their evolving friendship, promising a posttherapy continuation and supposed benefits, which the APA ethics code (3.05a) specifically defines as unethical (see also ACA: A.6.a; NASW: 1.06.c). Ironically, Dr. Nami herself provided these facts as her ill-fated defense, noting how well they got along and had both agreed to the friendship during therapy. This scenario also illustrates how one can never count on a new role working out as well as the first one. Nami's authoritative personality was compatible with this client in therapy but played poorly outside the office.

So, can therapists ever safely establish relationships with former clients? Survey findings revealed such relationships are less likely to be judged as unethical and occur with some regularity (S. K. Anderson & Kitchener, 1996; Salisbury & Kinnier, 1996). The view that friendships with clients are always off limits might deny opportunities for what could

become productive, satisfying, long-term friendships (Gottlieb, 1993, 1994). The next case provides one such example.

Case 8-41: Mountain bike enthusiast Wilber Wheel consulted Spike Speedo, Ph.D., whom he had casually met at a biking exhibition. The therapeutic relationship went well and terminated after 16 sessions. The two men found themselves in the same race a few months later and realized how much they enjoyed knowing each other on a different basis. A close friendship endured for 25 years, and Wheel delivered the eulogy at Dr. Speedo's funeral.

Whether this account represents a likely outcome holds less relevance than the necessary precautions whenever contemplating a friendship with a person who was once a client. S. K. Anderson and Kitchener (1998) provided a list of questions to consider before proceeding: "Did we come to a formal or identifiable closure to our work together? Is there a long enough time period between the termination and this new possible relationship to allow both of us to engage with new role behaviors? Can I maintain the confidentiality of the therapeutic relationship in this post-therapeutic relationship?" (p. 93). Recall that any attempt to deflect a role blending with current clients by promising or even hinting at the possibility of altering the roles after therapy termination instantly alters the nature of the current relationship.

Accepting Clients' Referrals of Their Close Relations

It may feel tempting to relax the criteria used for accepting clients during times of declining reimbursement for psychotherapy services. Many referrals are generated through word of mouth from colleagues and current or previous clients. However, care must be taken when satisfied clients recommend you to their own close relations. The potential for conflict of interest, unauthorized passing of information shared in confidence, and compromises in the quality of professional judgment constitute ever-present risks (see NASW: 1.06).

Case 8-42: Dum Tweedle felt pleased with his individual therapy progress and asked Rip Divide, Ph.D., to also counsel his fiancée Dee in individual therapy. Dum eventually pressed ethics charges against Dr. Divide for contributing to a breakup, a process that began, Dum said, at the time Dee entered therapy. He contended that Dr. Divide encouraged Dee to change in ways detrimental to him and to their relationship. Dr. Divide argued that his responsibility was to facilitate growth in each party as individuals, a responsibility he felt he had upheld.

Case 8-43: Tuff Juggle, Psy.D., accepted Jane Amiga as a client knowing full well that she and Sandy Comrade, an ongoing client, were best friends and that aspects of the friendship were serious treatment issues for Sandy. He reasoned he could compartmentalize them, and that the women would benefit from the fact that he knew them both. One day, he slipped and shared with Sandy something Jane had told him during a private session. Jane brought ethics charges against Juggle for breach of confidentiality.

Dr. Divide ignored the invisible "third client," namely, the relationship between the engaged couple—and attempted the improbable task of treating a duo as if they were unconnected entities. Although Dr. Juggle's situation involved a less-engrossing affinity between two clients, the fact that the friendship was an issue for one of them should have provided a sufficient front-end warning. Juggle's slip of the tongue to the wrong party is an example of an ever-present pitfall when consulting people who know each other well enough to share some of the same material during their individual sessions. Even the sharpest of memories may fail under such circumstances.

We are not suggesting that accepting referrals from current clients is always inappropriate. Therapists must, however, assess as thoroughly as possible the relationship between the potential client and the referral source, the potential client and the context in which the established client and the referral know each other, and the motivations of the client to make the referral

(Shapiro & Ginzberg, 2003). If things have any potential to become sticky, we advise referring the potential client to a suitable colleague.

EXCHANGING GIFTS AND FAVORS

Therapists often receive tangible items as expressions of appreciation or to commemorate a special event. Holidays and the termination session are other times some clients choose to bestow gifts. These exchanges can result in a positive experience for both parties (Evans, 2005; Hahn, 1998; Knox, Dubois, Smith, Hess, & Hill, 2009). However, how gifts are received requires careful forethought and application due to how they might have an impact on both treatment relationships and outcomes (Barnett & Shale, 2013; ACA: A.10).

Accepting small material tokens, such as homemade cookies or an inexpensive item, typically poses no ethical problem. Some therapists with whom we have spoken refuse any gift as a matter of principle. However, the majority of surveyed therapists believe turning down small “safe” gifts would constitute rejection or an insult to the detriment of the client, although most would turn down an expensive gift (Borys & Pope, 1989; Pope et al., 1987). There will be times when accepting certain types of gifts (e.g., a nude calendar, boxer shorts, a condom, or any other highly personal or emotionally laden item) would be inappropriate and better addressed as a therapeutic exploration with the client. At other times, the wise therapist might want to consider what meaning certain small gifts had to the client, based on the individual circumstances (e.g., purchased flowers, a key chain, a baby doll, or a family heirloom).

Gifts, as we all know, are also bestowed for reasons unrelated to appreciation. Gifts have the power to control, manipulate, or symbolize far more than the recipient may grasp. A client may give a gift in an attempt to gain favor, to ensure he or she is liked, or even to implement what Gutheil and Brodsky (2008) called “the golden fantasy,” the belief that the therapist is capable of serving the client’s every need. Some clients may offer gifts in an attempt to

equalize power within the relationship (Knox, Hess, Williams, & Hill, 2003) or gain the therapists’ favor over some other relevant individual, such as the client’s spouse (Zur, 2007). When a gift is no longer a gesture of gratitude or given to mark a special event or when even a small gift raises a therapeutic issue, questions of ethics and competent professional judgment arise. Several cases demonstrate how lines can be crossed, and ethical or other adverse consequences follow.

Case 8–44: Wealthy Rich Porsche gave his recently licensed therapist, Grad Freshly, Ph.D., a new car for Christmas, accompanied by a card stating: “To the only man who ever helped me.” Dr. Freshly was flattered and excited. He convinced himself that his services were worth the bonus because Porsche had churned through many previous therapists with disappointing results.

As a more seasoned therapist might well have predicted, Mr. Porsche soon began to find fault with Dr. Freshly and sued him for manipulating him into giving an expensive gift. Although, among professional organizations, refusing expensive gifts from clients is specifically mentioned in only the AAMFT code (3.9), we agree that a very costly item should be refused regardless of the giver’s conscious motivation. Even those who can afford it may have second thoughts should the therapeutic alliance shift. Or, a valuable gift might be a power play or setup for expecting future payback.

Case 8–45: Phatel Attraction brought Newton Callow, Ph.D., suggestive little presents to almost every session. These included handkerchiefs hand-embroidered with tiny women in bikinis, a T-shirt imprinted “Therapists Do It in Groups,” erotic poems, and a fancy bottle with a label “Chemical Making Therapists Irresistible to Clients.” Ms. Attraction ultimately pressed ethics charges against Callow for abruptly terminating and abandoning her after promising he would “be there to make her better.”

Discomfort and uncertainty may interfere with a therapist’s ability to provide a therapeutic

response to gifts (Hahn, 1998). During an ethics committee inquiry, Dr. Callow relayed how he initially found Ms. Attraction to be a “fun client” who needed acceptance to boost her self-confidence. As therapy progressed, he felt uneasy with her flirtations. What seemed at first amusing and flattering turned demanding and scary and more than he could handle. When Callow suggested referring her to another therapist, she became livid and stalked out, allegedly threatening him with reprisal for leading her on. Both Freshly and Callow illustrated naïveté and inexperience, which are fairly common denominators among therapists who accept gifts and favors beyond the realm of small one-time or appropriate special occasion tokens.

Gifts should always be understood and evaluated within the context in which they are given (Hundert, 1998; Zur, 2007). A strong professional identity and “knowing one’s clients” appear to be key ingredients in responding appropriately with offers of gifts and favors and the probable motivation behind them on a case-by-case basis. Aside from inappropriate items or offers, the numerous factors to be considered before accepting or rejecting a gift suggest against specifying rigid prescriptive guidelines given that different responses may be appropriate under various conditions (Spandler, Burman, Goldberg, Margison, & Amos, 2000).

The meaning behind gift giving differs among cultural groups, requiring a sensitive response by therapists. In Native American, Asian, and Indian cultures, for example, bestowing gifts often serves as a symbol to honor the recipient. The reasoning behind the tribute can be misunderstood by a culturally different therapist. For example, one of our colleagues agreed without hesitation to a request to cancel appointments for a month because the client required hospitalization and a recovery period. At the next scheduled session, the client brought a gift bag containing a silk sari. The client explained with tears in her eyes how grateful she was to be allowed to miss appointments. Our colleague was taken aback because she would do the same for any client, but she also realized that refusing the gift would insult and confuse this particular client. Therapists appear to be more likely

to accept gifts when they are culturally relevant (C. Brown & Trangsrud, 2008).

What about therapists giving gifts? Many clients coming into therapy feel ignored, abandoned, violated, or uncared for. Despite a sincere effort to cheer them up by offering gifts, they may more easily misinterpret the therapists’ motivations. Besides the potential complications and misunderstandings, there is an ever-present possibility that the therapists’ own benevolent intents are unconscious and self-serving.

Case 8-46: Benny Nowalls, Ph.D., gave many of his clients little trinkets he thought they would enjoy. These included decorative key chains, figurines, and stuffed animals. He also sent them cards when he was on vacation, hugged them, and met them for lunch or drinks. Eventually, several clients complained about Dr. Nowalls for a variety of reasons, most dealing with abandonment issues when they learned they were not “special.”

Dr. Nowalls was stunned when those to whom he had been so kind and giving turned on him. He could not grasp how the multiple intrusions of his personal essence into his clients’ lives interjected dependencies and expectations he could never satisfy. The question also arises regarding whether clients can feel free to address negative feelings with a therapist who gives them gifts (Gabbard, 1994).

Of course, motives for gift giving are not necessarily unconscious or rationalized. The next case illustrates a therapist who knew exactly what he was doing.

Case 8-47: Herman Hustle, Ph.D., gave all of his clients, current and past, expensive cheese baskets at Christmastime. He confided to a colleague, “I want them to think about me as this terrific guy and then pass my name along to their friends.”

Dr. Hustle wanted to drum up business and was attempting to enlist clients as his sales force. Such a tactic is simply unprofessional.

So, can therapists ever give gifts or do clients favors? We say yes, on occasion, and after careful consideration. A book may be offered

to a client when therapeutically indicated, especially if the client is on a limited budget. Therapists may also go out of their way to help clients locate other needed resources relevant to improving their overall life situation. Small favors based on a situational need and common sense, such as giving a client a quarter for the parking meter, would not raise concerns. In these acceptable cases, no ulterior motives pertain, and the scope is either related to the therapy or of a very specific and limited nature.

Case 8-48: Darla Childs sought therapy with Gladys Gifter, D.S.W., as a way to overcome a troubled childhood and establish the trust needed to sustain adult relationships. At stressful points in treatment, Childs would pick up one of the toy puppets Gifter kept in the office for her younger clients and speak through it. Those conversations were often emotionally powerful communications and led to important progress. Two years later, Childs was winding down therapy and engaged to be married. At their final session, Gifter presented Childs with one of the puppets as a memento of their work together.

In this instance, Gifter attempted to effectively summarize important work the client had done with a metaphorical token of little value but significant emotional import. The gift had particular meaning to both and served to reinforce the work they had done together.

A special situation can arise when the client is a child. Here, at times, it may be appropriate to give a gift attending to the symbolic meaning that would advance the therapeutic function. For example, an anxious child about to leave for 3 weeks of summer camp might be soothed and emboldened by the gift of a flashlight.

Gifts and (usually) favors should never, of course, be requested *from* clients or those we are entrusted to teach or supervise. Unfortunately, cases involving direct solicitations have come to our attention. One therapist asked a client who owned a two-station beauty salon to do her hair every week for free in addition to paying the regular therapy fee.

Another asked to borrow significant sums of money from his clients and then went bankrupt, leaving them all unpaid.

When limited, situational-based favors or requests are involved, the picture grays a little. For example, a therapist may ask if an appointment can be switched to accommodate the therapist's need to be somewhere else. Even if no contraindications exist in a specific case, any favor requiring more than a trivial inconvenience to a client should not be requested. Therapists must remember that a client may feel he or she has no choice but to comply with any request. The therapist who fell ill in the presence of his client in an otherwise-deserted office complex, requiring the client to assume rather major responsibilities for a short time, is an example of the exceptional case.

Finally, those with a "no gifts" policy would be wise to explain up front, perhaps as part of an information sheet given to new clients, as a way of avoiding a potentially awkward situation down the line.

RURAL SETTINGS AND OTHER SMALL-WORLD HAZARDS

In 2010, approximately 60 million people (19% of the population) lived in rural communities (U.S. census, <https://ask.census.gov/faq.php?id=5000&faqId=5971>). Estimates indicated between 16% and 20% of rural residents struggle with significant substance dependence, mental illness, and medical-psychiatric comorbid conditions (National Rural Health Association, 2008; Roberts, Battaglia, & Epstein, 1999). The necessity of being a generalist as the only practitioner within many miles can either be satisfying or unsettling, depending on one's overall competence, training, and self-efficacy. Unfortunately, demand in these underserved areas for in-person services exceeds existing resources (Benson, 2003; Klugman & Dalinis, 2008; Nelson, Pomerantz, Howard, & Bushy, 2007; Schank & Skovholt, 2006). The few therapists in town (sometimes only one) will know many of their clients in other contexts, and the townspeople will also

know a great deal about the therapists and their families. Therefore, even though multiple-role relationships are likely to be accepted as ordinary, boundaries still demand consideration in relation to the sociocultural contexts of the community (Roberts et al., 1999).

Attributes of small communities further complicate ethical dilemmas in the context of delivering mental health services. Information passes swiftly, and standards of confidentiality among professionals and community service agencies may be relaxed (Hargrove, 1986; Helbok, 2003; Solomon, Heisberger, & Winer, 1981). In smaller, isolated communities, gossip can be rampant, making it even more difficult to ensure client confidentiality (Sleek, 1994). Following every mandate of the ethics code of one's profession can be challenging and sometimes impossible (Schank & Skovholt, 2006).

Most traditional graduate programs do not sufficiently prepare therapists for the array of interactions that become impossible to avoid when working in small, isolated communities (Campbell & Gordon, 2003; Schank & Skovholt, 2006). Although most extratherapy contacts may be described as casual as opposed to "having a relationship" (Horst, 1989), as anyone who has lived in a small town can readily attest, face-to-face interactions with clients outside the office inevitably occur, sometimes on a daily basis. One psychologist, who was the only mental health provider within 60 miles, relayed to us the special care taken to ensure that he and his client, the only sixth-grade teacher in town, could avoid difficulties arising due to the presence in her class of the psychologist's rebellious 12-year-old son. Another small-town marriage counselor shared the burden of scheduling neighbors to avoid unwelcome face-to-face meetings in the waiting room. Yet another colleague requested guidance from an ethics committee when a client's alcoholic and abusive husband yelled profanities at him at every opportunity—in the barbershop, bowling alley, restaurant, market, and even as they passed each other in their cars.

Residents of small communities are often more hesitant to seek professional counseling and are slow to trust outsiders, preferring to

rely on their kinship ties, friends, and clergy for emotional support. Because those who do seek therapy prefer someone known as a contributing member in the community, it may not be possible to commute from a neighboring town and expect to have much business. Ironically, then, earning acceptance and trust means putting oneself in the position of increasing complicated relationships (Campbell & Gordon, 2003; Stockman, 1990). Consider, for example, what might happen when a client works as a salesperson at the local car dealership. When the therapist buys a new car—and everyone will know what make and model and where it was bought—the client may be deeply offended if the therapist purchased it elsewhere. Yet, would the therapist have any latitude to negotiate the price? Or, would the client feel obligated to give the therapist a better deal? And, what if the car turns out to be a lemon? This is the kind of dilemma small-town therapists must routinely juggle, and the best answers are not always obvious.

Just because mental health professionals in smaller communities cannot separate their lives entirely from those of their clients does not mean boundaries become irrelevant. On the contrary, therapists must make constant and deliberate efforts to minimize role confusion. For example, no matter how small the community, a therapist and a client should never need to socialize *only* with each other. Potentially risky acts over which therapists always have complete control regardless of community size, such as giving gifts to or going into business with clients, can still be avoided. The therapist can maintain confidentiality and refrain from chiming in during gossip sessions taking place outside the office. The therapist's family may also need instruction on how to interact in certain situations, while minimizing the details regarding why. Feelings of isolation and burnout are ever-present risks for therapists in rural communities due to the strain of managing multiple roles coupled with the smaller pool of potential close friends as well as the lack of easily available peer support (Hastings & Cohn, 2013).

The therapist in the next case failed to attend to more than one ethical requirement, despite

the more accepted practice of bartering in rural communities.

Case 8–49: Due to stresses caused by economic hardships, the Peeps required more counseling sessions than originally estimated. The Peeps's chicken farm income had become insufficient to pay the regular bills, let alone bills for therapy. Ronald Rooster, M.S.W., proposed a deal to accept 2,000 chicks in exchange for counseling, provided it did not last beyond a year. Mr. Rooster's wife had long wanted to start a chicken farm, so this deal would also fulfill one of the therapist's needs. The Peeps reluctantly agreed. Soon thereafter, a lethal virus dangerous to humans and believed to be carried by poultry resulted in the destruction of millions of chickens in Canada, driving up the price of chickens from unaffected areas. The Roosters made a huge profit and, at the same time, were also in business competition with the Peeps. The Peeps were locked into a therapy situation with which they felt very uncomfortable and successfully sued Dr. Rooster.

This case, adapted from Roberts et al. (1999), reveals the highly unethical relationship blending that can occur in rural settings where roles are often already enmeshed. Taking an exchange in advance for services that may not be needed is the tip of the iceberg. Bartering a vulnerable client's assets to start a competing business is unconscionable.

Small communities are found not only in rural areas or geographical isolation. Close-knit, cultural, LGBT (lesbian, gay, bisexual, transgender), military, criminal justice and corrections, disability, faith-based, school, and ethnic communities are among those existing within a larger community (Kessler & Wachler, 2005; Schank, Helbok, Haldeman, & Gallardo, 2010; Schank & Skovholt, 2006). The primary advantage of working in a heavily populated area is the availability of more alternatives. Still, when a cohesive population is embedded in a larger city, complications similar to those faced by rural therapists can arise. LGBT clients, for example, often prefer LGBT therapists. These therapists, as people, want to be part of an accepting community, which means that

negotiating complicated multiple roles is likely (L. Brown, 2011; Graham & Liddle, 2009).

Case 8–50: Lisa Lorne, Ph.D., specialized in counseling lesbian women. She accepted into her therapy group a female client who had just moved to the city. During the second session, the new client gleefully announced she had just met someone named Sandra Split, and they were going to start seeing each other. Dr. Lorne was still devastated by Sandra Split's recent breakup with her after 16 years together.

If Dr. Lorne's own issues would make it impossible to work with a specific client, arranging for an alternative that keeps the client's best interests in mind is advised. Furthermore, the new client is very likely to learn of Split's relationship with Lorne sooner rather than later.

Small-world hazards often occur in unexpected ways. A therapist might learn his client is his wife's best friend's secret lover or his son's new boss. Such information is unlikely to be known in advance, as it would likely be in a small town. Discoveries may emerge during the course of psychotherapy that can be handled by staunchly maintaining the professional role without regard for the coincidences linking the therapist and client in other ways. Therapists are more likely to be judged culpable when a small-world hazard was perceived in advance and adequate alternatives were available.

We are witnessing an increase in the use of electronically based distance therapy. These may ease the shortage of resources and relieve many of the ethical problems inherent in rural communities and other small-world situations when appropriate options are scarce (Bischoff, Hollist, & Smith, 2004; Farrell & McKinnon, 2003). Of course, with technology-based therapies other ethical challenges pertain. Ironically, forms of distance therapy provide new types of small-world hazards (Lannin & Scott, 2013), as covered in Chapters 4 and 11.

NONTRADITIONAL THERAPY SETTINGS

Therapeutic goals can sometimes be better achieved away from a professional office-style

setting. Delivering therapy in clients' residences can forestall the need for hospitalization or alleviate difficulties for clients who are physically frail or do not drive (Knapp & Slattery, 2004). Action-oriented therapies, including crisis modalities, may involve working with clients in out-of-office situations. For example, a therapist might accompany his "fear-of-flying group" on a flight from Los Angeles to San Diego and back. A stress-reduction group might hold a special weekend at a serene lakeside lodge. A mental health professional, as part of an established eating disorder clinic program, may go out for a meal with a client to assist in addressing anxiety about food in a public context. Therapy delivered electronically qualifies as a nontraditional setting, given that the clients and therapists could be in their own rooms wearing robes and slippers. (E-therapy and electronic boundary issues are discussed in Chapter 4)

Excursions beyond traditional professional settings do require careful forethought to preclude subsequent complaints of exploitation because of the potential for multiple-role or conflict-of-interest overtones, confusion, or impairment of the therapists' objectivity. When employing an atypical setting or technique, it becomes critical to clarify the therapeutic context and the activity.

Case 8-51: Homa Cloister feared crowds. Her therapist, Rip Vivo, Ph.D., suggested they go out to dinner at busy, fine dining restaurants after therapy sessions as a way of conditioning her to feel more comfortable around people. He did not charge an additional fee for the after-hour activity but did require her to pay the dinner bills. The treatment proved ineffective and uncomfortable for this client. Homa later charged exploitation by Dr. Vivo for repeatedly disguising a free meal ticket as psychotherapy.

Case 8-52: Several encounter group members complained that the counselor associated with the Touchit Clinic conducted weekend retreats at a local hotel that also inspired coercive and promiscuous behavior among the participants. They believed the various exercises encouraged and stimulated some members to become obnoxious

and to pressure others into sexual activity after the formal evening activities concluded.

Case 8-53: Jake Sprint, Psy.D., suggested that he and Hal Jogger conduct their counseling sessions on Monday and Wednesday mornings as they ran in the park. Later, Jogger complained to an ethics committee how he was not getting better because it was hard to concentrate, hear what his therapist was saying, respond, and run at the same time. Jogger believed he was paying a substantial sum for Dr. Sprint to engage in his personal exercise routine.

Vivo's technique with his agoraphobic client may have a therapeutic rationale, but he included the trappings of a social event and structured the financial aspects poorly. The Touchit Clinic staff did an insufficient job of setting ground rules and monitoring compliance. Sprint's motives may not have been as Jogger perceived, but attempting to perform therapy while engaging simultaneously in another activity is difficult to justify.

Case 8-54: Winter Bones broke both legs skiing and would not be able to drive for 6 weeks. Bud Visit, L.M.H.C., agreed to see Bones in her apartment. On arriving, he found lunch waiting for the two of them, including a glass of wine. While eating, they engaged in small talk. Six weeks later when sessions resumed in the office, Visit attempted to get things back on track in the professional setting. An affronted Ms. Bones decided to find another therapist.

Mr. Visit settled too comfortably into the temporary therapy setting, and the relationship shifted just enough to compromise it. Bones now perceived of herself as a rejected friend. Mr. Visit should have anticipated the dynamics of a home-based setting and prepared his client with the ground rules, which would not have included meals or alcohol. Therapists who make home-based visits or offer community-based treatment of those with more serious mental problems must remember that boundaries are challenged in ways not ordinarily present in professional

office or hospital settings (Knapp & Slattery, 2004; Perkins, Hudson, Gray, & Stewart, 1998).

Earning a living without leaving home may be an attractive-sounding option. The increasing popularity of working out of one's personal space is understandable from both convenience and financial standpoints. While not inherently inappropriate, we do not advise conducting therapy in one's home. If one must do so, the room should be furnished along the lines of a typical therapy office and ideally have its own entrance. Some clients, however, may find receiving therapy anywhere in the therapist's home (even in a dedicated home office) confusing, and their emotional status could become compromised by connotations attached to the setting.

Therapists who practice out of their living quarters also risk professional isolation unless colleagues are actively sought out in other venues. As noted, isolated therapists may be more likely to look to clients to fulfill their own needs. Other clients could potentially become burdens on the family. A client could even act out in frightening ways. Unless the home office therapist has another location available to screen new clients, one cannot know in advance who will walk through the door. The next case describes an actual horrifying incident.

Case 8–55: Kevin Homebody, L.M.H.C., held counseling sessions in the den of his home. Lady White, a quiet and refined woman, sought assistance in dealing with stress and Snow, her cocaine-addicted daughter. Mrs. White brought Snow along to several sessions. One night while the Homebody family was watching TV, three knife-wielding men broke into Homebody's house. They terrorized the family for several hours as they gathered valuables. It was later learned that Snow had told her drug dealer about the "nice stuff at her mom's counselor's place" and provided him with the address and a drawing of safe points of entrance.

Decisions to venture away from a professional venue must be based on several criteria: a treatment plan for individual clients that justifies the arrangement as a more effective

setting for facilitating specific therapeutic goals as opposed to mere convenience; ensuring that the client understands the proposed experience and gives informed consent; enforcing appropriate client and staff behavior for group experiences; and preparing the client for the actual sessions or event. Also, as Case 8–55 illustrates, matters become more complicated in multiple-client therapy sessions or when the primary patient seeks to bring a family member or significant other into the session for a limited purpose. (See family and group therapy discussions in Chapter 4 and confidentiality/records discussions in Chapter 6.)

UNANTICIPATED ENCOUNTERS WITH CLIENTS

Every mental health professional is at the mercy of coincidence, and an unexpected compounding of roles can occur by chance. Although the appropriate response may be difficult to discern on the spot, therapists must attempt to ameliorate the situation as best they can (Canter et al., 1994). Therapists who find themselves in a possibly harmful multiple-role relationship due to unforeseen circumstances must take reasonable steps to resolve it in the most ethical manner possible (APA: 3.05; NASW: 1.06). A therapist's response, which often must be made quickly, will depend on several factors. Confidentiality issues usually pertain. Unless the therapist and client have discussed how to handle situations when they encounter each other by chance, the therapist will not know how to take the client's preferred option into account. The urgency of the situation is also a factor. Sometimes, problems can be deflected if there is time.

When dealing with unforeseen factors, usually no *lasting* multiple-role relationship actually develops. The nature of the encounter itself determines, in large measure, its impact. Seeing each other in line at the post office is one thing, naked in the gym shower is quite another. Most therapists who have had unintended encounters with ongoing clients express surprise, uncertainty about what to do, discomfort, anxiety, and embarrassment (Sharkin & Birk, 1992).

Fluke crossings are more likely to occur in smaller communities, but unexpected situations can arise anywhere. In fact, three of the four incidents described in the next examples occurred in large metropolitan areas.

Case 8-56: Mildred Suit, a client of Gina Squeezed, Ph.D., announced an intent to sue a lawyer for rendering incompetent services during her child custody hearing. Suit informed Dr. Squeezed that she will be subpoenaed to testify about the mental anguish she endured. Suit also, for the first time, reveals the name of the lawyer she is suing. It is Orin Trial, another client of Dr. Squeezed. (Case adapted from Leslie, 1994.)

Dr. Squeezed may be able to extricate herself from the case by discouraging Suit from calling her to testify, but only if she genuinely believes she has nothing useful to offer the court. In addition, Ms. Suit's attorney may concur because opening a discussion into her mental state could lead to far-ranging inquiries that might ultimately hurt her case. If Ms. Suit still plans to call Dr. Squeezed as a witness, her other client, Attorney Trial, will soon learn of the relationship. Dr. Squeezed will be on a list of potential witnesses, and Trial's own lawyer will most likely depose her. Ms. Suit, on the other hand, will not know of Dr. Squeezed's relationship to Mr. Trial unless he chooses to reveal it. In the deposition, Dr. Squeezed will most likely have to testify about Ms. Suit's psychological life under oath in front of both clients. In a technical sense, Dr. Squeezed could testify or prepare an affidavit (i.e., a sworn written statement) regarding Ms. Suit's mental suffering without reference to Mr. Trial or even an acknowledgment of his status as a client. Obviously, he will have some feelings about this, as will Ms. Suit if she becomes aware of details after the fact. In addition, matters could become complicated if Mr. Trial's defense involved an attack on Dr. Squeezed's credibility or expertise.

The best advice to Dr. Squeezed would be to consult her own attorney and, in the interim, avoid breaching the confidentiality of either client. Her attorney can ask Ms. Suit's lawyer

whether and when Squeezed will be disclosed as a potential witness. When that occurs, she can discuss the fact of this listing (but no details of Suit's case) with Mr. Trial and discuss the implications for their continued work together.

Case 8-57: Gilla Social gleefully announced to her psychotherapist husband that artist Pablo Miroklee agreed to speak at her monthly art guild meeting. She wants to volunteer their home for the event and to entertain Miroklee for a quiet dinner afterward. The artist, who is emotionally volatile, has been a long-term and difficult client of Social's husband.

At first blush, the Socials' problem seems easy enough to solve. If the client already knows about the art guild arrangement, Dr. Social should discuss the quandary with his client. But, what does Dr. Social tell his wife? Spouses, after all, are not exempt from confidentiality mandates. All therapists should reach an understanding with their partners and older children about the multiple-role problems that may occasionally impinge on their lives. Close relations can be informed of possible changes in plans, possibly abrupt ones. Like many health service providers, sacrifices also touching others may have to be made. Therapists must ensure that their family members understand that no details can be given and no questions can be answered. Mrs. Social's husband, if he has already reached an understanding with his wife, may simply say, "I'm sorry, the art guild meeting and dinner cannot take place here." She may be disappointed but would understand there is a good reason even if she will never know exactly what it is.

Case 8-58: During a New Year's Eve event at a fashionable restaurant with some friends, Eva Close, M.S.W., spots one of her clients at a table across the room. This client is particularly sensitive and worries constantly about anyone finding out that she even knows a psychotherapist. Mrs. Close and her husband had planned this evening for weeks and paid \$200 in advance. Mrs. Close thinks she may be able to stay in her corner of the dining area, but as guests begin to drink, they

also move around the room to chat and meet new people. Mrs. Close's husband and friends are also urging her to "get out there and dance."

Mrs. Close may have to figure out how to keep a low profile at the New Year's Eve event. She should not become intoxicated. In small communities, clients with such intense concerns about discovery might better be referred to someone in an adjacent city, or they may be suited for telephone or web-based counseling.

Case 8–59: Fortuna Yikes, Psy.D., agreed to have dinner with friends and a blind date they arranged for her. On arriving at the restaurant, she peeked inside and recognized the man sitting with her friends as one of her clients.

In the actual situation, the therapist was able to leave before being seen. She texted her friends in the restaurant, saying she had a client issue that demanded immediate attention (without specifying that it was about the man at the table). Because such twists of fate do happen and quick exits may not be an option, we suggest that therapists working in smaller or tight communities attempt to learn in advance the identities of people with whom they will be meeting in intimate social situations.

We also strongly encourage mental health professionals to raise chance encounter management plans early on. Some clients will prefer to pretend they do not know their therapists. Others may favor acting as though they are acquaintances and exchange brief greetings. We advise that therapists *not* be the ones to take the lead during chance encounters, and that clients understand in advance that the decision to interact with or to ignore each other rests entirely with them. Clients should be assured that the therapists will be comfortable either way. Our plan is recommended for *all* clients. That way, the therapist does not have to remember which reaction each client prefers (and even these could vary, depending on the circumstance). There is no risk of being perceived as rejecting because the client will know to take the lead when the two notice each other outside the office setting. With a preapproved plan well

in place, common situations involving clients, such as finding oneself in the same line at the bank, can be handled somewhat gracefully and without incurring more than minimal discomfort. Pulakos (1994) surveyed clients who had already experienced outside encounters with their therapists. Of these clients, 54% expressed wanting a brief acknowledgment, 33% wanted a conversation, and only a small number preferred to be ignored. Twenty-one percent would want a different response from the one they actually received. These results verify that no one size fits all.

Of course, conflicts and role complications can occur in other than face-to-face situations. For example, an employer may call for a recommendation of an individual you know in the community who is (or was) also a client and about whom you would have reservations based on what transpired in therapy. In an actual case, a prominent psychologist was contacted by a state psychological association to approach a politician who had considerable power to affect the outcome of pending legislation favorable to psychologists. What the organization did not and could never know was that the psychologist had worked with the politician's family some years previously on a sensitive problem of the sort that could ruin the politician's career. The psychologist felt torn between agreeing to set up some kind of meeting (even though he would not to be present) and alienating his professional organization by refusing to do it. He decided to tell the association's staff that "family problems" precluded his involvement, leaving the staff to infer that the family to which he was referring was his own.

WHEN THE THERAPIST IS SQUEEZED IN THE MIDDLE

We have focused on multiple-role relationships in which the mental health professionals directly occupied one of the roles. However, situations can pinch them between two or more other forces. For example, demands of the agencies employing therapists may conflict with the needs and welfare of the agencies' clients. This

dilemma is increasing as managed care takes over privately contracted services between a therapist and a client.

Case 8–60: Paul Plastique, Ph.D., provides psychotherapeutic care at a Megahealth Memorial Hospital to children with chronic medical conditions. For 3 years, he has worked with 8-year-old Zachary Mug through several stressful craniofacial surgical procedures to deal with malformations caused by Crouzon syndrome. Zack has experienced self-esteem and peer problems, school disruption, and painful recoveries, but Zack and his parents feel that Dr. Plastique understands him and his life experiences very well. The Mug family is covered by Monolith Insurance through Mr. Mug's employer. Monolith recently "carved out" their mental health benefits and subcontracted these to CFI Care Services. Contract talks between CFI Care and Megaville Memorial Hospital on a new contract for mental health services broke down. While Zack will still have medical and surgical care through Megahealth Memorial covered by Monolith, Dr. Plastique's psychotherapeutic services will no longer be covered. CFI Care has referred Zack and his family to a counselor in the community who has no familiarity with Crouzon syndrome or children with craniofacial surgical abnormalities.

The issues confronted by Dr. Plastique and the Mug family have become all too common as third-party payers continually strive for economic advantage through the use of carved-out contracts and competitive pricing agreements. Coordinated continuous care in a single setting by therapists with the most relevant training and experience have become difficult to maintain. Perhaps Dr. Plastique and the Mug family can make a special circumstances plea to CFI Care or Monolith Insurance. Perhaps Megahealth Memorial will offer some reduced fee to the Mug family in the absence of coverage. Perhaps Dr. Plastique's practice is such that he can continue to treat Zack outside the Megahealth/Monolith system. More likely than not, however, Dr. Plastique and his client will find themselves trapped in an arcane

world of contractual and fiscal constraints that allow little latitude to consider the best interests of individual patients. (See also Chapter 12)

Government policy, legal requirements, or the welfare and safety of society in general may also clash with therapists' judgments regarding what might be in the best interests of individuals with whom they are working. The identification of priorities and loyalties can cause acute stress and conflict-of-interest dilemmas. Ethics codes specify that therapists should proactively attempt to resolve conflicts (APA: 1.02, 1.03; AAMFT: Preamble; ACA: I.1, I.2; NASW: preamble, 3.09) or refrain altogether from accepting a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to impair their objectivity, competence, or effectiveness or expose an individual or an organization to any harm or exploitation (APA: 3.06; NASW: 3.09.f). Often, therapists are not in an objective position when acting under such conditions because the more powerful of the conflict sources, such as the legal system or the employer, may issue sanctions if the therapist's actions do not comport with the position of the more powerful party. (See also Chapter 13.)

COMPLEX RELATIONSHIPS WITH STUDENTS

Many mental health professionals teach or supervise full or part time. Teaching content is only one role educators and their students share. They invariably interact in other contexts, and without remaining self-aware, complicated and ultimately harmful incidents may ensue.

On-Campus Risks

Appropriate boundaries with students and educators can be more difficult to draw than with therapy clients. Teaching-related activities are governed by the same disciplinary bodies for other mental health professionals, but the student-teacher relationship is not considered a

fiduciary relationship as for the client–therapist relationship (Knapp & VandeCreek, 2006). Whereas therapists and their clients must willfully make specific arrangements to alter a professional relationship, professors and students often do not. Indeed, encouragement to attend many of the same activities (e.g., sports events, festivals, club parties, receptions, and so on) outside the classroom is commonplace. Because professor–student relationships usually do not involve the same level of trust or possess the emotional closeness characteristic of psychotherapy relationships, mixing the contexts in which educators interact with students on a casual basis does not necessarily raise concerns. Nonetheless, responsibilities toward students and the power of educators to influence or exploit them and their life opportunities are forceful enough to warrant caution (APA: 3.08; AAMFT: 4.1; ACA: F.10; NASW: 3.02).

Case 8–61: Several students complained to the department chair about Royal Payne-Diaz, Ph.D. They claimed he blatantly favored the students he liked and froze out those he disliked. Professor Payne-Diaz responded that he may have seemed friendlier to some students than to others because he spent time with the more assertive ones, who sought out his company for coffee at the snack bar or just to chat in his office.

Professors who wish to form closer relationships with current students must be aware of the misunderstandings that often arise, including what meaning other students might place when observing a professor and only one or selected other students off by themselves. Educators must remember that students are sensitive to issues of equity and believe those who operate (or appear to operate) on a tilted playing field are extremely unethical (Keith-Spiegel, Tabachnick, & Allen, 1993; Owen & Zwahr-Castro, 2007). Students are inclined to be more accepting if student–educator relationships are perceived as strictly professional (Holmes, Rupert, Ross, & Shapera, 1999). Professors should also remain self-aware to ensure that they are not viewing students as primarily fulfilling their own needs for companionship. The next case involves a professor who put herself first.

Case 8–62: Patsy Pawn, the daughter of the boyfriend of Linda Pleasemore, D.S.W., was encouraged to enroll in Dr. Pleasemore's section of an introductory social work course. Pleasemore thought this experience would help solidify her relationship with the girl's father. Halfway through the semester, however, the relationship between Pleasemore and Pawn's father dissolved. Pawn's final course grade was a D. Miss Pawn and her father filed complaints with the university charging Dr. Pleasemore with seeking vengeance by assigning the daughter a poor grade.

Pleasemore's professional judgment was faulty on several grounds. She not only instituted a multiple-role relationship up front but also used a professional relationship as a vehicle for advancing a personal agenda. Even if the relationship had worked and the daughter had received a higher-than-deserved mark, the ethical issue would remain unchanged, although it would not likely be contested.

Graduate students in training are often in a position to develop multiple-role relationships with other students, usually undergraduates, resulting in ethical dilemmas (Oberlander & Barnett, 2005). They may interact with these students as their classroom teachers or teaching assistants, in the course of conducting research, and, most challenging, as clients in the counseling center (Dallesasse, 2010). Sometimes, graduate students are in an awkward position because they are performing in a professional role while students.

Case 8–63: Graduate teaching assistant Ivan Lusty teaches an introductory psychology course in which a female student caught his eye. Mr. Lusty was aware of the faculty prohibition regarding dating undergraduate students, but he reasoned he was not "real" faculty. He stopped the young woman after class and asked her for a date. She did not welcome this solicitation, turned him down, and yet felt anxious for the remainder of the semester, worried that Mr. Lusty would punish her somehow for rejecting him.

Regardless of how Mr. Lusty took the rebuff, he placed his student in an untenable position.

When in the role of an educator, students must play by educator rules. (See also Chapter 9)

Off-Campus Behavior

Professors would be wise to monitor their behavior whenever and wherever students are around, even when not on campus. Professors are readily recognized by students, and they discuss among themselves what they see. Professor Plaster in our next case would no doubt wish he had followed our advice.

Case 8–64: The team won the game, and the victory party at the local pub was raucous. Plenty of liquor was consumed, and Professor Plastered downed several. When a student disagreed with Plastered's choice of the team's best player, he tossed a glass of beer in her face.

The actual incident from which our beer-tossing case is adapted ("University Suspends," 1995) was widely publicized. The professor (not a mental health professional) was suspended for a semester.

Case 8–65: Marsha Scholar, Ph.D., was popular among students and socialized with many of them. She felt shocked when a student filed a grievance claiming Scholar had given her a low grade because the student's boyfriend disagreed with Professor Scholar's husband about the effectiveness of psychotherapy while at an off-campus student party. Scholar claimed her husband never mentioned any such incident and insisted she had graded the student objectively.

The most conservative yet safe course of action is for educators to attempt to limit outside social contacts with classroom students to occasions associated with the institution (e.g., departmental social events or other functions where other instructors will be in attendance) until the students graduate.

A more common situation is difficult to evaluate, perhaps because it satisfies everyone's needs far more often than not.

Case 8–66: Professor Henry Hire lives in a small university town. He regularly hires students

seeking part-time employment to do yard work, house repairs, and dog sitting.

Ethical issues are mostly defused when student employees are not in the same departmental unit. However, the practice of hiring students one knows for part-time work is so prevalent that the attendant ethical issues are rarely considered. But, what if the student accidentally cuts down the wrong tree or loses the family pet? There are precautions to take for the sake of students as well as one's own professional standing to diminish the possibility of untoward fallout. First, students currently enrolled in one's classes should not be employed to do nonprofessionally related work. Second, student employees should be selected for their competence and trustworthiness and paid a fair wage. Third, expectations and agreements should be well formulated in advance, including provisions for termination predicated on respect for the needs and welfare of students.

A question with ethical ramifications arises regarding whether a student who is concurrently being evaluated by an educator or advisor (or will be in the future) can turn down *any* request, even when the student will be paid. For example, an advisee with artistic skills is asked to create the illustrations for her advisor's PowerPoint presentation for a fee of \$150. Dare she tell him how overwhelmed she is with her own workload, to the point of not getting enough sleep? Educators must consider the unintended pressures and attempt to ensure that any arrangements do not disadvantage the student.

Mentoring Students

Perhaps the most complex multiple-role relationships occur between student protégés and their mentors. Professors often become close with those they mentor, usually graduate students with whom they actively collaborate, in a way that is absorbing and satisfying for both parties. Relationships occurring toward the end of the training period can last a lifetime.

In Chapter 10 we discuss the complex role of clinical supervisor/student. Mentoring, however,

is a cut above, involving a close alliance with a “professional parent.” Mentoring often bestows the protégé career opportunities. For example, it is common for mentors to instigate contacts who can open doors. Such relationships also offer personal benefits, such as emotional intimacy and a wide range of shared activities and contexts (Johnson & Nelson, 1999). Mentors teach the “ropes” that matter, tips that may never be taught in the classroom or during routine advisement sessions. When such relationships run smoothly, protégés thrive. Successful mentoring also rewards the mentors with both a collaborator and feelings of pride for bringing students in training under their wings and teaching them to fly.

Complex relationships are also vulnerable to breakdowns and dysfunction to the detriment of protégés as well as to the mentor and the institution (Scandura, 1998).

Case 8–67: Lend Anear felt initial excitement about working with Ivana Dump, Ph.D. Dr. Dump promised Mr. Anear access to her professional world as well as opportunities to work on her research as a coauthor. However, as their relationship grew closer, it also became more burdensome on Mr. Anear, who felt forced to spend hours listening to Dr. Dump’s complaints about colleagues and the ongoing difficulties she was having in her personal life. When Mr. Anear would attempt to divert the conversation to their professional relationship, she would chide him for being unsupportive. Mr. Anear chose to terminate the relationship. Dr. Dump reacted poorly, leaving Mr. Anear to worry about whether she would try to cause him harm.

Although some degree of emotional intimacy and reciprocity usually defines mentoring relationships, Dr. Dump was using her protégé to serve her own needs to the neglect of Mr. Anear.

Case 8–68: Rare Help, Ph.D., was delighted to learn that a new doctoral student, Iben Pushed, claimed an attraction to his obscure specialty area. At first, the relationship seemed to be proceeding well, but soon Mr. Pushed cancelled

several appointments and seemed less interested in working with Dr. Help. One afternoon when Mr. Pushed entered late for a meeting, Dr. Help pronounced, “You are irresponsible, and I believe you declared an interest in my research as a way of getting accepted into the doctoral program. That’s fraud.” Mr. Pushed retorted with, “No one warned me about how controlling and rigid you are and how much you expect me to do.”

The failure of the relationship between Dr. Help and Mr. Pushed is more difficult to predict, given that clashing personality styles can override other seemingly compatible indicators. Dr. Help may have been strict and critical. Mr. Pushed seemed ill-prepared for the demands placed on him and reacted in a passive-aggressive manner. However, although mentors typically expect reciprocity as the relationship unfolds, expectations from protégés can be inappropriate for a number of reasons, including immaturity, gender, and culture (Shore, Toyokawa, & Anderson, 2008). Mismatches can readily lead to unmet expectations, which in turn cause the relationship to degrade and even become abusive (Perrewé, Zellars, Rogers, Breaux, & Young, 2010). Although responsibility for the negative outcomes of dysfunctional mentoring relationships is often placed on the mentor as the more powerful player, protégés can also be active contributors to the dysfunction (Eby & McManus, 2004, Feldman, 1999).

It is unfortunate that protégés may feel exploited, harassed, or demeaned and that mentors may feel unappreciated, betrayed, and disappointed. Ideally, prospective mentors have already assessed the compatibility with the pool of potential protégés and have laid out procedures for openly addressing concerns emanating from either party.

Relationships With Former Students

Social relationships with students after graduation pose a somewhat different set of dynamics than with therapy clients after termination. Once students leave, the primary student–professor role ceases forever. Some

students will become colleagues with whom educators will interact at professional meetings or in other professional capacities. Continuing scholarly collaboration among educators and those who were once their students is not uncommon.

Both ex-students and their professors can cause each other grief if their relationships disintegrated while also remaining in the same circles (e.g., each can complain about how the other was as a student or as a teacher). But, this issue is a problem of interprofessional relationships, as discussed in Chapter 10, rather than a conflict of roles. (Additional discussions about relationships with students, including sexual liaisons, appear in Chapters 9, 10, and 14.)

WHAT TO DO

- Focus on maintaining professional boundaries that offer clients a safe haven from extraneous influences.
- Remain mindful of the risks of forming multiple-role relationships and avoid those that might exploit or harm clients or cause a loss of objectivity.
- Prepare in advance for possible chance encounters with clients outside the therapy setting.
- Use a decision-making checklist and consultation with a colleague when contemplating boundary crossings or multiple-role relationships.

WHAT TO WATCH FOR

- Before attempting complex role relationships with clients or students, take care to avoid even the appearance of self-interest or conflict of interest.
- Remain aware that the dynamics and functions of family and close friend relationship are markedly different from those of a professional therapy relationship.
- Carefully evaluate the risks of accepting ongoing clients' referrals of their friends or family.

- Take special precautions to inform and protect clients when conducting therapy in non-traditional settings.
- Recognize students' sensitivities to what they perceive as uneven playing fields, such as giving certain students privileges others do not receive.

WHAT NOT TO DO

- Avoid self-disclosures that seem unlikely to advance the goals of treatment.
- Never use clients for self-gratification or entertainment.
- Avoid friendships with ongoing clients as they may cause conflicts and confusion for the clients.
- Do not make promises or plans for post-termination relationships while therapy remains active.

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9

Attraction, Romance, and Sexual Intimacies With Clients and Subordinates

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief, and in particular of sexual relations with both female and male persons, be they free or slaves.

Hippocratic Oath (ca. 400 B.C.E.)

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In 1972, one of the authors of this book (P.K.S.) attended a debate hosted by a local California psychological association. The topic was, “Is having sex with clients helpful?” Three licensed psychologists with solid credentials argued that sexual intimacies with clients was curative and boasted about their successes. Clients they believed benefitted most were typically vulnerable, inexperienced, sexually inhibited, fearful of intimate relationships, experiencing low self-esteem, suffering from aversive experiences in childhood, and distrustful of men. (By today’s standards, think “easy targets.”) These clients were also described, without exception, as younger women. The highlight of the evening occurred when a therapist of substantial girth and in her 50s stood up and asked, “If I were a client, would any of you have sex with me?” The audience held its collective breath as the three psychologists froze like deer in headlights. The message was clear—these therapists were in it for themselves.

By the later 1970s and into the early 21st century psychotherapy’s “problem with no name” (Davis, 1977) sprang from obscurity accompanied by a flood of surveys and commentary. Condemnations of sexual exploitation of psychotherapy clients were soon incorporated into ethics codes, licensing statutes, and laws. Books were devoted to the subject of erotic transference and countertransference (e.g., Mann, 1999) and sexual contact with clients (e.g., Baur, 1997; Bates & Brodsky, 1989; Pope, 1994; Pope & Bouhoutsos, 1986; Pope, Sonne, & Holroyd, 1993; Russell, 1993). Although incidents continue to plague the helping professions, most relevant studies and original scholarly writings were published in the late 20th century.

Today, any ambiguity about sexual acting out in therapy is long gone. As Shapiro and Smith (2011) summarized the current status, “Sexual contact with clients is malpractice. It is unethical, and every psychologist knows this, and it creates clear liability” (p. 119).

SEXUAL ATTRACTION

Therapists Attracted to Clients

Over the course of your career, you will more than likely face erotized stirrings in the context

of your professional relationships with at least one client. Unexpected, intense, or reciprocated attraction can blindside and befuddle any therapist, no matter how competent or well trained (Pope, 2013). Fleeting erotic feelings toward others are part of human nature; how we manage such feelings lies at the heart of ethical professionalism. Nevertheless, therapists may experience surprise, embarrassment, even shock, upon recognizing that they have sexual feelings toward one of their own clients (Pope et al., 1993).

It should have astonished no one when the first published survey reported that very few therapists reported *never* feeling attracted to any client (Pope, Keith-Spiegel, & Tabachnick, 1986). Of the 95% of the male therapists and 76% of the female therapists admitting feeling attracted to at least one client, the majority felt guilty, anxious, or confused. Older female therapists were less likely to report ever being attracted to a client, whereas the attraction rate for younger female therapists approached that of male therapists. As those “younger respondents” of the 1980s would be today’s “older respondents,” the percentages separating the sexes may now be far less disparate. Despite the high rates of attraction, however, a much lower percentage of therapists (9.4% of the men and 2.5% of the women) reportedly allowed the attraction to escalate into sexual liaisons with their clients. A study using the same survey form (Bernsen, Tabachnick, & Pope, 1994) reported similar high rates of attraction for social workers, often causing guilt, anxiety, and confusion, with relatively few reporting acting on their feelings. In a survey of marriage and family counseling students, Harris (2001) found most would feel cautious, uncomfortable, and nervous. Some would feel embarrassed, vulnerable, and even scared.

Another survey almost a decade later (Rodolfa et al., 1994) found only 12% of their large sample of psychologists claimed to have never felt attracted to a client, and only a few had ever acted on these feelings. Pope and Tabachnick (1993) reported in their national survey that almost half of the therapists experienced sexual arousal during a therapy session.

About a third believed that their clients had, on occasion, become sexually aroused while with them.

To whom are therapists attracted? Based on the Pope et al. (1986) survey, the overwhelming characteristic was, not surprisingly, "physical attractiveness." "Positive mental/cognitive traits" (e.g., intelligent, well educated, articulate) and "sexuality" were next followed by "vulnerability" attributes (e.g., needy, child-like, sensitive, fragile) and "good personality." Smaller percentages of respondents admitted attraction based on clients who fulfilled their needs (e.g., boosted the therapist's image, alleviated the therapist's loneliness or pressures at home) or based their attraction on the perception that the clients seemed attracted to them or reminded them of somebody else. A small number admitted feeling attracted to clients with serious psychopathology. We may debate whether some reasons seem more understandable than others. Nevertheless, a few therapists based their attraction on personal, nonprofessional needs and, in doing so, may have placed their most vulnerable clients at additional risk.

Under what conditions should feelings of attraction become a cause for concern? How should they be handled? If a therapist feels an attraction, should outside consultation be sought? In an interview study with postdoctoral interns, most participants admitted to behaving in a more invested and attentive manner to those clients to whom they felt attracted, but the attraction also caused them to become easily distracted and less objective (Ladany et al., 1997). Because the therapy process may be contaminated, it is regrettable that only half of the sample in this study reported disclosing their feelings to their supervisors. The next case suggests why.

Case 9-1: Supervisee Jack Captivated's new client was a sweet breath of fresh air. He struggled to keep from offering advice that clearly revealed his own desires. When she expressed ambivalence about moving away to be with her boyfriend, he advised such a move would not serve her well. He admitted the conflict regarding his feelings to himself but did not know how to resolve it. He

was afraid to approach his supervisor because he feared that she would likely place negative comments into his record.

Ideally, supervisors form alliances early on that encourage their supervisees to self-reflect and openly discuss their feelings. Competent supervisors strive to help trainees address all manner of ethical challenges. Jack knows he has stumbled, so the time is right to ask for supervisory help. Because handling sexual feelings probably qualifies as the most uncomfortable supervision topic (Ladany, Friedlander, & Nelson, 2005), we would expect supervisors to acknowledge their pervasive occurrence and discuss management options before supervisees actually experience such feelings. Sonne and Jochai (2014) recommended an "attitude adjustment" that acknowledges the pervasiveness of sexual attraction toward clients and to treat it as a topic for open exploration during supervisory sessions.

If therapists (and supervisees) find themselves unable to bring their feelings under control or sense such attraction compromises working with a client, and when consultation proves ineffective, we suggest a sensitive termination and referral as a way to protect all parties from complications, confusion, and harm. The therapist might say something like, "I would recommend working with someone more skilled than I in addressing the issues of concern to you." In the next case, the therapist got it only half right.

Case 9-2: Lovitt Firstsight, Ph.D., realized after a few minutes into the initial session with Venus Exquisite that he could not be her therapist. He felt like a schoolboy again, had trouble focusing on what she was saying, and became sexually aroused. He had difficulty finding his "therapist voice," and after 10 minutes, he gently interrupted her to explain how he was not the right psychologist to work with her. Mr. Firstsight offered to recommend another therapist.

At least Mr. Firstsight became immediately aware that his intense feelings may not subside and his ability to perform competently was already compromised before anything

resembling a therapeutic alliance developed. He also rightly recognized that the less the client disclosed, the better. Unfortunately, in the actual incident, the therapist did not maintain a cautious stance. He married the woman within a matter of months, only to have the relationship dissolve shortly thereafter. Once the sparkle wore off, the flattered “almost client” and the spellbound “almost therapist” had little in common and had multiple areas of conflict.

Some might argue that Firstsight did not behave unethically because the woman was not, strictly speaking, a “former client.” Ten minutes hardly seems enough time to establish a therapist–client relationship. If the woman is defined as an ex-client, Dr. Firstsight committed an ethical infraction. Why? Because even if the two remained happily married forever, he did not heed the required moratorium period (discussed further in this chapter). Regardless, the fleeting encounter involved sufficient emotional intensity to have warranted far more caution than Dr. Firstsight ultimately exercised.

Most instances of sexual attraction between clients and therapists do not strike with such a mighty force. More likely, a recognition that this person is pleasing to look at or intriguing in some way flickers and dissipates or remains at a safe level as the therapist focuses on the demands of a working professional relationship. Of course, attraction feelings can also escalate, and things can unravel, which is why we recommend never ignoring such feelings. Frequent daydreaming about the client outside therapy, taking more care with grooming on the client’s appointment day, wanting to touch the client, eliciting irrelevant personal information, and having trouble focusing during the sessions are among the alerts requiring attention. (See Chapter 17 for a full list of red flags that may predict ethical violations.)

Should one discuss such feelings with the client? Some therapists may perceive sharing as positively received (Giovazolias & Davis, 2001). But, after considering all of the possible downsides, we and others do not recommended it (Fisher, 2004; Gelso, Pérez Rojas, & Marmarosh, 2014). Why? First, the client may not be able to deal with a frank admission

of the therapist’s attraction and could easily become confused, uncomfortable, and unclear about how to respond. Second, such a disclosure injects the therapist’s own issues into the client’s life. Third, if unwelcome, a client might perceive such revelations as harassing or even repulsive. Finally, an intrigued client may readily interpret the revelation as an invitation to follow the therapist’s lead outside the office, which may not (and should not) be the therapist’s intent. We do strongly advise therapists to discuss lingering attraction feelings toward clients with someone, preferably another therapist, an experienced and trusted colleague, or an approachable supervisor. A fresh perspective will often prove helpful in clarifying the risk, neutralizing rationalizations, and offering advice on how to proceed.

The next cases illustrate how overt expressions of attraction, even if they are not actually felt, can be problematic.

Case 9-3: A young Asian client saw herself as homely and unlikable. Letme Fixit, Ph.D., explained how he was only trying to boost her self-esteem when he told her she had beautiful eyes and how he could imagine her having a close relationship with a “white man” like him, even though it could not be him as much as he would like that. His attempts to exonerate himself on the grounds that he went overboard trying to convince the client that she was attractive were not persuasive to a licensing board.

Dr. Fixit may have meant well in his own mind; however, his actions illustrate insensitivities and cultural bias. He focused on physical attributes of the client and clearly asserted white privilege with an implication that attraction to people of Asian ancestry holds less value. Most therapists would not attempt to alter a client’s self-perceptions without first attempting to understand the basis for the feelings.

Case 9-4: Jenny Curvy complained to her new therapist that her former therapist, Buster Oogle, Ph.D., often focused his eyes on her breasts instead of making eye contact during therapy. He often made comments about her “incredible

body." She became so self-conscious that she quit therapy. With Jenny's permission, a new therapist called Dr. Oogle to discuss his offensive behavior. Rather than deny it, Oogle replied, "Since when is admiring a pretty girl unethical?"

It is possible that Dr. Oogle actually thought he was paying his client welcomed compliments. We can hope that Ms. Curvy's new therapist inflicted on Dr. Oogle much needed insight.

Clients Attracted to Therapists

Clients sometimes become sexually attracted to, and direct sexualized behaviors toward, their therapists, such as suggestive looks or teasing (Sonne & Jochai, 2014). This should come as no surprise, given the intimate nature of psychotherapy. Such powerful feelings can be experienced as love, or something like it, although they may be based more on the therapeutic context as opposed to the therapist as a specific person (Shopland & Vandercreek, 1991). In a survey of female psychologists, almost half reported sexualized behavior emanating from their male and, less often, female clients. The younger the therapist, the more likely the perceived sexualized behavior directed toward them (deMayo, 1997).

Three components, according to Hartl, Zeiss, Marino, Regev, and Leontis (2007), require internal processing when a client expresses attraction in an inappropriate way. First, how does the therapist interpret the meaning of the client's behavior? Was it intentional? Was it perhaps an attempt to control, seduce, or dominate? If it seemed to be unintentional, was the client trying to affiliate or bond? Second, how does the therapist view his or her part in bringing this on? What role did he or she play that may have elicited this behavior? Might a joke or offhanded comment have prompted inappropriate behavior? And, finally, what was the therapist's own internal emotional response? Did it feel flattering, bewildering, annoying, or disgusting? Other contextual variables also need to be considered before making the appropriate response, such as the personal

styles of both client and therapist and the duration and purpose of therapy.

When a client directly expresses erotic feelings, it is important to preserve professional boundaries and protect the client's self-esteem. Leaping into interpretations of unconscious issues may seem like the safe way to go but could be experienced as humiliating by the sincere client who has mustered up the courage to disclose innermost feelings. A therapist's too-fast declaration that acting on any such feelings would be unethical may come across as an anxious overreaction. And, therapists must remember that when a client discloses erotic feelings toward the therapist, it does not necessarily mean that the client expects them to be acted on. What the therapist interprets as seductive behavior could be signs of dependency (Gregory & Gilbert, 1992). The better course of action is further exploration of the client's feelings and putting the focus back on why the client is in therapy.

What if the therapist also harbors unspoken sexual feelings toward the client who has now openly disclosed attraction to the therapist? In an attempt to better understand such a situation, Goodyear and Shumate (1996) simulated therapy sessions portraying a client disclosing a sexual interest in a therapist; these sessions were rated by groups of therapists. The portrayal of the therapist who disclosed reciprocal attraction (followed by an indication that it would not be acted on) was seen as less therapeutic for the client and less skillful than was a condition in which the therapist remained noncommittal.

We suggest that whenever a client makes any request or disclosure for which reciprocation would be inappropriate, first ask the client how fulfilling the request would help them. Then, follow with a discussion about why granting the request would not be in the client's best interests. This way, the focus remains solely on a caretaking orientation. In that rare case when a client becomes aggressively seductive, Gutheil and Gabbard (1992) suggested a more unyielding approach of telling the client that therapy is a "talking relationship" and discussing why the behavior is inappropriate. Gutheil and Brodsky (2008) suggested saying something along these

lines: "There are many people who are available to sleep with you, I'm trying to make a different contribution to your life. I'd like to be your therapist and what you're asking is not what a therapist does," or, "This room is meant to be a safe space for you to learn what it's like to have a caring relationship without sex, so that you can confront the problems for which you came to get help" (p. 187).

Rarely, a patient's acting out of exceptionally strong sexual or romantic interests may be uncontainable. This drastically limits the available interventions (Ogden, 1999). In such circumstances, the best course of action is to refer the client to another therapist.

Case 9–5: Edie Persistent's therapy with Tyler Engulfed, Ph.D., proceeded without incident at first. But soon, Ms. Persistent became belligerent, demanding that Dr. Engulfed allow her to sit on his lap during the entire therapy hour. She flailed about uncontrollably whenever Engulfed attempted to get her back into a chair. The demands accelerated and became more bizarre, including wanting him to watch her masturbate and have sex with her to simulate a rape she endured as a child.

Although the actual therapist on whom we based this case never engaged in sexual relations with the client, he suffered a highly publicized licensing board hearing that resulted in sanctions for continuing to treat a client whose pathology fell well beyond his level of competence.

We acknowledge that the close and intimate nature of psychotherapy can result in a special kind of caring between clients and therapists. It is important to attempt to differentiate caring, positive feelings toward clients from what Gelso and his colleagues (2014) referred to as conflict-based sexual feelings emanating from the transference and countertransference experience.

PHYSICALLY TOUCHING CLIENTS

Touch can come across in many ways. It is an intensely intimate, complex mode of communication to convey support, consolation, empathy,

caring, and sincere concern. Touch can also signal sexuality or elicit anxiety, aggression, and fear. The relationship between the "toucher" and the "touchee" and how and where each party is being touched can create complicated ethical dilemmas for everyone, including therapists. Whereas boundaries violated in the extreme are unanimously viewed as unethical, far more variability of opinion pertains to the use of touch in psychotherapy (Martin, Godfrey, Meekums, & Madill, 2011).

Nonerotic Touching

Historically, the "laying on of hands" has been an integral part of the healing process. The calming and attendant physical benefits of supportive stroking during childbirth and massage for relief from a wide variety of physical ailments and emotional disorders have been repeatedly demonstrated. Indeed, massage as therapy pre-dates recorded history, and "rubbing" was a major form of medicine until the advent of pharmaceuticals in the 1940s (Field, 1998). It would seem, then, that appropriate touching should be an integral procedure in mainstream psychotherapy (E. Smith, Clance, & Imes, 1998; Zur & Nordmarken, 2011).

According to Zur (2007), touch in psychotherapy is the most controversial of all boundary crossings, largely because both culturally and professionally touch is associated with sex. The topic, in general, provokes anxiety and confusion (Westland, 2011). When therapists do touch clients, the circumstances most frequently considered appropriate include expressions of emotional support and reassurance or during initial greeting or closing of sessions. Children and the distressed or depressed may benefit from appropriate touch (Holroyd & Brodsky, 1977; McNeil-Haber, 2004). Very brief nonerotic touching on the hand, back, and shoulders involves the safest areas of touch and can still convey a compassionate, supportive message (Wilson, 1982).

A survey of clients who experienced touch by their therapists reported a low incidence of negative reactions to nonerotic touch and a high incidence of positive reactions, such as facilitating

trust and feelings of acceptance, creating greater openness with their therapist, and enhancing self-esteem (Horton, Clance, Sterk-Elifson, & Emshoff, 1995). Nonerotic touch can have paradoxical effects, however, even when experienced as positive. For example, Gelb (2001) suggested that when clients find nonerotic touch as gratifying, they may then be reluctant to disclose any negative feelings.

In early studies, the majority of psychologists and psychiatrists never or rarely engaged in nonerotic touching (Holroyd & Brodsky, 1977; Kardener, Fuller, & Mensh, 1973). Approximately half of the therapists responding to the Holroyd and Brodsky (1977) survey thought nonerotic contact (such as hugging, cheek kissing, or affectionate touching) could benefit both male and female clients under certain conditions, but only 27% reported ever actually doing so. Subsequent surveys suggested that nonerotic touching of clients began to increase. Stake and Oliver (1991) reported reasonably high rates of touching of the shoulder, arm, and hand and hugging by both male and female therapists with both male and female clients. Average rates were highest for women therapists and their female clients, and these touching behaviors were rarely viewed by the survey respondents as constituting misconduct. Similarly, the majority of respondents in the survey conducted by Pope, Tabachnick, and Keith-Spiegel (1987) reported "sometimes" or "often" hugging clients or shaking their hands. The prevailing attitude was that both of these behaviors were ethical under most circumstances.

More recent work suggested a return to a cautious stance regarding touching clients. Stenzel and Rupert (2004) found that 90% of their national survey sample never or only rarely touched clients, most often to shake hands on entering or exiting a session. Legal suits against therapists for charges of sexually motivated touching and sexual harassment may have chilled any form of touching beyond traditional formalities.

Clients may initiate touching because of a desire to be physically close to their therapists, and a therapist's decision to touch or not touch must often be made quickly. Consider a dilemma most therapists will face:

Case 9-6: Ivy Holdme, a divorced mother with custody of two unruly children experiencing troubles at school, had her car stolen the previous day. At the close of a dreary session, the mother said to the therapist, "I really need a big hug."

The nature of the already-established therapeutic alliance will play a large role in the therapist's response. Several questions will come to mind: Should I do it? Would it affect our therapeutic relationship? What kind of a hug should it be: short, long, tight, limp? The therapist's own level of comfort with touching and being touched will also come into play (Kertay & Reviere, 1993). For therapists who have recognized their own physical attraction toward a client, extra caution must be exercised.

Risk management approaches to touching (Knapp, Younggren, VandeCreek, Harris, & Martin, 2013) advise therapists to consider carefully how they think the client would react and whether the act will confer any therapeutic benefit. The intent of the initiator may not come through clearly to the recipient. The following case illustrates how differing perceptions of touch can lead to ethical charges:

Case 9-7: Janet Demure complained to an ethics committee that her therapist, Patten Strokem, Psy.D., behaved in a sexually provocative manner, which caused her considerable stress and embarrassment. He allegedly put his arm around her often, massaged her back and shoulders, and leered at her. Dr. Strokem was shocked on learning of the charges and vehemently denied any improper intentions. He claimed he often put his hand briefly on his clients' backs and patted or moved his hand with the intention of communicating warmth and acceptance. His customary constant eye contact was his way to communicate that clients had his full attention. He admitted that Demure seemed uneasy but expected this would quickly pass as it did with others who were not used to such expressions of caring.

Dr. Stroke's training as a humanistically oriented practitioner disposed him to considerable nonerotic touching of clients (Durana, 1998; Holroyd & Brodsky, 1977; Zur & Nordmarken,

2011). Regardless of therapeutic orientation, however, it is necessary to remain aware of individual clients and their special needs, issues, and a sensitivity that may well require an alteration in one's usual demeanor. Cultural factors regarding touching traditions and tolerances must also be taken into consideration.

For some clients, touching can be poorly tolerated under *any* circumstances.

Case 9–8: The 6-month-long therapeutic relationship between Connie Sole, Ph.D., and Jason Mourner never involved physical touching. On learning that Jason's father fell unexpectedly ill and died suddenly, Dr. Sole reached for Jason to give him a hug. Jason's body went rigid, and he did not reciprocate the gesture.

In an attempt at consolation, Dr. Sole misjudged her client. Dr. Sole should openly address the incident, if only to apologize for unintentionally causing her client discomfort.

So, would it be safest for therapists to adopt a no-touch policy? We do not propose a ban on nonerotic touching given that judicious use can be helpful on a case-by-case basis. For example, do you think holding a patient's hand throughout the entire initial session is inappropriate? Consider the next case:

Case 9–9: Irving Flexible, Ph.D., was called to consult on the case of a 23-year-old woman with advanced lung disease secondary to cystic fibrosis. After introducing himself to the patient and sitting in the chair at her bedside, the psychologist asked how he could be helpful. The young woman, who was having great difficulty breathing despite wearing an oxygen mask, gripped his hand tightly and said, "Don't let go." Between attempts to catch her breath, she spoke of her terror at sensations of suffocation and the thought of dying alone.

Normally, touch should be used cautiously after less risky interventions that might bring about the same result are considered (Bonitz, 2008). Yet, occasionally, significant variations from prevailing professional conventions constitute the highest standard of care. Deviations, however, should occur only when the following

question can be answered in the affirmative: If my action became known to my colleagues, would they say my client's needs are being well served and not my own? Dr. Flexible easily passed that test.

Erotic Touching

When therapists intentionally touch clients with *erotic intent*, a boundary violation has occurred. Behavior primarily intended to arouse or satisfy sexual desires is the general definition of erotic contact offered by Holroyd and Brodsky (1977, 1980). Such touching (excluding intercourse) was anonymously self-reported by 9% of male and 1% of female therapists sampled in their 1977 survey. The advantage of a definition focusing on the intent rather than the act itself is that touching *any* part of the body is unethical if the purpose is self-gratification. A drawback is that accused therapists can always deny their intent, which may or may not be truthful.

Case 9–10: Hands Solo, L.M.H.C., had his license to practice suspended when two clients came forward complaining about his belligerent physical advances. Although Dr. Solo never proposed having a sexual relationship with either woman, he would pull them in close to his body and rub against them on their arrival for sessions. Both clients directly expressed discomfort, but he only winked and ignored their complaints.

Dr. Solo practiced in a room in his home next to a bedroom. It is unclear whether he had additional plans were his physical advances warmly received.

Another way to think about inappropriate contact focuses on which body parts are touched. For example, improper touch would include coming into contact with the bare skin or through clothing of the breast of a female or the sexual organ, anus, groin, or buttocks of either sex. Keeping such a list in mind implicitly allows other forms of touching that should not normally raise concerns, such as shaking hands or a reassuring pat on the back. But, the list approach is also problematic because humans can experience sensations as sexual just about

anywhere on their bodies, and the way one is touched is almost as telling as what is touched.

When all is said and done, therapists know whether the intent is personal gratification, which is the primary signal of a boundary violation.

Kissing, Romancing, and Casually Dating Clients

A letter written by Sigmund Freud in 1931 to his disciple, Sandor Ferenczi, reveals how sexual innuendo in therapy was brewing almost 90 years ago. Ferenczi suggested that showing physical affection to patients might assist in neutralizing early emotional deprivation. Freud responded:

You have not made a secret of the fact that you kiss your patients and let them kiss you. . . . Now I am assuredly not one of those who from prudishness or from consideration of bourgeois convention would condemn little erotic gratifications of this kind. . . . But that does not alter the fact . . . that with us a kiss signifies a certain erotic intimacy . . . Now picture what will be the result of publishing your technique. . . . A number of independent thinkers will say to themselves: Why stop at a kiss? Certainly one gets further when one adopts "pawing" as well, which after all doesn't make a baby. And then bolder ones will come along who will go further, to peeping and showing—and soon we shall have accepted in the technique of analysis the whole repertoire of demiviergeerie and petting parties, resulting in an enormous interest in psychoanalysis among both analysts and patients. (Jones, 1957, pp. 163–164, cited in Marmor, 1972)

Was Freud correct in suggesting that therapists who touch and kiss clients are also more likely to have sexual relationships with them? Once certain boundaries are crossed, a slippery slope does appear to exist (Borys & Pope, 1989; Holroyd & Brodsky, 1980; Lamb & Catanzaro, 1998). Critics of the slippery slope argument suggest such thinking is a holdover from rigid psychoanalytic theory that sexualized any role crossing. A commentary by Arnold Lazarus (in Barnett, Lazarus, Vasquez, Moorehead-Slaughter, & Johnson, 2007) agreed that predatory therapists may start with innocent gestures as a prelude to sexual exploitation but that stringent rules will not deter them.

Far more often than not, based on our experience with ethics cases, the offending therapist is not a predator, at least not at the beginning. We have been struck with how most ethics cases involving sexual misconduct started with seemingly harmless compliments before advancing to such acts as gift giving, going out for coffee, a kiss on the cheek, moving the client's appointment to the last one of the day, and proceeding from there. Clients' own accounts have confirmed that pre-meditation was not originally at issue. Gottlieb and Younggren (2009) rightly pointed out that it is unlikely that *all* therapists are vulnerable to a slippery slope leading to sex with their clients, but we would argue that once behaviors routinely associated with dating and courtship rituals are inserted into the therapy relationship, the slope is sheer and slick. Although courtship-style behaviors are not classified as "sexual intimacies," casual social excursions outside the office become risky because they typically involve personal self-disclosure and other behaviors leading to misunderstandings or confusion in clients, even with no therapist motivations beyond platonic pleasantries (Simon, 1991). The next case describes how things go wrong.

Case 9-11: Willy Inchworm, Ph.D., was attracted to Selma Receptive, his client of several months. Selma readily accepted what Dr. Inchworm believed, at the time, to be a professionally appropriate invitation to attend a lecture on eating disorders, given that Selma's sister had a history of anorexia nervosa. The lecture concluded at 5 p.m., so Dr. Inchworm invited Ms. Receptive to stop for a bite at a nearby bistro. The next week, Inchworm accepted Receptive's gift of a book written by the speaker from the previous week. The following week, Inchworm agreed to a reciprocal dinner at Receptive's apartment. Afterward, as they enjoyed a third glass of wine, they looked into each other's eyes, embraced, kissed for a while, and retreated into the bedroom.

It does not take a clairvoyant to predict such an outcome. In this actual case, an affair persisted for a few weeks. In the meantime, the therapist met someone else of more interest to him. When the client was told they would no longer be seeing each other outside of therapy,

she expressed considerable anger toward him. In response, Inchworm terminated the therapy. The client sought and won a large damage award through a civil malpractice complaint.

SEXUALLY INTIMATE BEHAVIOR WITH CLIENTS

Clients new to therapy are unsure of what to expect. They place their trust in someone they believe possesses highly specialized skills and who is being paid to act only in their best interests. In addition, clients usually come into therapy with vulnerabilities and likely feel in a “one-down” position as they walk through the door. The personal power of therapists can be so strong that it interferes significantly with clients’ capacity to make decisions that, under other circumstances, would be relatively easy.

The American Psychological Association (APA) did not adopt a prohibition against sexual intimacies with clients until 1977. Yet, even prior to the late 1970s, sex with clients was generally viewed as poor professional practice, a dual-role relationship, and likely to be exploitative. Without an explicit directive, however, complaints were difficult to adjudicate and not always taken seriously. Feminism, consumerism, and a growing admission and realization by therapists that such contact occurs with unacceptable frequency were among the factors leading to a swell of concern about those who would take sexual advantage of their clients. Today, all major mental health professional codes have clear prohibitions against engaging in sexual behavior with current clients (APA: 10.05; American Association for Marriage and Family Therapy [AAMFT]: 1.4; American Counseling Association [ACA]: A.5.a; National Association of Social Workers [NASW] 1.09).

Incidence

It is difficult to estimate accurately the frequency of sexual intimacies between psychotherapists and their clients. Anonymous self-report surveys, even if we assume that none

who did not return their survey forms had been sexually intimate with clients, revealed that far more therapists engage in sexual behavior than is ever reported to ethics committees and state licensing boards (e.g., Parsons & Wincze, 1995). Early survey data indicated that as many as 26% of male and 3% of female therapists acknowledged engaging in sexual intimacies with their clients (Schoener, Milgrom, & Goniorek, 1984). Another survey revealed no significant differences across psychiatry, social work, and psychology in the rates of self-reported sexual relationships (Borys & Pope, 1989). Somewhat more recent self-report surveys offered welcome signs that fewer therapists were engaging in such behavior with clients, students, and supervisees (Lamb & Catanzaro, 1998; Lamb, Catanzaro, Salvatore, & Moorman, 2003; Pope, 1993, 2001; Rodolfa et al., 1994), although Jackson and Nuttal (2001) reported an alarmingly high rate (almost 16%) for male psychologists and 1.5% for female psychologists.

If rates are declining, we can only speculate on why. Licensing boards have become more aggressive in pursuing charges of sexual exploitation, criminalization in some states may serve as a deterrent, and the relevant issues are being discussed more openly in training programs (Shapiro & Smith, 2011). Furthermore, exploited but empowered clients have taken to the Internet with blogs and websites devoted to exposing unethical mental health professionals. In addition, more women than men have entered psychology and other mental health professions in recent years, and female therapists have consistently been less likely than males to act out sexually with clients.

Who Is Responsible?

Some clients may actively and knowingly contribute to the creation of a sexually tempting atmosphere in the therapy setting. In interviews by Somer and Saadon (1999), almost one fourth of clients who claimed to have had sexual relations with their therapists admitted that they initiated the first embrace. Ethics committees and other hearing panels are not impressed, however, when therapists whine about being

lured and snared as defenseless victims of beguiling clients.

Case 9-12: Hap Bowlover, Ph.D., wrote a letter in response to an ethics committee inquiry insisting he was worn down by a client who “showed up wearing dresses with the neckline and the hemline almost meeting and started flirting with me the minute she walked into my office.” He was convinced that she set a trap for him.

Such excuses surface more often than you might think. Some commentators seem sympathetic toward therapists, who, as Wright (1985) contended, are enticed into lustful moments by unscrupulous clients seeking to exploit their therapists’ weaknesses. Nevertheless, shifting blame or responsibility to the client—even one who is adeptly manipulative or seductive—is never an excuse for incompetent, unprofessional behavior. The obligation to uphold ethical, legal, and professional standards is not a duty to be evaded, excused, or assigned to clients.

Harms to Clients

When sex enters into therapy, a helping environment has been shattered. Even early surveys of psychologists (Holroyd & Brodsky, 1977) and psychiatrists (Kardener et al., 1973) revealed doubts that erotic contact or sexual intercourse with clients could be beneficial and sometimes compared such acts to rape or incest (Barnhouse, 1978; Masters & Johnson, 1976). Indeed, one of the most unsettling research findings to date is that adult survivors of familial incest are at especially high risk for subsequent sexual abuse by their therapists (Armsworth, 1990; Broden & Agresti, 1998).

Available evidence confirms the harmful and exploitative impact of sexual activity with clients due to abuse of power, mishandling of the transference relationship, role confusion, and other factors pertaining to clients as individuals. Although some may quibble about the quality of research and the generalizability of the findings (Slovenko, 1991; Williams, 1992), such debates obscure the basic point: Sex

with clients is unethical and lies well outside accepted standards of care.

The available data were gathered primarily from what clients disclosed about previous abusive therapists to new therapists, responses to surveys and interviews by exploited clients, and formal complaint records. Taken together, the majority of clients assessed from these populations reported sex with therapists as damaging (e.g., Bouhoustos, Holroyd, Lerman, Forer, & Greenburg, 1983; Feldman-Summers, 1989; Kluft, 1989; Pope, 1990b, 2001; Pope & Vetter, 1991; Taylor & Wagner, 1976). Several poignant and absorbing personal accounts attested to the harm caused by sexualized therapy relationships (e.g., Bates & Brodsky, 1989; Freeman & Roy, 1976; Noel & Watterson, 1992; E. Walker & Young, 1986).

Pope (1989a, 1994) described a cluster of symptoms seen in some clients who endured sexual relationships with their therapists. These included ambivalence about the therapist akin to that of incest victims who hold both love and negative feelings toward the offending family member; feelings of guilt, as if the client were to blame for what happened; feelings of isolation and emptiness; cognitive dysfunction, particularly in the areas of attention and concentration; identity and boundary disturbances; difficulties in trusting others as well as themselves; confusion about their sexuality; lability of mood and feeling out of control; suppressed rage; and increased risk for suicide or other self-destructive reactions.

Some clients may view sexual relationships with therapists as pleasurable in the beginning, or at least shield the abusive features, but later come to view them as exploitative (Somer & Nachmani, 2005; Somer & Saadon, 1999). We saw, while serving on ethics committees, the manifestations of such feelings. The complainants typically expressed outrage over what was done to them; described other damaged or destroyed relationships in their lives; suffered feelings of abandonment, exploitation, and hopelessness; questioned whether they could possibly trust another therapist again; and often admitted pressing charges to help ensure that the therapists would not harm anyone else.

Ambivalence and guilt were evident as well. For example, some complainants expressed not wanting anything bad to happen to their therapists; they just wanted them to know what they did was wrong and hurtful.

WHO ENGAGES IN SEXUAL RELATIONS WITH CLIENTS?

Mental health professionals themselves may puzzle over how intelligent, educated men and women living in a world of carnal opportunity could be so stupid that they engage in behaviors that are blatantly unprofessional and dangerous to their clients as well as to themselves. We may also assume that therapists found guilty of sexual intimacies with clients consist chiefly of the poorly trained, obtuse, seriously disturbed, or psychopathic. Amazingly, actual cases from our personal knowledge include a past president of a state psychological association, current and former members of state licensing boards, a professor at a major university who authored an article on professional ethics, a chair of a state psychological association ethics committee, and even an author of an article condemning sex with clients. No one appears to be fully immune from temptation or the potential to be exploitative.

Common Offender Characteristics

Available reports suggest that therapists who engage in sexual intimacies with clients are likely to have one or more personal issues or characteristics (Butler & Zelen, 1977; Dahlberg, 1970; Gabbard & Lester, 1995; Hetherington, 2000; Lamb et al., 2003; Layman & McNamara, 1997; Norris, Gutheil, & Strasburger, 2003; Olarte, 1991; Pope, 1990a; Solursh & Solursh, 1993). These include

- feelings of vulnerability;
- fear of intimacy;
- crises in their own personal sex, love, or family relationships;
- feelings of failure as professionals or as individuals;

- high needs for affection, positive regard, or power;
- idealizing a special client;
- poor impulse control and an inability to set limits;
- feeling depressed or burned out;
- social isolation;
- overvaluation of their abilities to heal;
- isolation from peer support;
- sexual identity and other unresolved conflicts;
- diagnosis for a depressive or bipolar disorder;
- narcissistic, sadistic, and other character or predatory psychopathologies; and
- insufficient training.

Offending therapists also tend to have strong denial or rationalization defenses in place, are more likely to engage in rescue fantasies, have a family history of sanctioned boundary transgressions, and are intolerant of negative transference (Celenza, 1998, 2007). They are more likely to work alone (Somer & Saadon, 1999). They often deny to themselves that their behavior has any adverse impact on clients (Holroyd & Bouhoustos, 1985) and are deficient in their ability to empathize (Regehr & Glancy, 2001). Most sexualized relationships apparently do not last long. Even among those not formally complained against, about half the time such affairs were judged, in retrospect, as not worth having (Lamb et al., 2003).

The most common offender is a male in his 40s or 50s (Brodsy, 1989; Butler & Zelen, 1977; Notman & Nadelson, 1994; D. Smith & Fitzpatrick, 1995; Sonne & Pope, 1991) and around 15 years older than the clients the offender beds (Hetherington, 2000). Middle-aged therapists going through a divorce or having other problems in a primary relationship should remain alert because the risk of overinvolvement with clients is exceptionally high (Twemlow & Gabbard, 1989). Some abusing male therapists may have themselves experienced sexual abuse as children (Jackson & Nuttal, 2001).

Clients exploited by their therapists are mostly younger women. Perhaps as many as 5% are minors at the time of the sexual activity,

and almost a third have been victims of incest or physical abuse as children (Pope & Vetter, 1991). Homosexual clients of either sex with the same-sex therapist appear to belong to the next most frequent category, albeit a distant second (Brodsky, 1989).

Although hardly an excuse, therapists who engage in sex with clients are often facing regrets, calamities, or deficits in their own lives. Mr. Sorry is typical.

Case 9-13: Samuel Sorry, L.M.H.C., a counselor in his late 40s, explained to an ethics committee how his sexual relationship with a 26-year-old client was sparked primarily by a series of rapidly accelerating crises in his personal life. His wife of 25 years left him for another woman, he and his best friend had a falling out, and his father recently passed away. He was feeling lost and saw himself as a failure. His young client was trusting and complimentary, and in his exact words, "She was the only thing in my life I looked forward to."

That most clients who become involved in sexual intimacies with male therapists tend to be younger females suggests that sexually exploitative male therapists may view such women as easy sources of "as if" intimacy or as a means to recapture waning youth and virility.

The first sign of deterioration after the relationship becomes more actively sexualized can occur when the client expresses a wish to extend the relationship and deepen the commitment between the two of them. At this point, therapists (especially those who are married or in another committed relationship) may react with some form of distancing. Whether a response to fear, guilt, delayed moralistic stirrings, disinterest, or a belated recognition that serious therapeutic and ethical errors have been committed, such withdrawal is often experienced by the clients as rejection and abandonment. The now-jilted clients may seek redress.

Case 9-14: Jack Scared, Ph.D., became concerned when his client, Gladys Hooked, with whom he had intercourse on several occasions, started calling him at home "just to say hello." He had not predicted these intrusions, and he worried

his oldest son might be suspicious. He terminated Ms. Hooked's therapy. She asked if they would then be "just lovers." When Scared responded that this was not to be either, Hooked contacted a state licensing board.

A fair number of offenders appear to believe that transference-like feelings are not a result of the therapy dynamics but rather emanate from clients' genuine attraction to them as persons. They convince themselves that the clients would have the same response to them had they met in another setting under a different set of circumstances. Often complicating this profile is the rescue fantasy some therapists attach to their clients' idealization of them (Folman, 1991). Here, a perilous "fairy tale" dimension is interjected, with the therapists seeing themselves as heroes who will create "happily ever-after" endings.

Another fairly common offender profile involves inappropriate reactions to the dependent or sad client who expresses implicitly or explicitly a need for physical comfort. This client can be exploited by a therapist who too easily melts down professional boundaries.

Case 9-15: Adam Octopus, Ph.D., found the delicate and petite Wilma Wilt fetching. Wilt would fall into his arms and sob every time they discussed the son she recently lost in an automobile accident. Octopus began to massage and fondle her during these episodes, eventually making sexual moves to which she did not object at the time. Ms. Wilt soon realized, however, that what she needed and what she was getting were hardly one and the same. She told a subsequent therapist about Octopus's behavior, and the new therapist encouraged Wilt to press ethics charges.

Finally, therapists who enter sexually intimate relationships with clients may attempt to excuse their behavior on the grounds that they sincerely loved these clients. Gartrell, Herman, Olarte, Feldstein, and Localio (1986, 1989) reported that 65% of offenders sampled stated they were "in love" with the patients they bedded, and 92% believed their clients were in love with them.

Case 9–16: Elmer Smitten, M.S.W., was attracted to Luna Fond early on. He recalled wanting to reach out and hold her, to take care of her. He thought about Ms. Fond constantly and eagerly anticipated every session with her. Eventually, the lunches became dinners and then motel rooms. Smitten maintained that, were he were free, he would have committed himself fully to this woman. Soon, the guilt about having an affair with a married man and father began to gnaw at Miss Fond. Frequent spats occurred. Fond terminated both the therapy and the personal relationship, consulted another therapist, and together they contacted an ethics committee. Smitten continued writing Ms. Fond love letters, even after an investigation was under way.

Compared with other offender profiles, the lovesick therapist may evoke pity. But, no “true-love exception” exists in the eyes of ethics codes or the law (Shapiro & Smith, 2011). Twemlow and Gabbard (1989) and Gabbard and Lester (1995) described the lovesick therapist unsympathetically as a narcissistic, emotionally dependent individual who enters an altered state of conscience when in the presence of the special client, which then impairs judgment in that case, but not for others. The state of lovesickness may reduce guilt because the therapist becomes convinced that he or she can provide quality therapy with noble motives. Such therapists lack insight into the potentially destructive nature of their behavior.

Female therapists have a lower rate of engaging in sex with clients than do male therapists. Perhaps female sex roles have allowed women to learn and practice a spectrum of techniques not involving sexuality for communicating love and nurturance. Traditional cultural conditioning of women to refrain from taking the sexual initiative may have led to better control of sexual impulses as well as effective ways of resisting sexual advances. When female therapists are respondents in ethics hearings or civil suits, the complainants will likely be lesbian clients or the wives, partners, or family members of the men with whom the therapist had an alleged sexual relationship.

Case 9–17: Maria Skeptic was suspicious of her husband’s claim that he was in therapy every Thursday night. She drove to the office to check if his car was in the parking lot. She arrived just in time to observe her husband pressing the therapist up against his car for a passionate full-body embrace.

We hear less about men complaining about sexual involvement with their therapists. Slovenko (1991) suggested that it never occurs to the male client, even in litigious times, to sue a woman for having had sex with him. It has even been opined that men would welcome such advances by their female therapists and perceive them as esteem building. However, a colleague who has treated several male clients in the aftermath of harm caused by sexual relations with their previous female therapists told us that men do not make formal complaints because they fear a response of ridicule rather than of compassion and concern.

In more recent times, female therapists and their male clients have made headlines. Here are examples:

Case 9–18: A female psychologist tried to get her license back after starting an affair with a sexually abused male client; her grounds were that her own failing marriage constituted mitigating circumstances. The story made headlines because the client was a high-profile lawyer who exposed child sexual abusers and had demanded she apologize and compensate him for the damages she caused (Herman, 2011).

Case 9–19: Two female psychologists had affairs with imprisoned clients, one a brain-damaged child killer and the other serving 21 years for murder (Hall, 2014; Milovanovic, 2010).

Case 9–20: A female psychologist was accused of sexual assault (a Class 4 felony in Colorado) when her client, a member of the armed forces assigned to receive counseling, complained that he did not want to keep their relationship a secret. She allegedly told her client that they could not be open about it for 2 years. When the soldier did not want to wait 2 years, she terminated their relationship, and he complained (Ruiz, 2014).

Case 9-21: Perhaps the highest profile case to date involved psychiatrist Margaret Bean-Bayog and a young male Harvard Medical School student. Although two books written about this bizarre case came to differing conclusions, no one disputes the evidence that Dr. Bean Bayog engaged in a number of strange techniques of an intense erotic nature prior to the client's deterioration and taking of his own life (Chafetz & Chafetz, 1994; McNamara, 1994). After losing her M.D. license, she practices as an unlicensed psychotherapist.

These cases have scandalous features attracting media attention and no doubt give a skewed profile of female therapists who became sexually involved with their clients. We know less about more ordinary sexual intimacies between female therapists and male clients that did not break into the headlines.

Less Common Offender Scenarios

Only the rare case appears driven by a therapist's premeditated attempt to exploit, such as the counselor who hypnotized clients for the purpose of getting them to masturbate in his presence or the psychologist who had sexual relationships with the 3 most intriguing of his dissociative client's 16 personalities. These acts are apparently (and thankfully) exceedingly rare.

A somewhat more frequent scenario is an attempt by the therapist either to consciously manipulate or to rationalize sexuality as a legitimate component of the therapy. They convince themselves that they are genuinely charitable by offering clients something special to alleviate their problems. Rescue fantasies are also common in this group (Notman & Nadelson, 1994). Again, such therapists often have little insight into the self-serving nature of their actions.

Case 9-22: John Bestman, M.S.W., convinced Marcia Willing that a therapist was the perfect person with whom to have a sexual affair because no one else could better understand her needs or be as trustworthy.

The client found Mr. Bestman a mediocre lover, and the therapy became confusing and

somewhat disgusting to her. She contacted an ethics committee.

We also know of cases in which the therapists invented specialized techniques built around sexual exploitation. Again, these examples are scarce but highly visible because they attract media exposure.

Case 9-23: Ben Strippem, Psy.D., asked his young, female client to remove her clothes so he could measure her "vitals." He claimed this procedure constituted an essential component of his smoking cessation program.

Case 9-24: Blunt Force, M.D., performed his "Soma Release Therapy" on scores of women before his license was suspended. He argued that having his client wear flimsy robes while he put extreme pressure on their genitals and breasts would "emancipate suppressed emotions."

Case 9-25: Nonnie Tittler, M.S.W. practiced "radical re-parenting" therapy with clients who had experienced what she regarded as inadequate nurturing in their early years. This included having male clients wearing nothing but adult diapers suckle at her breast. When challenged by an ethics committee, Ms. Tittler observed that there was nothing sexual about her work.

These perversions of psychotherapy appear to represent attempts to satisfy the therapist's own peculiar proclivities without regard for those seeking help. The real Mr. Strippem attempted to explain a connection between smoking and taking measurements of nude clients to an ethics committee using machinations involving little more than twisted psychobabble. In the meantime, he had retired from practicing. Dr. Force also attempted a convoluted justification for his Soma Release Therapy, but lost his license anyway. Ms. Tittler lost her license and membership in her professional association.

Another infrequent scenario is the therapist who uses drugs or alcohol to enhance the treatment-seduction process.

Case 9-26: Pearl Blanca, who had been rescheduled to the last appointment of the evening by Cokie

Snort, Ph.D., agreed to start staying a while later at the end of her sessions to help Dr. Snort "relax" after a long day of conducting therapy. At first Snort served only wine. Then, one evening Snort produced cocaine. Sex and drugs soon became an integral part of their after-hour tradition.

This therapist, whose actions were adapted from another high-profile case, had abandoned any concept of boundaries. Eventually sued by several parties, he lost his license to practice. Another lawsuit, from which we adapted the next case, reveals an even more sinister use of drugs.

Case 9-27: Manuel Comatose, M.D., treated over 200 women presenting sexual problems by drugging them with a potentially dangerous relaxant and then encouraging them to become sexually aroused in his presence. Sometimes, he would touch them on their breast or genitals to stimulate them before commencing a guided imagery exercise during which his patients simulated sexual interaction.

The psychiatrist in the actual case was tried for indecent assault based on 11 complaints but won acquittal with his claim of gaining their informed consent. His license was briefly suspended, but surprisingly he was allowed to resume practicing so long as he did not use this particular technique.

Although not a frequent complaint, therapists have manipulated clients' dependencies by using sex as a tool to extend the length of therapy.

Case 9-28: Sam Trap, Psy.D., was Sandra Mayhem's rock in a sea of turmoil. She saw him as her only source of stability and became increasingly isolated except for her sessions with him. When Trap suggested they have an affair, it did not occur to her that she had a choice. She would do anything he asked of her. She became his paying client and mistress for over 10 years. Only much later was she able to discuss this painful and lonely period of her life.

Unfortunately, many clients who succumb to therapists like Dr. Trap may not be assertive

enough to complain, making it difficult to ascertain the prevalence of this pattern.

Finally, the extent of cybersex with psychotherapy clients remains unknown as of this writing. Even though no physical contact may occur, a case could be made that such communications through e-mail or other means are unprofessional at the very least. "Sexting" and electronically sending nude or provocative photos has brought down politicians, prominent businessmen, and at least one physician, an anesthesiologist, who was suspended for sexting during surgery (Grisham, 2014).

RISKS TO THERAPISTS WHO ENGAGE IN SEXUAL BEHAVIOR WITH CLIENTS

Consequences to sexually exploited clients can be life shattering, but many therapists have not fared any better. The extent of the devastation is typically more pervasive than the fallout from committing other types of ethical violations. Perpetrators have lost their jobs, licenses, families, and reputations. No expert witnesses will argue that the act did not deviate from acceptable standards of care. The liability is strict, and any excuses of "we were in love at the time" are irrelevant. Therapists can be held liable civilly and sometimes criminally even when the relationship did not commence until after termination (Schoener, 2001). Sexual transgressions with clients appear to be the most frequent *specific* cause for disciplinary action (Kirkland, Kirkland, & Reaves, 2004; Pope & Vasquez, 2011).

No doubt a few long-lasting marriages resulting from sexual liaisons with therapists exist. But, we must mention Susan Polk who, while married to her previous therapist, ended up brutally stabbing him to death. How their relationship commenced was a focal issue in her (unsuccessful) defense (Pogash, 2008).

He Said, She Said

Some might think those who engage in sexual intimacies with clients are risking very little

because sessions are conducted in the absence of witnesses. If a client complains, the accusation can be denied. Therapists may cite “fantasy,” “delusion,” or “transference” as the basis for the charges. Does this work? Sometimes it does. Not all sexual intimacy cases are decided definitively because neither party’s story can be substantiated by a preponderance of evidence. But, damaging fallout occurs anyway because others often know of the charges, including confidants, spouses, and employers.

When a violation cannot be sustained, the therapists are not fully exonerated by default. Cases closed on account of lack of evidence about a single complaint may be reopened if a subsequent charge against the same individual suggests a pattern of offending.

Exploited clients have increasing support in addition to ethics committees and licensing boards, although the particulars vary among the states. Sources of redress include civil suits and tort actions (including malpractice), mandated reporting statutes, injunctive relief, and criminal law (Haspel, Jorgenson, Wincze, & Parsons, 1997). In some states, clients are also protected against unlicensed therapists who do not fall under the authority of ethics committees and licensing boards. Still other resources include the availability of expert witnesses, subsequent therapists who are prepared to testify regarding the damage caused by previous sexual activity with previous therapists, and clinics specializing in treating sexual abuse by mental health professionals. The ethics codes of all helping professional associations are often brought out as favorite “witnesses” for the prosecution.

If a guilty verdict is reached in court, therapist/defendants may ultimately bear the total cost of any damages, and these can be substantial. If the therapist claims innocence, the policy will cover a defense but refuse to pay damages above the cap if the therapist is found liable. Most malpractice insurance policies have a relatively low cap or limit on damages relating to sexual intimacies. For this reason, it is rare for a therapist to be sued solely for sexual misbehavior. Typically, the grounds are some form of improper treatment, making a case for incremental non-sex-based damages. For

example, the family in the Dr. Bean-Bayog case involving the seduction of a suicidal client settled a wrongful death charge with the psychiatrist’s insurance carrier for \$1 million.

Modern technology has been brought to bear in these cases. An undercover agent wore a radio transmitter to substantiate how a psychologist sexually preyed on his attractive female clients. Numerous technological options for clients to prove guilt include saved e-mails, text messages, and information recorded on other devices, not always with the offender’s awareness.

Case 9–29: Little did Sam Snore, M.A., know until hearing from an ethics committee that his now ex-client, Annie Quickpic, photographed him lying nude on a motel bed. His explanation that the photos must have been stolen from his office desk drawer by a now-vengeful client was not persuasive.

Modern “CSI-style” forensics came into play in one high-profile case. A psychiatrist was found innocent of having relations with the more lustfully assertive of his client’s multiple personalities. Her DNA evidence of his semen on her underwear did not sway a jury that exonerated the psychiatrist, believing the defense attorney’s contention that the woman was fanaticizing and transferred his semen to her own panties after stealing underwear from the psychiatrist’s home trash bin. Subsequent DNA tests run by CBS’s *48 Hours* indicated, however, the patterning and large amount of semen on the client’s panties could not have resulted from such a transfer (Kohn, 2002).

The False Allegation

Therapists may fear being charged by a client’s misunderstanding of what was said or done. Some clients are sensitive to a fault. Gutheil and Gabbard (1993) described a client who brought sexual exploitation charges against a psychologist for conducting therapy with the top two buttons of his shirt undone.

It is difficult to acknowledge that anyone would unjustly risk destroying someone’s

professional and personal life with a false accusation, but it has occurred in an estimated small percentage of cases (Pope & Vetter, 1991; Schoener, Milgrom, Gonsiorek, Leupker, & Conroe, 1990). The therapist is left with a daunting task of trying to prove something never happened. Caudill (1997), suggested that the truth may emerge by refuting charges based on verifiable alibis that counter a client's assertions of where and when.

How can therapists protect themselves against unwarranted claims of sexual impropriety and still be a caring human being? Before engaging in any form of nonerotic touching or paying a compliment that could be interpreted as flirtatious or suggestive, we highly recommend making certain you thoroughly understand your client's psychological functioning and history. Some clients may remain unsuited to such comments or any form of touching for the duration of therapy.

Boundary crossings of a nonsexual nature (such as taking a client to lunch, giving a client a gift, writing an "affectionate" note, considerable self-disclosure) may be taken by ethics committees and state licensing boards as presumptive evidence to corroborate allegations of sexual misconduct (Gutheil & Gabbard, 1992). Thus, any act that could conceivably be misconstrued at some later point should be entered into the client's file (e.g., "sent flowers for husband's funeral," "drove client to her workplace because her car wouldn't start and had to be towed," or "helped client up and down stairs due to her injured ankle"). Hedges (2007) advised therapists to document incidents involving clients' sexually laden or intense personal interest as well as the response.

Unless part of the demands of the job, such as evaluative home visits to treat an incapacitated client, we recommend seeing clients only in a professional setting. Also, consider avoiding an isolated solo practice in favor of nonsecluded locations where a receptionist or other practitioners work nearby.

You may experience a sense of exasperation at this point. How can one be a helping professional and also avoid behavior that could be misconstrued or interpreted by someone else

as unprofessional or unethical? We believe competence, sensitivity, and a habit of regularly monitoring every client's treatment needs as well as remaining fully self-aware will preclude problems from erupting and still allow numerous avenues for expressing caring and compassion.

Finally, here is a case offering a perspective to consider:

Case 9–30: J. B. Flirt, Ph.D., and Chablis Coquette met at a hotel bar. Ms. Coquette revealed many of her personal secrets and sexual proclivities on learning of Dr. Flirt's profession as a psychotherapist. After drinking for a while, they retired to Ms. Coquette's room for a night of raucous lovemaking. Afterward, Dr. Flirt made it clear that the rendezvous was, for him, a one-time hookup. A humiliated Ms. Coquette attempted to press ethics charges.

Regardless of any attributions about Dr. Flirt's moral compass, Ms. Coquette did not prevail. No client/therapist relationship was established despite the discussion of Coquette's personal issues. Nevertheless, a stressed-out Dr. Flirt was forced to defend himself to his peers.

SEXUAL RELATIONSHIPS WITH FORMER CLIENTS

Taken together, available findings suggest that between 3% and 10% of survey respondents had sex with former clients (e.g., Borys & Pope, 1989; Lamb et al., 2003; Lamb, Strand, Woodburn, Buchko, Lewis, & Kang, 1994; Pope et al., 1987, as cited in Pope, 1993). Fewer than half of the psychologists in Akamatsu's (1988) survey judged sex with ex-clients as a serious ethical problem. And, sexual relationships with current clients was viewed as more unethical than sex with former clients (Thoreson, Shaughnessy, & Frazier, 1995).

The Uneasy Rules

Whether clients and their therapists should be ethically free to commence a sexual relationship once therapy concludes poses an awkward

dilemma for mental health professions. After all, when a professional role no longer exists, are not consenting adults accorded a right to decide with whom they consort without interference from a rule created by individuals they do not even know? Are not client autonomy and self-determination primary goals of psychotherapy, even when we believe ex-clients are not making decisions we agree with (Bersoff, 2008)? Some contend that when the conclusion of a therapeutic relationship involves fully informed consent (as opposed to terminating therapy for the purpose of entering into a sexual relationship) and the trust and power discrepancies dissolve, ethical concerns have been neutralized (Sarkar, 2009). Others have said that policies should be formulated that avoid unnecessary intrusions into the lives of consenting adults (Appelbaum & Jorgenson, 1991). We argue that it is not that simple.

Earlier ethics committees could pursue a case if a complainant presented a compelling argument substantiating improper or irresponsible termination resulting in harm or exploitation (Gottlieb, Sell, & Schoenfeld, 1988). The next case is among those that ethics committees did accept for adjudication, even before mention of posttermination sex with clients became an issue.

Case 9–31: Tim Anxious, Ph.D., was attracted to his client Sara Reciprocale. He sensed Sara felt the same way toward him. Although Sara's treatment issues were far from resolved, Dr. Anxious terminated her without recommending further treatment. Their sexual relationship began shortly after termination. It was brief, contentious, and unsatisfying.

Ms. Reciprocale charged that Dr. Anxious maneuvered her into a sexual liaison and then abandoned her when their relationship did not meet his expectations, leaving Reciprocale considerably more troubled than she was before seeking therapy. An ethics committee agreed that Anxious improperly terminated the client.

Case 9–32: A psychiatric resident, after treating a patient for alcohol and drug abuse, initiated a

posttreatment relationship with the patient. They smoked marijuana and drank alcohol together, and their sexual activity resulted in the ex-patient becoming pregnant.

The court found the resident's behavior constituted malpractice and intentional infliction of emotional distress because the client's specific vulnerabilities were exploited (*Noto v. St. Vincent's Hospital and Medical Center of New York*, described in Appelbaum & Jorgenson, 1991).

In the 1990s, the ethics code of the American Psychological Association (1992) confronted the overall issue regarding sexual involvement with clients after therapy was terminated, as did most state boards and ethics codes of other mental health professions. In 1992, the APA ethics code revision team proposed a lifetime ban on sex with previous therapy clients based on the risks to clients, practitioners, and the profession (Vasquez, 1991). After lengthy debates, the APA arrived at a clumsy compromise. A 2-year post-termination moratorium clause placed clear limitations in the short run but opened the opportunity for sexual relations without professional repercussion after 2 years. The code did not, however, condone eventual liaisons, stating they were likely to be harmful and would undermine public confidence in the profession. Thus, psychologists who entered into sexual relationships with former clients bore the burden of demonstrating that no exploitation was at issue should former clients press a complaint.

The 1992 APA code also listed considerations to be weighed before embarking on a sexual relationship with an ex-client. Time passage since termination was a primary consideration, presuming the longer the delay the lower the ethical risk. Other weighting factors included the client's current mental status and degree of autonomy, type of therapy, how termination was handled, and what risks may still present themselves should a sexual relationship commence. The 1992 APA code also defined as unethical any statements or actions on the part of the therapist while therapy was active that suggested or invited the possibility of an eventual relationship with a client. Subsequent

revisions were almost identical to the 1992 version, adding only that psychologists refrain from sex with ex-clients even after 2 years post-termination except “in the most unusual circumstances,” the definition of which was left unspecified (APA: 10.08).

Other codes of professional organizations offer similar concerns and cautions. Earlier, the AAMFT code had mandated a 2-year moratorium on sexual activity with former clients and, interestingly, their close family members, with the burden of responsibility shifted to the member should complaints arise. However, the 2015 revision of the AAMFT code prohibits sexual intimacies with former clients and known family members with no further options down the line (AAMFT: 1.4). The ACA (A.5.c) mandates a 5-year period before a sexual relationship—either in person or electronically—could commence. The NASW bars sex with former clients altogether, but with a small wiggle space. Should social workers claim exemption under extraordinary circumstances, they assume the full burden that the client was never exploited, coerced, or manipulated intentionally or unintentionally (NASW 1.09.c.). Currently, the American Psychiatric Association (1992, 2013) and AAMFT are the only organizations to place a total ban, with no exceptions no matter how extraordinary.

The complaint in the next case would be heard by an APA ethics committee despite the passage of any minimum time frame before sexual activity occurred.

Case 9–33: On termination of 4 years of psychotherapy, Mattie Stringalong, Ph.D., suggested she and Lenny Endure keep in touch. They exchanged cards and letters, spoke on the phone almost every week, and occasionally met for lunch. After 20 months, Dr. Stringalong informed Endure that they could become sexually involved soon if he was still interested. They eventually married. Mr. Endure asked for a divorce a year later, also complaining to a state licensing board that Dr. Stringalong had been “laying in wait” to get her hands on his substantial financial portfolio.

Here, the sexual activity occurred in the “correct” time frame, but the therapist kept an uninterrupted relationship afloat. Even if Dr. Stringalong was not guilty of plotting to gain financially, her active perpetuation of an emotionally charged relationship was unethical.

The next case illustrates an inappropriate comment at the end of the last session.

Case 9–34: When Geraldo Futura, Psy.D., and his client Cecelia Sanguine acknowledged a mutual attraction, Futura allegedly told her they would not start an affair because he would get into “big trouble.” However, during their last session, Dr. Futura winked and whispered to Cecelia, “Give me a call in a couple of years.” Ms. Sanguine started calling Futura only a month after termination, asking if they could get together sooner, that no one had to know. Futura firmly declined. A friend of the now-heartsick Ms. Sanguine informed her that Futura’s final comment was unethical. They contacted an ethics committee.

Futura’s parting shot set up an expectation resulting in a significantly altered way the therapeutic experience was processed by the client. The sincere-sounding client did not prevail in the actual case, probably because the charge was difficult to prove, and Futura used a “stalking” defense against her. Assuming the original complaint is an accurate description of what happened, however, Dr. Futura harmed his client.

So, what kind of posttermination relationship might be ethically acceptable? The next two cases would likely be of no concern to an ethics committee, even if the ex-clients complained.

Case 9–35: Vasti Weight signed up with Slim Downe, Ph.D., for a weight reduction program using behavioral techniques. Ms. Weight lost her goal of 17 pounds in 10 weeks, and the sessions were terminated by preagreement. Three years later, Ms. Weight and Dr. Downe found themselves face to face at a party. Ms. Weight had to remind Downe who she was. They talked for a while, discovered each was free to date, and started seeing each other.

Case 9–36: Millie Later, Ph.D., and her client Saul Someday terminated psychotherapy after 16 months. Both agreed the therapeutic goals had been reached. Three years later, Mr. Someday called Dr. Later to ask if she would be able to work with a friend who was having serious marital difficulties. During this conversation, they learned both were again single and agreed to meet for coffee to “catch up.” They eventually married and had three children.

The linkup between Weight and Downe was coincidental. The relationship of Later and Someday evolved on the spot. In short, all four were on their own as far as ethics committees are concerned. Questions do remain unanswered. Does knowing a posttermination sexual involvement is possible affect the service provided? Under what circumstances do posttermination sexual relationships result in harm? Are individuals able to exercise autonomous choices to enter into sexual involvement with a former treating therapist (Behnke, 2004)?

The Case for Perpetuity

Given the available evidence, along with transference and trust issues, we have serious concerns about engaging in posttermination sexual relationships, even with the stated qualifiers. Anyone who has felt a strong attraction to another person knows passions cannot be masked for long. Data suggest well over half of the posttermination sexual liaisons between therapists and their clients began quickly, within the first 6 months (Gartrell et al., 1986).

Our primary concern is that placing a time stamp for posttermination sex may alter the therapy relationship from the onset by establishing the “silent” dual role of therapist and potential lover. If clients feel attracted to their therapists (a common occurrence) or therapists feel attracted to their clients (also very common), how likely is either to do or say anything to put them in an unbecoming light during active therapy? Would what was disclosed during sessions constitute psychotherapy or an investment in a future relationship? Vasquez (1991) put it plainly: “The verbal disclosures,

behaviors, attitudes, and feelings with a potential lover are quite different from those with a therapist who is clearly and solely a therapist” (p. 48).

Although transference began as a psychoanalytic construct, even therapists using cognitive, behavioral, or other approaches to treatment often agree that the therapist becomes imbued by the client with special attributes conveying a kind of emotional authority or influence. Such feelings do not simply evaporate once clients are no longer in active therapy. From a psychodynamic perspective, an “internalized therapist” continues to assist a client in coping and integrating processes (Ebert, 2006; Gabbard, 1994; Gabbard & Pope, 1989; Vasquez, 1991). Strong attachments to the therapist, not as a sexual being but as a secure base and a source of confidence even if only as a mental representation, can last and offer a benefit to clients indefinitely (Parish & Eagle, 2003; Wzontek, Geller, & Farber, 1995).

A therapist’s responsibilities do not conclude at termination. Clients may want to reenter therapy at some point. Client rights to privacy, confidentiality, and privilege remain unaffected. The possibility of a subpoena of records and resulting court appearances also exists. As a result, clients could be severely disadvantaged should they have need of professional services from a therapist who was also a lover (or ex-lover), especially if the subsequent sexual liaison ended badly, as illustrated in the next two cases.

Case 9–37: Donald Reprisal, D.S.W., and his ex-client Alka Hollick were married two and a half years after therapy was terminated. They had a child the next year and divorced a year later. During a bitter custody battle, Dr. Reprisal brought up his wife’s previous alcohol abuse and other issues raised in therapy.

Case 9–38: Lola Snub and Milton Castoff, Ph.D., her therapist of several years, ran into each other at a singles bar 2 years after termination. The reunion culminated in a subsequent date, which concluded with a sexual act. When Dr. Castoff called for another date, Ms. Snub declined. Dr. Castoff’s

further attempts to see his former client were also rebuffed. When Snub contacted Castoff several months later to obtain financial billing records needed for a tax audit, he told her to get lost.

Therapists must remain responsible for any continuing duties and execute them free from conflict and role confusion. Dr. Reprisal used knowledge shared in confidence to the disadvantage of his former client. Dr. Castoff's refusal to comply with his previous client's request was unprofessional at best.

We must also note how difficult it would be for a therapist to defend him- or herself should a client complain, even when the 2-year moratorium period ran out. Many factors could be submitted to substantiate a charge of harm or exploitation. For example, forming a sexual relationship with a client diagnosed as having a borderline personality or who was previously abused, depressed, or involved in any other circumstance suggesting vulnerability could be considered by an ethics committee as sufficiently poor judgment on the part of the therapist. One can never know in advance how an ethics committee is going to rule when an allegation is up for interpretation, as it would almost always be in these cases. The therapist bears the full burden of proving that no manipulation or exploitation occurred, which would likely be difficult (Shapiro & Smith, 2011).

DELIVERING PSYCHOTHERAPY TO FORMER SEX PARTNERS

In what seems like a no-brainer, entering into therapy relationships with former lovers is unethical (see APA 10: 10.08; ACA: A.5.b; NASW: 1.09.d). Such a prohibition reflects common sense given the probable inability to remain objective. Both parties come with emotional baggage. The next case illustrates how a therapeutic relationship can disintegrate, even when the therapist's initial motive appears to be sincere.

Case 9–39: Sonja Ex, L.M.F.T., agreed to work with Dennis Didit as a client, even though 5 years previously they had an intense romantic relationship

lasting several months. Despite Ms. Ex's disclosure that she was now happily married with two children, Didit started recalling lustful moments from their past and began making suggestive remarks. After four sessions, Ms. Ex terminated therapy with Didit because, as she told him, "You are not taking therapy seriously." Didit wrote to an ethics committee, stating, "Ms. Ex took me for \$400 before tossing me out as revenge for having dumped her 5 years ago."

Mrs. Ex attempted unsuccessfully to defend herself by arguing that her decision to see Mr. Didit was based on his claim to have nowhere else to turn. She vigorously denied any interest in revenge. Accepting him as a client in the first place, however, was an imprudent error in professional judgment. A sexually intimate past is not a foundation on which to build an effective therapeutic alliance. Mrs. Ex could have assisted Mr. Didit by offering an appropriate referral.

SEXUAL RELATIONSHIPS WITH CLIENTS' SIGNIFICANT OTHERS

Less has been written about sexual involvement with the sisters, brothers, guardians, adult children, parents, or very close friends of current psychotherapy clients even though the ethics codes of professional associations disallow entering into sexual relationships with such persons (APA: 10.06; AAMFT: 1.5; ACA: A.5.a; NASW: 1.09.b) and forbid terminating the active client as a way of circumventing compliance (APA 02: 10.06).

Case 9–40: Mary Parent quit therapy abruptly and complained to the state licensing board on discovering that Rob Cradle, Psy.D., "slept with my little girl." Although the daughter was 23 years old, Parent felt betrayed by Cradle. Parent assumed Cradle had shared everything discussed in therapy with her daughter while he was also taking advantage of her.

In this case, the therapist knew in advance he was dating his client's daughter. He erroneously reasoned that because the daughter did not have client status, and because the two were

consenting adults, no ethical obligation pertained. However, it should have been obvious to Dr. Cradle that the ethic admonishing therapists to refrain from entering into any relationship if it appears objectivity could be impaired clearly applied in this situation.

Case 9–41: Wadyo Wannado, Ph.D., a clinical child psychologist, treated Bobby Boyster as an outpatient. Bobby, age 7, was showing signs of an adjustment disorder in reaction to his parents' deteriorating marriage. Dr. Wannado saw Bobby alone on a weekly basis for several months and met jointly and individually with his parents on three or four occasions. Soon after Bobby's therapy was terminated, the relationship with Bobby's mother became sexually intimate. The father filed an ethics complaint against Dr. Wannado, who claimed no wrongdoing because he was no longer seeing Bobby, and the mother was never a client.

When the client is a child, it becomes therapeutically and ethically critical to consider the family as the unit of treatment. Although Dr. Wannado's clinical attention had focused on Bobby, his parents had legally contracted with her for professional services. In addition, meeting with the parents in any professional capacity constitutes a therapist-client relationship. Dr. Wannado owed ethical duties to Bobby and both parents equally. Dr. Wannado's treatment termination with Bobby did not end his professional obligations to the boy. Even after divorce, children harbor fantasies of parental reunion. Most likely, Bobby will feel ambivalent, if not outright betrayed, by the invasion of his therapist into the relationship between his parents. Dr. Wannado's conduct was particularly reprehensible as it intruded adversely into the relationships of three people undergoing a difficult transition, all of whom were owed a duty of care.

PREVENTION, EDUCATION, AND DEALING WITH OFFENDERS

Educating the Public

In the late 1980s, the Committee on Women in Psychology issued a brochure, "If Sex Enters Into the Psychotherapy Relationship" (1989), offering specific advice about what to do should clients be exploited. Educational materials appear to successfully enlighten consumers about inappropriate therapist behaviors (Thorn, Shealy, & Briggs, 1993). Furthermore, such materials apparently do not result in a decrease of trust in psychotherapists, suggesting no need to be concerned about sharing such information with clients (Thorn, Rubin, Holderby, & Shealy, 1996). For new clients, some therapists include in their descriptions of how they work that therapy will be free from any sexual harassment or activity, setting up no expectations from the start.

Educating Students in Training and Already-Practicing Therapists

The front line of prevention of sexual activity with clients is sensitive and competent professional training. As of the last two decades, virtually all training programs addressed these issues. Simply delivering a strong message that having sex with clients is off limits, however, is not enough. As stated previously, many activities besides intercourse can be considered (or perceived to be) sexual. Continuing education courses for already-practicing therapists abound with boundary violations of all types as popular offerings.

Supervisees must feel comfortable disclosing their feelings of attraction frankly with supervisors (Berkman, Turner, Cooper, Polnerow, & Swartz, 2000; Blanchard & Lichtenberg, 1998; Hamilton & Spruill, 1999; Housman & Stake, 1999; Lamb et al., 2003; Mittendorf, 2000; Paxton, Lovett, & Riggs, 2001; Pope & Tabachnick, 1993; Strasburger, Jorgenson, & Sutherland, 1992). As noted, supervisory discomfort with sexual feelings leads to the subtle and unfortunate communication that

such matters are not to be discussed (Falender & Shafranske, 2004). Worse yet, some educators and supervisors provide appalling models to their students because they, themselves, are sexually exploitative (Glaser & Thorpe, 1986; Pope, Levenson, & Schover, 1979).

Rehabilitation, Sanctions, and Criminalization

Intervention programs present a dilemma given that a substantial proportion of sexually exploitative therapists move on to take advantage of multiple victims (Bates & Brodsky, 1989; Jehu, 1994; Strasburger, Jorgenson, & Randles, 1990). So, should rehabilitation programs for therapists, who either enter counseling voluntarily or are mandated to do so, be made readily available? Opinions clash regarding whether offenders should ever be allowed to practice again, whether counseling is effective (especially if mandatory), and if investing public resources is a worthy priority (see Gartrell, Herman, Olarte, Feldstein, & Localio, 1988; Gonsiorek, 1997; Pope, 1987, 1989b, 1994).

Rehabilitation potential is likely related to the type of offender. Appropriate disciplinary actions are best decided on a case-by-case basis, and some offenders may be safely returned to practice. Those who become aware of a one-time impropriety, experience sincere misgivings, are willing to mediate with the client, demonstrate a willingness to cease their sexual acting out, and show a desire to explore their motives are less likely to be repeat offenders.

Psychotherapy, tutorials, limiting practice to exclude certain types of clients, and clinical supervision are rehabilitation options. The APA Ethics Committee sometimes recommends supervision or referral for therapy among the sanctions sexual offenders receive. The penalty often includes expulsion from the APA or a forced resignation, stipulating conditions for reinstatement (usually after 5 years) if the psychologist can offer evidence of rehabilitation. The downside of kicking sexual offenders out of professional organizations and stripping them of their licenses is that they are now afloat. Some may set up practices using their earned degree (which a professional organization or licensing board cannot revoke) and

an unprotected title (e.g., "Phoenix Hoodwink, Ph.D., relationship coach"). In such cases, it may prove more challenging for any subsequent victims to find redress.

Is punishing offenders as criminals a wise idea? No one would disagree that the psychiatrist who used electric shock to sexually assault his clients deserved to be found guilty of rape and imprisoned (McGreal, 2012). Yet, whether seducing a client who does not resist (i.e., consents) constitutes *criminal* rape is not clear from a legal perspective (Jorgenson, Randles, & Strasburger, 1991; Stone, 1976). Criminalization is, however, an option in several states. Such penalties might be the only hook capable of influencing the behavior of therapists whose perceptions of lesser consequences are apparently insufficiently threatening or whose passions or pathology cannot be brought under control. One would think that stories ripped from the headlines would stop therapists contemplating sexual liaisons with a client stone cold in their tracks. However, abuses continue even in jurisdictions with severe penalties.

Case 9–42: A Michigan psychologist was convicted on three counts of fourth-degree criminal assault for having sex with a teenage client. He will serve 60 days in jail, receive 5 years of probation, and be listed as a sexual offender for 25 years (Genellie, 2011).

Case 9–43: An Ottawa psychiatrist convicted of repeatedly sexually assaulting a male patient received a 2-year prison sentence. The sentence was upgraded due to the "manifestly inadequate" original sentence of 2 years of house arrest given "the extreme nature of the breach of trust" (Canadian Press, 2010).

Case 9–44: A child psychologist entered into an Alford plea deal (*North Carolina v. Alford*, 1970) and will spend 18 months in a Maryland jail and a year of home confinement for sexually assaulting three girls, ages 7, 9, and 10. (The original sentence was to be 6 years. A lesser sentence, due to the psychologist's serious health problems, was renegotiated.) The psychologist lost his license and will be a registered sex offender in perpetuity ("Former Fallston Psychologist," 2011).

Case 9–45: A Wisconsin psychologist was sentenced to a year in jail for having a yearlong affair with a client even though he claimed the affair started after the file was closed (Vielmetti, 2011).

Case 9–46: A psychologist practicing in New Hampshire was charged by a grand jury with 30 counts of aggravated felonious assault for having sex with a client less than a year after marital counseling with the client and her husband concluded. He was sentenced to 6 months in jail and turned in his license shortly after being charged (Jarvis, 2013).

Case 9–47: An unlicensed therapist in New York was found guilty of 59 counts of sexual abuse and sentenced to 103 years in prison for a sexual relationship with a female client commencing when she was 12 years old (Otterman, 2013).

Perhaps the toughest attempt to date to criminalize sexually offending mental health professionals occurred in Maryland, where an exploited client instigated legislation that passed unanimously in the Maryland State House but ultimately failed in the Senate. “Lynette’s law” would convict therapists of statutory rape, add their names to the sexual offender registry, and include potential prison terms of up to 3 years (Heller, 2013).

Criminalization, we must note, is not without unintended repercussions. When punishments are draconian, clients and colleagues may become less inclined to accept responsibility for putting another person in jail. Any motivation for sexually exploitative therapists to confess and receive needed rehabilitative assistance evaporates. Clients who have suffered and could benefit from an award of damages in a civil procedure are not afforded that advantage in a criminal proceeding.

We conclude this section with an odd quandary. Once offending therapists are dealt with, the client/victims are ignored, even if still in pain. Brown (1997) argued that helping professions should consider making amends to the victims as part of their rehabilitation process. While serving on ethics committees, we made a point of “speaking for the profession” when corresponding to complainants after their cases

resulted in holding the psychologist responsible. Although details of the deliberations and outcomes were not shared with complainants, the strong APA stance regarding sex with clients was made clear. It was not unusual to receive notes of appreciation from these complainants, thanking us for helping them heal.

TREATING SEXUAL EXPLOITATION BY FORMER THERAPISTS

Clients who have been sexually exploited by a previous therapist may never receive competent follow-up help. When one member of an occupational class abandons a fiduciary duty, all other members can become suspect in the victims’ eyes. Even though exploited clients recognize the need for counseling, they often do not trust their own ability to make wise decisions and may even fear revictimization (Wohlberg, 1999). Treating such clients presents a unique set of subsequent treatment challenges, including the probable need to address whatever brought the client into psychotherapy in the first place (P. S. Plaut, 1995; Wohlberg & Reid, 1996.)

Practicing therapists’ chances of encountering at least one client claiming abuse by a previous therapist are estimated to be about 50%, and only a small percentage of those allegations are believed to be false (Pope, 1994; Pope & Vetter, 1991). Clients reporting sexual contact with previous therapists were reported by 43.6% of a sample of Missouri therapists (Stake & Oliver, 1991). In a survey of Rhode Island therapists, a quarter of the sample reported evaluating at least one client who had engaged in some form of sexual involvement with a former therapist. Virtually all respondents agreed the victims had been harmed (Parsons & Wincze, 1995).

Sonne and Pope (1991) presented an array of potential reactions experienced by subsequent therapists when clients reported sexual exploitation by previous therapists. These include disbelief and denial that a well-trained colleague could have done such a thing, a suspicion that the client may be exaggerating or even lying, and a tendency to minimize the amount of

harm, perhaps as a way of protecting a member of one's profession. Consider the next case.

Case 9-48: Mary Wary, a fragile and highly anxious woman, sought therapy with Kantbe So, Ph.D., claiming her previous therapist fondled her breasts and tried to have intercourse with her. The accused therapist, well regarded in the community and active in the local psychological association, seemed pleasant and happily married.

Put yourself in Dr. So's place, and you will empathize with his difficult position. Nevertheless, Dr. So has an obligation to work with this client, although he should not make a formal complaint on his own. Dr. So can certainly refer the client to an attorney or licensing board for consultation and provide emotional support for her during any proceedings Ms. Wary wished to pursue. Depending on where Dr. So practices, he may have a legal mandate to report the accusation to a state agency. As for the client herself, Wohlberg (1999) asserted that therapists must recognize and accept the victims' difficulty in trusting as well as ambivalent feelings toward the abuser.

SEXUAL RELATIONSHIPS WITH STUDENTS AND SUPERVISEES

Stories of college professors engaging in sexual liaisons with their young, nubile female students persist as durable an academic stereotype as ivy, football, tower clocks, caps and gowns, and founder statues in the quad. Given the trappings of most educational environments, some students and some professors will confront the temptation to enter into romantic relationships based on motivations running the gambit from gaining some future advantage to consummating true love. Indeed, most of us know educators who married one of their own students. However, times have changed, and institutions of higher education have taken more vigorous stands to discourage educators from dating students. This stems from neither prudishness nor pressure from feminists. Rather, the increase in sexual harassment charges (and reporting

requirement of Title IX, also known as Public Law 92-318) against professors and trainers, sometimes resulting in lawsuits (and sometimes countersuits by the accused) has created an economic motivation to deter such relationships. (For further discussion of sexual harassment not involving sexual intimacies, see Chapter 10.)

As for supervisees, the supervisor-supervisee role itself also becomes vulnerable to blurred boundaries (Burian & Slimp, 2000; R. Walker & Clark, 1999). It is disturbing to note that data from anonymous surveys revealed that sexual contact between clinical supervisees and supervisors occurs fairly frequently (Glaser & Thorpe, 1986; Pope et al., 1979). These two surveys were conducted before 1992, when the APA ethics code first expressly disallowed sexual relations with supervisees in training (APA: 7.07), but such activity persists (Koenig & Spano, 2003; Lamb & Catanzaro, 1998).

The ethical issues regarding sex between student and educator revolve around the abuse of power and conflicts of interest more than about sex per se. Whereas policies across the country may fall short of an outright ban on all student-instructor dating, most campuses have rules that prohibit, restrict, or dissuade instructors from dating students over whom they have direct evaluative authority, such as those currently in one's class, advisees for theses or dissertations, and supervisees. Although male educators and female students remain the prevalent pairing, as more women enter academia as educators, as more older individuals return to the classroom as students, and as scattered cases of gay and lesbian student-faculty relationships surface, a discussion of dating students can no longer be confined to male academics and their 18- to 22-year-old female students.

Opponents of the ethical ban on sexual relationships with psychotherapy clients are no longer to be found, at least not out in the open. However, critics of bans on romantic and sexual relationships among faculty and students remain visible. It is argued that prohibitions against student-professor sex infantilizes students and creates an atmosphere of paranoia, causing professors to make themselves less accessible (Gibbs, 1995). Others have declared

that those who have reached their 18th birthdays can be intimate with whomever they please on their own time. We note, however, that restrictions designed to prevent conflicts of interest in the workplace may legitimately extend to higher education settings and thereby not infringe on constitutionally guaranteed privacy rights (Mooney, 1993).

Regardless of the debate, we doubt anyone would openly approve of clearly coerced sexual activity, as illustrated in the next case.

Case 9-49: Cloris Push, Psy.D., made numerous suggestive remarks to her student, Stan Shun, implying the closer their personal relationship, the more likely Shun's successful completion of his degree program. Shun was not particularly attracted to Professor Push, but he believed that rejecting her advances would endanger his academic status.

Some ask whether students can give meaningful consent to persons who hold, or are believed to hold, authority or an evaluative responsibility or other advantages over them. Because of the unequal status coupled with the potential for negative consequences should the more powerful educator decide to exercise it, voluntary consent becomes problematic (Quattrella & Wentworth, 1995; Zalk, Paludi, & Dederick, 1990).

In a now-classic nationwide survey of psychologists (Pope et al., 1979), 10% of the respondents reported having had sexual contact, as students, with their educators, and 13% reported entering into sexual relationships, as educators, with their students. Moreover, when these students became psychotherapists, 12% of the men and 3% of the women reported sexual contact with their clients, which was a slightly higher percentage for both sexes than revealed in other surveys of therapists taken during that era. In addition, student-educator sexual relationships seemed on the increase at the time the survey was conducted. Of the recent female graduates, 25% reported having had sexual contact with their educators, compared with 5% of those who had earned their degrees more than 21 years before the survey was conducted.

Other research replicated both the extent of sexual relationships with mental health educators or supervisors and the later judgment that such involvement proved detrimental to them. In Robinson and Reid's (1985) survey, 96% of their female respondents who had experienced sexual contact or sexual harassment as students believed harm came to one or both parties. Glaser and Thorpe (1986) found that 17% of their survey respondents had sexual contact with their educators as students, a little over a third of these with clinical supervisors. Whereas 28% of the respondents felt coerced at the time, overall attitudes about the relationships also became far more negative in retrospect. The survey by Hammel, Olkin, and Taube (1996) suggested the situation was not improving. Fifteen percent of female graduate students and 2% of male graduate students had experienced sexual contact with their educators. The modal pairing was a single female second-year graduate student with a 40-year-old married male educator. Again, in retrospect, most found the experience to be coercive and a hindrance to their working relationship.

Currently, the major professional organizations have mandates against sexual relationships with supervisees and others who have or who may have direct authority or power over them (APA: 7.07; AAMFT: 4.3; ACA: F.3.b, F.10.a; NASW: 2.07.a). Technically speaking, educators and supervisors may retain the power to evaluate indefinitely, given that the student or supervisee may require employment recommendations for years after graduating from the program.

Risks to Students and Supervisees

Neither students nor educators may be in touch with their respective vulnerabilities when relationships turn sexual. When the affairs of students and their educators go askew, the effects must be reckoned with in both the private and professional realms. Emotional fallout can include grief, embarrassment, fear, bitterness, and a desire for vengeance. When these feelings become superimposed on the academic role, serious consequences for students, professors, or

both can ensue. In the extreme, professors who see themselves as entitled to enjoying students in whatever way they find satisfying can, almost overnight, find themselves reduced to the target of snide gossip and administrative or legal sanctions.

Educators are actually more vulnerable than therapists in several ways. Psychotherapy clients usually lack access to other clients' identities and find it more difficult to corroborate the offender's behavior pattern. Students, on the other hand, have ready access to each other, leaving the serial exploitative educator open to coalitions of accusers and with a greater probability for exposure. Also, students do not have to deal with off-campus licensing boards or ethics committees. Mechanisms for redress are available on campus. Other resources also remain available if the student does not find the campus response satisfying.

Case 9–50: After an affair between Gary Goferit, Ph.D., and Paula Jettison had ended, Jettison filed charges against Goferit for sexual harassment and exploitation. She also contacted the local newspapers. She was joined by several other students, who claimed they, also, had experienced the same abuse by Goferit. Dr. Goferit lost his job and his wife.

The contemporary popular press relishes stories like this, and even sophisticated academic publications, such as the *Chronicle of Higher Education*, feature them. We collected dozens of articles from the media, several involving mental health and social science educators, from which to adapt our cases.

Students also take far greater risks than they may appreciate. At the time, some may see their relationship with professors as exciting, possibly even as putting them on the fast rungs up the career ladder, only to later find themselves discarded and frozen out.

Case 9–51: Dexter Jerky, Ph.D., had a sexual liaison with one of his graduate assistants, Jane Switch, for almost a year. Then, Switch met a young man she wished to date exclusively. When she told Professor Jerky their affair was over, he allegedly became furious and expressed his intention to

punish her. He abruptly terminated her research assistantship. She heard rumors that Dr. Jerky told other faculty members she was fired due to gross incompetence and was not "doctoral-level material." When Switch confronted Jerky, he allegedly told her that he had status and clout and she should think twice about a career in the field.

Students may perceive their educators as wise and sufficiently mature to preclude any act of vicious retaliation. However, Dr. Jerky is not an isolated case. Scorned lovers, regardless of their intellect or position, may respond with every means at their disposal. A spurned therapist might cause emotional harm to a client, but the client's career would rarely also be at stake.

Sexual relationships also compromise the process of assigning unbiased and valid evaluations. Thus, sexual intimacies with students undermine the obligation to evaluate students fairly and accurately (Blevins-Knabe, 1992; Keith-Spiegel, Tabachnick, & Allen, 1993; Pope, Schover, & Levenson, 1980; Slimp & Burian, 1994). Further, students may alter their academic behavior in ways that inhibit or distort their learning. For example, a supervisee may not feel free to discuss feelings of attraction toward clients, fearing a supervisor/lover will interpret such a line of discussion as flirting (Bartell & Rubin, 1990; Pope et al., 1986). Finally, what may start as a consensual relationship often evolves into what feels more coercive (Falender & Shafranske, 2004).

In conclusion, academia provides the environment in which faculty and supervisors are paid to facilitate the intellectual, career, ethical, and personal development of students and supervisees. Mentoring students by passing along of the best one has to offer as a teacher can be emotionally intimate and exhilarating (S. M. Plaut, 1993). The intrusion of sexuality—always potentially volatile—into these fundamentally vital educational functions is diametrically opposed to the mission of higher education and professional training. Even when relationships work out better (or conclude more gently) than those we have presented here, serious concerns persist. We must ask the question, What are these students learning? It seems to us

they learn it is acceptable to gratify needs under whatever circumstances they choose, with minimal regard for maintaining objectivity and clarity in professional relationships with those over whom they will have substantial influence and responsibility.

Mature Students, Teaching Assistants, and Former Students

We have often heard remarked that undergraduate students should be off limits for dating and sexual relationships, but graduate students are fair game. Survey data revealed that professor and graduate student liaisons are perceived as more ethically acceptable (Quattrella & Wentworth, 1995; Skinner et al., 1995). Such beliefs are likely based on the assumed higher overall age and maturity level of graduate students. The fact is, however, graduate students are at *greater* risk than are undergraduates. Undergraduate students, even if exploited and scorned, can move to a new campus for graduate training and start over. Undergraduates may have lost a good reference if an affair goes sour, but letters from other professors could compensate. Graduate students do not have many options. Because advanced programs typically have fewer teaching faculty in a given specialty area, a highly desirable reference letter for jobs or continued training, funding decisions, and research opportunities (which are necessary to compete for jobs in academia) could be unavailable should a relationship go stale or collapse. Finally, in the worst-case scenario, if the sexual liaison involves the student's major professor, there is no place to turn should the relationship end badly.

What about the awkward status of the graduate teaching assistant (GTA)? When still a student and yet also an instructor, what rules apply? Can the GTA date fellow students? Can the GTA date colleagues? Or, is the GTA off limits to both populations? Again, casual observation reveals that GTAs often date individuals from both groups. However, because many of the problems we have presented apply to graduate assistants, GTAs should follow the general policy expected of faculty: to refrain from dating anyone over whom they have evaluative authority or who

has authority over them, thus defusing even an appearance of favoritism or conflict of interest.

Finally, what about entering into sexual relationships with ex-students? We all know of relationships between educators and their former students that worked out. Ethics codes are silent on engaging in relationships involving sex with former trainees. We also know of affairs and marriages that failed miserably, adding discomfort when both have similar, well-established careers in the same geographical locale. One academic couple essentially ended each other's part-time private practice by bad-mouthing the other around town. Love and sex remain intricate and potentially knotty enough under less complicated conditions, confirming research findings suggesting considerable caution given that the long-term risk outweighs short-term pleasure (e.g., Hammel et al., 1996).

WHAT TO DO

- Strive to remain self-aware when it comes to your feelings about clients, especially feelings of sexual attraction.
- Maintain professional contacts with whom to consult about boundary crossings and violations.
- As an educator or supervisor, ensure supervisees have adequate training in and freedom to discuss sexual feelings and relationships with regard to their clients.
- When tempted to disclose a personal feeling or touch a client, ask yourself, "How will this help the client?"

WHAT TO WATCH FOR

- Carefully evaluate clients and their vulnerabilities before engaging in any nonerotic touching. Some clients remain averse to touching.
- Be wary of entering into a sexual relationship with former clients, even if the moratorium period as mandated by your ethics code has passed.

- If you are facing crises, regrets, or emotional pain, realize that you may be at risk for inappropriate boundary violations.
- Avoid as much as possible seeing clients in social situations that could be viewed or misunderstood as dating or courtship behaviors.

WHAT NOT TO DO

- Never engage in sexual intimacies with current clients.
- Never engage in erotic touching or sexual activity with a current client or student over whom you have evaluation responsibilities.
- The kindness, passivity, adoration, and vulnerability of clients must never be exploited for personal gratification.
- Do not keep sexual feelings toward clients to yourself. Find someone appropriate with whom to consult.
- Avoid practicing in isolation.
- Never accept a past lover as a client.
- Do not engage in sexual relationships with students over whom you hold (or may hold in the future) evaluative authority.

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10

Relationships With Colleagues, Supervisees, Students, and Employees

In quarrelling, the truth is almost always lost.

Publilius Syrus

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Do mental health professionals get along better with others because of their expertise in understanding the complexities of human relationships? From our vantage point, any relative advantage we might muster in some situations can disintegrate in others. Professionals are

people first, and some do not function well under stress or when overly focused on their own needs to the detriment of the welfare of others. Some have entrenched personal styles that make the work environment unpleasant for those around them.

INTERPROFESSIONAL AND PEER RELATIONSHIPS

Colleagues in all specialties deserve our respectful treatment and equanimity in accordance with professional etiquette, even when we have reason to feel annoyed with them. Tossing impolite barbs can result in an escalating professional feud. Ethics complaints occasionally arise from issues that should have been resolved informally and much earlier in the dispute.

Cooperation With Other Professionals

Helping professionals are usually busy people who should not be expected to drop everything to satisfy a colleague's immediate need. Often, the best response can be a simple, prompt reply indicating when or if the request can be filled. Timeliness can become an ethical issue, however, when a colleague or professional in training feels completely ignored for an extended period of time. Sometimes, passive-aggressive behavior creates unnecessary lags.

The next cases imply a measure of passivity and lack of prompt cooperation.

Case 10–1: Gloria Seeker, D.S.W., proposed a research project to be conducted at a state psychiatric facility near her university. The project required approval by the facility's institutional review board, headed by Tyrone Plod, Ph.D. Seeker eventually filed a complaint alleging that Plod had procrastinated for 10 months in the considering her study, despite the fact that it posed no risk to the patients. She accused Plod of professional jealousy. Dr. Plod replied that he was kept very busy by his duties as chief psychologist and could not give high priority to a request from a colleague employed elsewhere.

While it is not clear whether Dr. Plod was intentionally thwarting Dr. Seeker's project, her request was obviously low on his list. At the very least, Seeker deserved to know approximately when a decision would be forthcoming and what position the committee might take given its official policies and research practices. If

evidence existed to confirm that Plod treated Seeker unfairly, given institutional policy or relative favoritism to others, his behavior would qualify as unethical.

Case 10–2: Rodney Freeman terminated counseling with Stefan Witholden, L.M.H.C., over a year ago. Mr. Freeman decided to begin counseling anew with another practitioner and signed a Health Insurance Portability and Accountability Act (HIPAA) Compliant Release-of-Information form that authorized sending all records and psychotherapy notes to the new practitioner. When no report or records were forthcoming, and after several unsuccessful attempts to contact Witholden, Freeman was finally told, "I don't have any materials that would be useful to you."

Witholden's behavior is not uncommon. At times, a former therapist may be angry at a client's decision to see someone else, even after an appropriate termination. Witholden's reluctance to share information with the new therapist at the client's request constitutes potential harm to the client and violates federal law (i.e., HIPAA). The ethics codes of professional organizations and several state statutes specify that records cannot be withheld because a client still owes money (American Psychological Association [APA]: 6.03; American Association for Marriage and Family Therapy [AAMFT]: 8.6; American Counseling Association [ACA]: B.6, D; National Association of Social Workers [NASW]: 1.07, 2.01.c). In this case, payment owed is not at issue, making Witholden's behavior even more indefensible.

Case 10–3: Susan Predoc's thesis draft sat among the piles of papers and books on Professor Sloth's desk for 4 months. When Ms. Predoc politely inquired about it, noting that she was anxious to finish her degree and move her family to another city, Sloth said he would get to it as soon as possible. Three more months passed, and still no feedback was forthcoming.

Ms. Predoc's dilemma is particularly troublesome because Sloth retains considerable power over her future prospects, and she does

not have professional clout to assist herself. How hard should she push? Should she enlist the assistance of one of Sloth's colleagues? If she angers her thesis chair, he may exact additional and less-passive penalties, such as finding fault with the work she submitted. Ethics codes address such unresponsive behavior by requiring appropriate feedback processes (APA: 7.06a; ACA: F.6–F.7; NASW: 3.02).

With all sorts of alternative medical and healing practices gaining popularity, such dilemmas as the one in the next case will likely occur more frequently.

Case 10–4: A client decided to drop Philip Customary, Ph.D., in favor of consulting Spaci Planet, an individual with no discernible credentials who claimed skill as a “psychic healer able to channel with Ormont on Jupiter.” The client requested that a copy of all treatment notes and assessment scores be sent to his new “therapist.” Dr. Customary reasoned that it would be improper to send records to someone whose competence he highly doubted.

One may empathize with Customary’s position, but it is one that may well make him vulnerable. Mental health practitioners can offer to provide treatment summaries but are also required to release records at the request of a client. As an alternative, Dr. Customary could provide the records to the client, expressing concern about the qualifications of the new practitioner, but allowing the client to decide what to share with Ms. Planet.

Interference With Ongoing Relationships

What about taking on a client while that person is still in an ongoing relationship with another therapist? Two common concerns are raised in this context. The first is agreeing to work with clients or others who initiate the contact but are currently involved in relationships with other professionals in a similar role. The other is active solicitation (“pirating”) of clients engaged in treatment elsewhere.

Accepting clients currently under the care of another professional is not necessarily unethical

if the therapist minimizes the risk of confusion and conflict and focuses exclusively on the client’s welfare (APA: 3.07, 10.04; AAMFT: 3.4; ACA: A.3, A.11; NASW: 3.06). For example, an individual may well benefit from participating in group or family therapy with one therapist while pursuing individual treatment with another. In such cases, both therapists should ideally know of the other’s involvement. We suggest careful reflection or consultation before agreeing to multiple-therapist arrangements to ensure that the “what-ifs” are well managed. There may be more to the story than you know.

Case 10–5: Sidney Switch was still in active treatment with a psychiatrist when he sought an appointment with Roberto Salvage, Ph.D. Switch tells Dr. Salvage that he believes his current therapist is not helping him. He would like to start seeing Salvage instead.

What are Salvage’s obligations and duties? We acknowledge that Switch certainly has the right to choose a new provider. In our view, however, it would be inappropriate and possibly foolhardy for Dr. Salvage simply take Switch on as a client, ignoring the other active professional relationship. Ideally, Salvage would recognize that negative transference or misunderstandings can potentially complicate therapy and would suggest that Mr. Switch discuss his dissatisfaction directly with his current therapist. If Switch is unwilling to do that for some reason, Salvage should seek his authorization to contact the therapist to confer about the case. If Switch refuses to permit this, Salvage would be wise to decline to offer him services. It could be that Switch intends to conceal some issues or is simply acting out in some way against his current therapist. Salvage might soon find himself embroiled in an uncomfortable situation with a troubled and vulnerable client.

Uninvited in-person solicitations, disallowed in previous APA codes, appear to be implicitly allowed in the current APA code (APA: 10.04). We continue to advise, however, that direct solicitation of clients receiving services from another mental health professional should be undertaken only when it seems clear that a client is in harm’s way as a result of the current

treatment. The sole focus should be on the client's individual needs and best interests (ACA: C.3; NASW: 4.07), and these may not always be immediately apparent.

Case 10–6: Sonia Victim sought psychotherapy with Anita Rule, Ph.D. Ms. Victim told Dr. Rule that she had recently decided to terminate her "psychotherapeutic" relationship with Peter Grossout, L.M.F.T., who had convinced her to engage in a variety of sexual activities with him as a means to "overcome the adverse psychological influence of her father in her life." Ms. Victim told Dr. Rule that she felt increasingly depressed and worthless in the wake of her encounters with Mr. Grossout. Rule inquired regarding whether Ms. Victim might wish to pursue a formal complaint against Grossout. The client responded that she wanted only to "forget those repulsive events" and begin treatment with Dr. Rule.

Ms. Victim's situation constitutes an exception to the generally preferred way of accepting new clients. As noted in a previous chapter, research suggested that about half of all therapists will encounter at least one client who reports abuse by a previous therapist (Pope & Vetter, 1991). Dr. Rule would doubtless like to see Mr. Grossout called to account for the allegations made by Ms. Victim. If Victim's accusations are true, then Grossout's future clients may be at risk for sexual predation. On the other hand, Victim's disclosures were offered in confidence and cannot be disclosed without the client's consent (see Chapter 6). The emotional cost of pursuing a complaint against Grossout may feel like too high a price, and the choice belongs to Ms. Victim.

Dr. Rule can and should inform her new client that the behavior she has described was unethical, unprofessional, and possibly illegal (depending on state law). The client should also be informed of avenues available to her for pressing formal ethics or legal complaints. Dr. Rule should not, however, attempt to pressure her client or pursue a formal complaint independently. Rule's client may ultimately develop sufficient personal resources to pursue the matter at a later time.

Not all ongoing relationships posing interference issues involve psychotherapy. Other types

of professional alliances can also yield troubling dilemmas.

Case 10–7: Tanya Trainee is an intern at a community mental health center where Lorna Doone, M.S.W., supervises her cases. Ms. Trainee disagrees with some of Doone's recommendations, so she approaches her assessment professor, Mucho Nicer, D.S.W., for his suggestions.

Ms. Trainee appears to be splitting off aspects of her relationship with Ms. Doone that seem unsatisfactory to her. Dr. Nicer must recognize and point out that the matters Ms. Trainee has approached him about fall under the authority of another supervisor. She should be advised to discuss differences directly with her designated supervisor or with the person directing the training program. For Dr. Nicer to offer supervisory consultation without the knowledge of Ms. Doone would create a potential for collegial conflict, even if that was not Ms. Trainee's intent. If Trainee has serious questions regarding the nature of Ms. Doone's supervision or competence, and if Doone is unresponsive to a direct discussion with her, she could then reasonably consult with another of Doone's colleagues for advice on how to proceed.

What about a request for consultation that turns into something more? Consider the following case examples:

Case 10–8: Fritz Couch, M.D., a psychoanalyst, has treated Hester Prynne for 3 years. Prynne has been blocking her free associations for several weeks, and Dr. Couch wonders about the possibility of an impending thought disturbance. He refers Ms. Prynne to Ursula Norms, Ph.D., for psychodiagnostic testing. During the course of the psychological assessment, Ms. Prynne tells Dr. Norms that she feels increasingly frustrated with the lack of progress in her treatment with Dr. Couch and asks whether Norms would take her on as a therapy client.

Case 10–9: Gladys Prudent, L.M.H.C., has significant concerns about Hedda Downward's persistent depressed mood. She refers Ms. Downward to Ingrid Remedy, M.D., for a medication consultation. Ms. Downward is impressed

when Dr. Remedy expresses the belief that medication should offer her relief and asks Remedy to begin managing her case completely, expressing a willingness to terminate with Prudent.

Clients often face temporary roadblocks or frustration in the course of therapy. Often enough, ethical therapists recognize the potential limitations in their ability to adequately diagnose or treat a specific problem and seek specific consultations from qualified colleagues (APA: 4.08; ACA: A.3; NASW: 3.06). When this occurs, the consultants can become imbued with a positive aura by the clients, who then ask the consultants to take over their care. The cases of Ms. Prynn and Ms. Downward illustrate a not-uncommon circumstance, and one can easily understand why. Clients have the right to free choice, even when the choice might run counter to their best interests as seen by their current therapists. Such consultants may become idealized by virtue of a therapeutic transference situation or a simple transitory contrast effect. In both cases presented, the correct course of action would be similar. The consultants should refer the clients back to their therapists with the recommendation that they discuss the issue directly. In Ms. Prynn's situation, this might mean working through a negative transference, whereas for Ms. Downward it might mean discussing the frustrations of a prolonged depressive reaction. Ultimately, the clients may choose to terminate treatment with their therapists and seek treatment from the consultants or elsewhere. But, the consultants should not encourage this, recognizing the unusual nature of their limited relationships with the clients. Assuming the clients have authorized the consultants to communicate with the referring therapists, it might also be wise for Norms and Remedy to inform Couch and Prudent, respectively, of their clients' concerns. Doing so as part of the consultation may advance the progress of treatment.

Colleague Versus Colleague

"Organizational civility" involves treating others with dignity, mutually respecting others' ideas (even if not always agreeing with them),

interacting constructively with colleagues, and taking a productive role in the stewardship of the institution (DiLeo, 2005; Pearson, Andersson, & Porath, 2005). Alas, incivility in the workplace appears to be rampant, sometimes with only a single person or a small group creating dysfunction in the entire setting (Braxton, Proper, & Bayer, 2011; Fox & Spector, 2005; Reeson, 2008; P. Smith, Phillips, & King, 2010; Trudel & Reio, 2011). At other times, individuals face serious and escalating forms of bullying known as "mobbing" (Branch, Ramsay, & Barker, 2013; Duffy & Sperry, 2014; Shallcross, Ramsay, & Barker, 2013; Twale & De Luca, 2008; Zapf & Einarsen, 2005).

Cooperation with other professionals and consultation with colleagues is encouraged (APA: 3.09; ACA: D; NASW: 2.01–2.06). The recognition of valid competencies and consumer interests should prevail in interprofessional relationships, yet this does not always happen. Complaints against mental health professionals, educators, and social/behavioral researchers lodged by their own colleagues are not uncommon, although this should come as no surprise. Colleagues are the ones most aware of relevant ethical standards and most likely to observe unethical behavior directly. The discouraging feature of many such complaints is the intensity—and occasionally bitter vindictiveness—with which such individuals pursue their grievances.

Performance and credential evaluations also generate conflict. The individual being assessed is usually under considerable stress, and the evaluator's failure to recognize and respond sensitively presents a hazard. Such edgy situations include doctoral examinations, tenure decisions, supervisory sessions, grievance hearings, annual salary reviews, or even the receipt of an unwanted exam or term project grade. Other situations that spawn disputes include poor communications among professionals and their students and supervisees, risky individuals, and a lack of predefined procedures for dealing with dissatisfied parties. Failure to live up to commitments made to one's peers also constitutes a potential risk for complaints. These unstable conditions can exist in any

institution or agency. The professional interests of different types of mental health professionals can sometimes clash with each other. Despite a common focus on human behavior and the resolution of emotional problems, interprofessional relations will often manifest themselves as political, economic, and territorial disputes.

Case 10–10: Horace Pill, Ph.D., a nationally recognized expert in psychopharmacology, began to advocate for laws authorizing prescriptive privileges for psychologists. He soon became the object of blistering attacks by psychiatrists. Editorials criticizing him in pejorative terms appeared in the *National Psychiatric News*, and officers of the Amalgamated Psychiatric Society wrote angry letters about Dr. Pill to his employer. Pill was invited to deliver a lecture at Urban Medical School. During the course of the talk, Pill made critical comments about the Amalgamated Psychiatric Society. Many psychologists in the interdisciplinary audience became distressed with Pill's remarks, believing that they complicated relationships with their psychiatrist colleagues at the medical school.

Even *within* each profession, the goals and views of some members can diverge with those of others. Deeply held differences in theoretical, practical, and methodological approaches abound. Such disputes can create conditions that erupt beyond the bounds of stimulating debate. We do not propose that professional disagreements must always follow the etiquette expected at an afternoon tea party. Yet, in virtually every circumstance, maintaining a professional demeanor will likely create the best climate for a reasonable outcome. (See Chapter 17 for recommended techniques for confronting unethical colleagues.)

Incivility

Incivility is typically defined as milder forms of negative interpersonal behaviors toward colleagues who may not always discern why they are targets (Pearson et al., 2005). Behavioral examples include rudeness, insulting or disparaging comments, denigration of the target's

work, bullying, and spreading false rumors (Sakurai & Jex, 2012). Too often, organizations passively dismiss incivility as transient or trivial and fail to intervene, despite having knowledge of ongoing antagonisms (Harold & Holtz, 2015; Lim, Cortina, & Magley, 2008; Powers & Maghroori, 2006; Twale & De Luca, 2008). Nevertheless, uncivil and warring colleagues can wreak havoc on everyone in the organization.

The potential for uncollegial behavior increases when one or more of the following conditions pervade the work setting:

- competitive environment;
- concern about allocation of scarce resources;
- limited opportunities for advancement;
- low morale;
- heavy workloads;
- inadequate or unpleasant working conditions (e.g., noisy, crowded, lack of privacy);
- incompetent, biased, passive, or ambiguous management styles;
- inconsistent decision-making processes;
- real or perceived inequities; or
- personality clashes.

Frequently, we find that once-reasonable people sink into an ongoing cycle, and the abuse hurled by one elevates the mistreatment perpetrated by the other.

Case 10–11: Drs. Rosemary Spat and Dameon Tiff cannot stand each other. No one at the clinic can recall when it all started. Both Spat and Tiff have created a litany of complaints against the other, ranging from misappropriation of a single postage stamp to maltreatment of clients. Each routinely stalks and spies on the other. The head of the agency has moved their offices to opposite ends of the hall and has even had to impose an internal gag order on both of them during staff meetings.

Everyone working in the agency, including the unaware clientele, has become disadvantaged by this unfit dynamic duo. No excuse exists for such unprofessional misbehavior, yet such entrenched, angry relationships occur far

more often than they should. If the combative parties cannot reach a level of professional maturity, they should at least keep their feud out of the work setting. Certainly, colleagues should have the freedom to criticize or disagree with each other, even in a public forum. However, framing an argument in well-reasoned and respectful ways constitutes the most constructive and professional response.

Case 10–12: Manfred Potz, Ph.D., and his colleague Stefan Blitz, Ph.D., have known each other personally and professionally for many years. After an unfortunate personal dispute dissolves their friendship, Potz complains to an ethics committee that Blitz has spread untrue rumors to a mutual acquaintance that Potz is a terrorist sympathizer and is having an extramarital affair with a woman one third his age.

The type of dispute between Potz and Blitz also occurs more often than it should, especially in group or institutional settings. Colleagues usually have no way of assessing the validity of such personal criticisms with respect to professional competence. If Blitz has some factual basis for criticizing Potz, then he should bring this evidence to appropriate authorities. Gossip and spreading rumors, however, violate both the obligations and the values of a professional role.

Risky Individuals

A particular irony is that complaints resulting from difficult personalities are rarely true ethics matters.

Case 10–13: William Cheapo, M.D., Frank Fussy, M.S.W., and Mildred Decibel, Ph.D., worked together in a group practice arrangement. They shared the cost of office space, utilities, and a receptionist's salary. As time went on, it became clear that each engaged in behavior that annoyed the other two. Dr. Cheapo demanded that he should pay less because he used fewer utilities and little receptionist time. Mr. Fussy complained about everything that seemed out of place, such as leaving a dirty cup in the coffee room sink. Dr. Decibel played her office radio so loudly that

it could be heard throughout the complex, and efforts to tone down the noise resulted in only temporary compliance.

How can three highly educated individuals get themselves into such a predicament? They thought of themselves as compatible, never once considering drafting contractual contingencies for handling disputes. Each has a strong will, and now they are threatening each other with ethics charges and legal action. This sort of problem happens frequently enough for us to suggest that any business arrangement among colleagues should include formal contracts—a professional prenuptial agreement, if you will—that deal with both operational contingencies and details of dispute resolution, such as an agreement to use binding arbitration.

Some individual styles are troublesome, although not necessarily a violation of specific ethical standards. Such people, however, may be perfectly satisfied with themselves, making conflict resolution especially difficult. Individuals who are emotionally labile or unstable certainly present some risk. Arrogance, narcissism, or critical personality styles also contribute to such problems. Some difficult colleagues may best be described as bullies (Lester, 2013; Twale & De Luca, 2008). We could create a long list of unwholesome personality traits—procrastination, impulsivity, hostility, and so on—but the point is clear. Given the basics of human nature, every risky situation often includes one or more difficult individual. By recognizing and dealing with hazardous persons, particularly as they may have an interface with precarious situations, ethical problems can often be avoided.

Case 10–14: Bernice Dweezel, Ph.D., is a distinguished psychologist whose research is world renowned. Unfortunately, she is also egotistical and brusque. Students willing to endure criticism and pontification often benefit from working with her, but not everyone can tolerate her presence. The faculty respects her scholarly work and appreciates how her professional reputation enhances the status of the department, although few would choose to socialize with her.

Dr. Dweezel may be an obnoxious individual by many standards and may border on behaving unethically when inconsiderate to her students and colleagues. Unfortunately, she may have little insight into the nature of how she is perceived, or if she does, she may not care. Unpleasant personality traits do not qualify as unethical conduct. In any event, a formal ethics complaint would likely fail to evoke positive change given ingrained characterological attributes. The more serious danger will occur if or when Dr. Dweezel encounters a hostile student or colleague more inclined to act out than back off. One might caution others about the hazards of working with her or suggest avoiding her entirely. Anyone whose opinion Dr. Dweezel admires might attempt some collegial consultation, with gentle references to a need for personal change. Regrettably, however, there will always be "Dr. Dweezels" in the environment, and ethics codes and committees are of little help in dealing with them. Rules and due process procedures, known to all and applied consistently and without bias (creating what is called *procedural justice*), comprise the most powerful tools available to deal with the difficult associate in a risky situation. While one cannot restructure personality to suit circumstances, it is possible to minimize risk in a volatile situation by imposing reasonable structure.

Beyond Incivility

If those in leadership positions fail to take action, incivility can devolve into more intense behaviors, such as outright aggression and open conflict (Basu, 2012; Fox & Spector, 2005; P. R. Johnson & Indvik, 2001; Powers & Maghroori, 2006; S. G. Taylor & Kluemper, 2012; Trudel & Reio, 2011). The acts themselves often have a childish quality. Angry colleagues may issue a complaint, viewing an ethics committee or licensing board almost as a parent figure who will swiftly redress the perceived wrong. Unfortunately, because the players are adults functioning in a professional venue, the consequences of their actions cannot be easily dismissed as mere immaturity.

Case 10–15: Rea Venge, Ph.D., gathered strong circumstantial evidence that her colleague and professional rival at Saltine University had stolen research notes from her lab. Dr. Venge was later observed by several witnesses releasing her colleague's laboratory rats in the university's botanical garden.

Case 10–16: When Charlene Newbody, Ph.D., was recruited to Chaos State University as head of a disorganized counseling psychology training program, she undertook a major revamping of departmental policies. As a result, Abe Oldster, Ph.D., was reassigned from teaching an elective graduate seminar to a less-desirable supervisory role. Insulted and angry, Oldster monitored Newbody closely and discovered that she had made a critical comment about his attitude to another staff member. Dr. Oldster sent a detailed complaint of alleged unprofessional conduct by Newbody to the APA ethics committee. He filed the same complaint 6 weeks later with the university grievance board. Because each group investigates complaints independently, Newbody had to defend herself serially in each forum. Although all complaints were ultimately dismissed, Newbody, much to Oldster's delight, spent considerable time and energy defending herself.

Case 10–17: Drs. Katz and Dawgs were colleagues with markedly different political views on several sensitive issues. Their loud and furious arguments took place with little regard for their surroundings. Those overhearing the two battle it out worried about the form any escalation might take. On a subsequent Saturday night, the police arrested an inebriated Dr. Dawgs for firing a gunshot into the front window of the Katz family home.

In the case of Dr. Venge, we see that a possible but unproven ethical breach by a colleague provoked Venge to commit a clear violation in retaliation. While one may understand her ire, the resulting act of releasing her colleague's rodents into the bush is unethical, probably illegal, and violated animal care standards.

It seems apparent that Dr. Oldster's primary goal was to complicate Dr. Newbody's life, and he did not care what resources he

burdened in the process. The APA and ACA codes specifically warn against filing frivolous or unwarranted complaints motivated to harass (APA: 1.07; ACA: I.2.e).

Little comment is necessary regarding Katz and Dawgs except to affirm that this incident actually happened. Such acted-out animosity by mental health professionals is extremely uncommon; yet, in a world in which interpersonal problems often impulsively escalate into violence, this alarming kind of incident has become less isolated. (See further discussion of impaired professionals in Chapter 2.)

Online Wars

The explosion of opportunities to interact with colleagues and the public over the Internet provides opportunities for enrichment never before available as well as for mischief and costly ethical mistakes. *Netiquette* is roughly defined as the capacity to remain civil and the ability to maintain some measure of dignity and decorum while communicating electronically, a practice we highly recommend. Modern mass communication has created forms of professionalism relating that some do not handle well. People who have never met face to face can trash each other online in ways that appear far more vitriolic than most face-to-face professional disagreements.

Because communicators are actually alone in their private space interacting with an inanimate computer, an illusion of privacy and safety exists. The odd situational context may largely account for blunted inhibition. Passion and fury in the absence of seeming danger may blur the fact that hundreds, even thousands, of others may witness the virtual carnage. Practical restraints, such as mustering the courage to go directly to an offending colleague or to bother writing and mailing a letter, no longer stand guard. Instantaneous communication affords no reconsideration or cooling of feelings that the passage of time and thoughtful reflection might otherwise invite. Everything happens so quickly: Slam the send button, and a hostile or otherwise-inappropriate message has left the building. Messages marked “confidential”

create the unwise illusion that recipients will not forward it.

Case 10–18: Bulah Blowout, Ph.D., read a message on a discussion group that was mildly critical of the academic program from which she received her degree. She ripped off a response that raked the critic’s graduate department as a “10th-rate program in an ugly building populated with doddering old guys who spend more time in the men’s room than anywhere else.” Over 700 people read her impulsive and ill-conceived message, and the responses were not positive.

Perhaps little harm resulted except to Dr. Blowout’s professional image. But, it would not take too much more to approach a legal definition of defamation.

Case 10–19: Uri Knock, Ph.D., asked members of his online psychotherapy list if they had heard that Hefty Target, Ph.D., a well-known clinical psychologist and not a member of the list, regularly abused alcohol. Knock said that someone told him this a while back.

It was most unfair and unprofessional for Dr. Knock to post this question to hundreds of people. Even though Knock himself is unsure of the veracity of the story, the accusation and the name have been planted in the recipients’ minds, and many of those may have passed the story along. Furthermore, unless someone informs Dr. Target of the charge, he cannot defend himself. When such slurs are publicly posted, we believe the gossiper should be held accountable online, and if the charge is serious, the target should be located and informed.

Case 10–20: A therapist in an electronic discussion group politely disagreed with the assertion of Negate Recall, Psy.D., that repressed memory was merely a “cash cow for therapists and that no such phenomenon actually exists.” Dr. Recall posted a message describing the therapist who spoke out against him as being “witless, dangerous, impudent, and dense.” A number of other subscribers came to the defense of the disagreeing therapist, suggesting that the topic of repressed memories

would profit from a scholarly debate. Dr. Recall then blasted the entire group for their stupidity and wrong-headedness and announced he was “unsubscribing immediately.” The remaining subscribers gossiped about Dr. Recall for months. Recall’s tirade was also forwarded to scores of other individuals and lists.

Dr. Recall’s outbursts provided prolonged entertainment for his colleagues, probably without his awareness. His reputation likely suffered as a result of the incident. Angry outbursts get noticed, even when one agrees with the transgressor.

Other problems can arise and come back to haunt Internet users who are sloppy or not proficient at negotiating cyberspace.

Case 10–21: Loosy Whoops, L.M.F.T., noticed that a past lover posted a message in a newsgroup. She was so excited to see his name that she fired off a passionate note, declaring that he was “always better than my husband,” and asking, “Am I still better than your wife?” Unfortunately, Dr. Whoops used the reply command instead of sending the message to her one-time lover’s private e-mail address. The message is known to have reached more than 1,000 recipients.

Although most such mistakes may not be quite as embarrassing and consequential, it is wise to take special care to ensure that the name in the “To” bar is who you intended. We also highly recommend making an agreement with yourself never to send online messages when feeling angry, intense, or impulsive. The expression of flaming feelings may well come home to haunt. When the anger subsides, the discussion of the issues can occur in ways that maintain professional decorum, with some discussions perhaps better done over the phone or in an old-fashioned letter. In addition, mental health professionals should remind themselves every time they send a message that it is “format ready” to instantly spread to whomever any recipient pleases.

Finally, there is no absolute freedom of speech in cyberspace. Defamation pertains when false and unprivileged data are published

and result in economic damages, imply that that a person is a criminal or has a stigmatizing disease, or injure an individual with respect to his or her profession or business. Thus, if someone can prove that the perpetrator damaged a reputation or good name by knowingly or recklessly spreading false information, the victim can sue for defamation.

Defamation and invasion-of-privacy legal actions based on Internet communications have already been won (Branscum, 1995) and will no doubt continue as casual use of the Internet mushrooms. As one example, a former professor at the Emory School of Medicine was awarded \$675,000 based on a false, anonymous Internet message placed on a Yahoo group. The perpetrator claimed the professor had taken kickbacks and was forced to resign his university position. With some clever sleuthing, the perpetrator was identified as a competitor of the former professor’s private business (Ackman, 2000). A woman who was a victim of a “Google bomb” attacking her and her work was awarded \$11.3 million in an Internet defamation suit (Dozier & Scheff, 2009).

As people spend more time on the Internet, the risk of erroneous or malicious gossip increases dramatically, and many more such suits seem likely. Maintaining “good Internet citizenship” is critical, not only because it bodes well for us as professionals but also because it is protective. Having solid proof to verify any negative public statement about someone provides protection, as does, although to a lesser extent, clearly presenting a statement as an opinion rather than fact.

Finally, loss of reputation and termination of employment are no longer unheard when quips and offhand comments are posted on one’s social media page or tweeted. Tasteless and seemingly offhand quips by a senior executive got her fired when her tweets went viral. A tech developer’s sexist joke was overheard by a colleague, who snapped his photo, tweeted it and the joke, resulting in the loss of the developer’s job. He tweeted his story naming the woman who got him fired, and she became the victim of a steady backlash, including death threats

(Ronson, 2015). The takeaway message is to be careful of what you put out there because the whole world could be watching. (See Chapter 11 for further discussion on ethical issues related to Internet use.)

Journal Editors and Reviewers

The publication of scholarly papers is critical to the evolution of a discipline and, depending on one's position, essential to professional status and career advancement. Those teaching in most traditional academic settings will not be retained or promoted unless they publish regularly, ideally in reputable, refereed journals. Even for positions that do not require publications, research and writing fulfill a variety of other professional and personal needs. Therefore, it comes as no surprise that traditional scholarly journals receive high volumes of manuscripts, yet only a small percentage are ultimately published. Competition for space in the most esteemed journals is especially keen, meaning that fairness in the journal review process is imperative given the critical importance of the acceptance/rejection decision-making process to those who submit their work.

Here, we focus on interprofessional relationship issues. Manuscripts are accepted or rejected by one's peers. And, as might be expected, criticisms abound concerning the treatment and negative decisions by journal editors and manuscript reviewers. (More on scholarly writing, including online and open-source publications, appears in Chapter 16.)

Case 10–22: Horace Night, Ph.D., was asked by a journal editor to review a manuscript by Lester Day, Ph.D., with whom Night had long had substantial theoretical disagreements. Night drafted a scathing review of the paper based chiefly on theoretical disagreements, including such comments as, "Dr. Day continues to cling to obsolete ideas in a narrow-minded and idiotic fashion."

Certainly, personal motives—including anger, jealousy, competitiveness, and inflated views of one's own importance—contribute to negative feelings toward colleagues. Shoddy,

deficient, or mean-spirited evaluations also rank high in frequency among the complaints we have heard about. Such treatment violates the spirit of professional ethics that call on colleagues to treat those with whom they work with respect and dignity (Hadjistavropoulos & Beiling, 2000; Sternberg, 2002, 2003). In the case of Dr. Night, it appears that the theoretical disagreements with Dr. Day have become inappropriately personalized. If Night is not prepared to give a critique in a dispassionate manner, he should consider informing the editor that he cannot offer a fair reading. The adjectives *narrow-minded* and *idiotic* have no place in an ethically formulated scholarly review.

Another common criticism by authors involves excessively long delays in providing feedback. Because the ethics of scholarly publishing require submission of articles to only one journal at a time, extended dwell time is wasteful, especially when the topic is timely.

Case 10–23: Editor Leonard Lag, D.S.W., rejected a manuscript about community emergency responses to the aftermath of a highly publicized natural disaster submitted 10 months earlier by Margaret Moment, M.S.W. Moment immediately sent her manuscript to another journal, and this time received a prompt response indicating that the article content was outdated. By now, three other journal editors quickly arrived at the same decision.

Journal reviewing is typically done by professionals in the field who volunteer their time to read and comment on manuscripts. Unless they are on the paid staff of professional organizations, editors typically receive only small stipends. Therefore, it is understandable why weeks would pass before reviewers find time in their schedules and for the editor to gather and distill the reviews and inform the author of the decision. Ten months, however, is too long, and Ms. Moment was wronged as a result of Lag's lack of responsiveness.

Case 10–24: Months went by before Drs. Didthey, Screwus, and Howe received word that the paper to which the three colleagues contributed equally

was accepted. However, only Dr. Didthey's name appeared as the sole author on the published article.

This vignette, adapted from Gurvinder (2013), highlights the issue of incompetent publication gate keeping. Given the high value placed on authorships in scholarly outlets, such errors cause awkward disruptions in professional documentations. Drs. Screwus and Howe will have to explain the error in their own records—an awkward situation at best. An errata published much later is a required but usually inconsequential remedy. As the senior and corresponding author, Dr. Didthey may be asked to explain why the problem was not corrected while reviewing prepublication proofs.

Charges of bias against lesser known authors or those affiliated with less prestigious institutions have also been leveled against editors (Bornstein, 1990), as has the practice of preselecting reviewers to ensure acceptance or rejection (Franzini, 1987; Marcovitch, 2012) and failure to disclose other conflicts of interest (E. Smith, Potvin, & Williams-Jones, 2012). Journal editors and reviewers have also earned criticism for exhibiting favoritism and prejudices toward specific authors and harboring biases against certain topics or theoretical approaches or findings that are not statistically significant.

The peer review process is hardly an exact science: The now-classic and still-controversial article by Peters and Ceci (1982) proves it. These authors assessed the capriciousness of the reviewing process of 12 prestigious psychology journals by resubmitting cosmetically altered (author and affiliation changes), *previously published* articles to each respective journal. Surprisingly, only three articles were detected as resubmissions, and eight of the nine remaining articles were rejected for publication by the same journals that had earlier published them. The authors confirmed that the rejection rates and editorial policies of the journals had not substantially changed in the interim.

The proprietary rights of the authors demand respect (APA: 8.15; ACA: G.4–G.5; NASW: 5.02). Improper use of materials under review is a serious ethical violation. Reviewers should treat manuscripts as confidential.

Case 10–25: Eileen Pilfer, Ph.D., agreed to review a manuscript in her area of expertise. She wrote a critical review, recommending that the piece not be published. A year later, the author of the rejected manuscript was shocked to see substantial material from his submitted (but rejected) article appearing in a published report by Pilfer.

Cases of improper acquisition of material, compounded by the apparently intentional blocking of competing work, are rare. However, the trustworthiness of reviewers is critical because of the temptation to misappropriate ideas or materials from works under review. However, because authors and reviewers are working in the same area, acquisition of the ideas or methodology of others is not always purposeful.

Currently, authors are usually not made aware of who reviewed their submissions. Whether to allow authors to know the identity of their reviewers is controversial. On the one hand, if referees have to stand behind their identifiable review, nasty and poorly done reviews may substantially decrease. On the other hand, unidentifiable reviewers may be more honest and candid.

CLINICAL SUPERVISORY RELATIONSHIPS

The transition from academic learning to supervised practice is a training milestone. The supervision component of professional training is the period when tomorrow's practitioners are guided and scrutinized to ensure their ethical and clinical competencies and when deficiencies can be detected and remedied. Those not suited to a profession in mental health service delivery can be identified and redirected, thus protecting them from future entanglements and failure as well as the public from inadequate practitioners. Underscoring the critical role of supervisors is the realization that they are the final gatekeepers before mental health professionals in training receive their license to represent the profession to the public in independent practice (Behnke, 2005). The ethics codes of professional organizations contain

explicit principles regarding ethical issues surrounding supervision (see APA: 2.05, 3.03–3.04, 3.08, 7.06, 7.07; AAMFT: 3.7–3.8, 4.1–4.8; ACA: F.7–F.8; NASW: 3.01–3.03).

A Complex Set of Roles

In actual professional settings, supervisors can act as exemplars of good practice or as agents of poor professional socialization. Supervisors are at once responsible for enhancing skills, teaching and modeling ethics content and appropriate behaviors, and ensuring that supervisees are functioning well in a personal sense (W. B. Johnson, 2003; Vasquez, 1992). The supervisor holds multiple roles, including teacher, mentor, evaluator, and facilitator of self-awareness and exploration (Goodyear & Rodolfa, 2012). In addition, supervisors will, of necessity, routinely address the feelings and emotional lives of their trainees as part of discussing their interactions with clients. In a paradoxical twist, the supervisor has legal and evaluative responsibilities for the trainee's work and yet, while encouraging the trainee to be open and honest, must also report errors or flaws that the supervisor may not have directly witnessed.

These inherent multiple roles in supervisory relationships can prove beneficial (Gottlieb, Robinson, & Youngren, 2007). However, roles do not always integrate smoothly, such as the need to sometimes be critical while evaluating a supervisee's therapeutic blunder and then listening empathically when the supervisee describes feeling stressed about a personal matter. Complicating matters further, these roles include third parties—the supervisee's clients—making responsible, ethical management even more imperative. Boundary crossings may occur that are harmful to one or both parties. Sexualizing the relationship is one obvious example, but any time a relationship becomes more complex, the possibility for breakdowns increases.

Students from cultures different from the supervisor or client population present additional, unique supervisory needs. International students who report feeling less acculturated (defined as the level of acceptance of and by the

culture and English proficiency) report weaker supervisory alliances. These findings suggest that international students become especially dependent on their supervisors for advice, support, personal validation, and discussions of cultural issues and differences (Nilsson & Anderson, 2004). The same issue can cut across racial/ethnic and socioeconomic divides in domestic students. Can a white supervisor adequately supervise a black student who experiences prejudicial comments from a white client? How can a student from an economically privileged background be helped to understand the challenges in the life of a financially strapped client?

Viewing supervision as a mere side activity, low on the list of priorities and taking only a small bite out of a one's time and priorities, is a common misperception (Welfel, 2013). Supervisory tasks carry similar ethical duties and responsibilities as those due to psychotherapy clients, except that clients are never formally evaluated with consequences attached to judgments about their progress or fitness. There is a growing recognition that the role of supervisor and the unique ethical challenges inherent in having a fiduciary duty to both the supervisee and their clients should not be learned simply by taking on a first supervisee and learning as one goes (J. T. Thomas, 2010). Rather, the role of supervisor should be conceptualized as a distinct professional activity (Falender & Shafranske, 2010). Given the variety of skills required to conduct effective supervision, not every otherwise-skilled practitioner is suited to it. Impatient individuals, perfection-oriented individuals, or those with a blunt style of relating to others may find supervising unsatisfying, and their supervisees would likely be frustrated, dejected, and prone to concealing perceived errors.

Clinical supervision has increasingly become recognized as a critical intervention (Bernard & Goodyear, 2013), perhaps fueled by recent research revealing the extent and the serious near- and long-range consequences of inadequate and harmful supervision. Books on how to supervise mental health professionals in training are not new, but an unprecedented number

have appeared in recent years. (e.g., Aasheim, 2012; Bernard & Goodyear, 2013; Campbell, 2006; Corey, Haynes, Moulton, & Muratori, 2010; Cutcliffe, Hyrkäs, & Fowler, 2011; Falender & Shafranske, 2004, 2008, 2014; Falender, Shafranske, & Falicov, 2012; Fleming & Steen, 2012; Harris & Brockbank, 2011; Ladany, Friedlander, & Nelson, 2005; Milne, 2009; Neill, 2006; Powell & Brodsky, 2004; Scott, 2014; F. M. Thomas, 2013; J. T. Thomas, 2010).

Supervisors should address several specific tasks to establish an ethical context for clinical supervision. Their duties include the following:

- creating a clear understanding of the contract between supervisees and supervisors regarding the nature of their relationship, mutual expectations, frequency of contact, feedback format and intervals, limits of confidentiality, and other contingencies, including legal ones, regardless of the supervision model adopted;
- teaching practical and clinical skills;
- making certain that supervisees fully understand all ethical and legal obligations and regulations relevant to their profession;
- monitoring and evaluating therapy skill status appropriate to the supervisees' skill level (e.g., via direct observation, review of recordings, cosigning case records, and so on) and ensuring that supervisees operate within their current level of competencies and scope of practice;
- encouraging supervisee self-awareness and monitoring transference/countertransference feelings;
- modeling ethical, competent, and responsible behavior to supervisees;
- recognizing the obligations that accompany occupying the more powerful position in the supervisory relationship;
- honoring the rights of supervisees to privacy, respect, dignity, and due process while striving for an open and honest relationship;
- fostering and supporting personal development and growth without requiring supervisees to disclose intimate personal information (unless the program requires such disclosures);

- giving supervisees complete, constructive feedback and evaluations in a timely manner;
- accepting that the more inexperienced supervisees are likely to make errors; working with them to understand and remediate mistakes;
- ensuring that the supervisees' clients are aware of the supervisor-supervisee relationship and have given voluntary and informed consent to participate;
- monitoring any other roles with supervisees (e.g., research collaborator, teaching assistant, etc.) to ensure that boundaries remain sufficient;
- possessing and modeling multicultural competence;
- understanding that supervisees, due to their dependency on their supervisor for support and guidance, may feel unwilling to share information (e.g., feeling sexually attracted to a client) for fear of reprisal and attempting to promote an open, noncritical style;
- helping supervisees with the client termination process;
- properly overseeing supervisee billings with third-party payers; and
- having a willingness to proactively attempt to ensure that supervisees with deficient skills or unresolved issues despite efforts to intervene do not progress further in the field.

As already noted, performing these various duties in the context of a single relationship is not always easy. On the one hand, compassionate support might prevail when a supervisee is struggling with a learning activity or a personal dilemma. But, softer approaches may not be right for some mistakes.

Case 10–26: Following a breakup with her fiancé, supervisee Tina Split was doing her best to keep a stiff upper lip in supervised client sessions at the university counseling center. Ms. Split and one particular client had formed an exceptionally positive relationship based largely on mutual interests and the client's strong motivation to deal with her own divorce. One afternoon at the end of the session, the client said, "You look down today. How about

we go for a drink at The Pub?" Ms. Split felt a need to be with someone who would understand her own pain. They had several drinks, and Split tearfully poured out her own sad story. Split did disclose the incident to her supervisor and defended it by saying, "My client was really great about it because she wanted to know more about me, and I felt much better afterward. It was good for both of us."

The colleague who told us a similar story was furious. Although she gave "Ms. Split" credit for coming clean, she wanted to grab her shoulders and shake her. Our colleague's task was to learn whether this rationalized breech was a temporary lapse based on the supervisee's stressors or suggestive of an underlying inability to be self-aware. In the actual story, the supervisor retained more composure and used the event as what she described as "a successful teachable moment." However, she was more vigilant with this supervisee and strongly encouraged her to go into counseling to resolve her own personal problem.

Finally, supervisors have legal obligations that must not be taken lightly. They may be vicariously liable for their supervisees' negligence as well as directly liable for their own negligence as a supervisor (Recupero & Rainey, 2007). Factors such as the supervisor's power to control the supervisee, the supervisor's failure to perform as a reasonable supervisor would perform, the motivation of the supervisee, and the setting and purpose of the disputed act are among the factors taken into account when negligence is in question (Disney & Stephens, 1994). Licensing board disciplinary actions frequently include those concerning supervisory misconduct (Welfel, 2013).

Case 10–27: Bertram Bizzy, Ph.D., served as clinical supervisor for Suzie Slipper, a graduate student placed at Bizzy's community agency 2 days a week for practicum training. Bizzy also juggled a thriving multioffice practice that involved frequent out-of-town consultations. Ms. Slipper appeared very independent and believed she functioned "just fine" without supervision. One month, Bizzy had to cancel a supervision hour because of professional travel and a second hour when he was

ill with the flu. Then, Ms. Slipper missed supervision the third week to attend a funeral. Slipper's schedule seemed to preclude makeup sessions, which was just as well as far as the preoccupied Dr. Bizzy was concerned. When they finally met after a hiatus of nearly 6 weeks, Dr. Bizzy discovered that Ms. Slipper had made some potentially serious errors in managing a case. He submitted an unflattering entry into her evaluation record.

Dr. Bizzy bears the brunt of the responsibility for Ms. Slipper's errors because he clearly abrogated his supervisory duties. Neophyte professionals often have more self-confidence than is actually warranted. Close supervision mitigates against overestimations of supervisee competence. Agency guidelines making backup supervision policies clear might have prevented this problem.

Of course, supervisors cannot be expected to remain in constant contact with their supervisees. The assumption, however, is that they are in close enough touch and sufficiently monitoring client progress to be aware of any negligent actions (Knapp & VandeCreek, 2012).

The Client's Right to Know

When a client receives services from a therapist who, in turn, is supervised or otherwise in training, the client has the right to know of this arrangement as well as the name of the supervisor (APA: 10.01c; ACA: f.1.c, F.5.c). Similarly, the supervisor should know the names, addresses, and other basic information about clients whose cases they supervise. The client should also be told explicitly that aspects of the case will be shared with the supervisor. Indeed, many clients would be pleased to know that their therapist will have ongoing consultation about their cases with a senior colleague. This should not come to a client's attention as a surprise at a sensitive moment, however, and is best presented factually as a part of the initial contract between clients and therapists in training.

Case 10–28: Amy Shy arrived at the mental health center for her usual weekly appointment with a psychology intern and was met by Solomon Foot,

Ph.D., the intern's supervisor. Dr. Foot explained that the intern had fallen and broken her ankle the weekend before and would not be back at the clinic for a couple of weeks. He offered to provide interim services for Ms. Shy because he was familiar with her case through his supervision of the intern. Ms. Shy was unaware that this stranger had such intimate knowledge of her personal problems and felt both embarrassed and upset.

Dr. Foot appeared to have Amy Shy's best interests at heart, although she clearly felt distressed by his awareness of the details of her case. We do not know whether the intern failed to inform Ms. Shy that a supervisor oversaw her case or whether Dr. Foot's introduction was a bit too abrupt for her to tolerate. Foot's behavior was not unethical, but it reveals the difficulty a sensitive client may face if supervisory relationships are not carefully articulated.

Insufficient and Harmful Supervision

Not all supervisors are themselves competent and ethical (Jacobs, 1991; W. B. Johnson & Huwe, 2002; Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999; Ladany, Mori, & Mehr, 2013). A number of potentially ethical mishaps can plague the role of the supervisor. These include

- authorizing assessment or other duties or pairing a client above the supervisee's attained level of competence;
- engaging in sexist or harassing behaviors with supervisees;
- having sexual relationships with supervisees;
- modeling poor ethical practice;
- engaging in any dual-role relationship with supervisees that could lead to exploitation or lack of objectivity;
- providing insufficient or shoddy monitoring of supervisees' work, including failure to review and sign the supervisee's case records or to provide written feedback in a timely manner;
- making negative evaluations without giving prior feedback;
- violating any rights to confidentiality;

- failing to ensure that clients understand and agree to the supervisee-supervisor program;
- treating supervisees disrespectfully;
- probing into supervisees' private business unrelated to the supervisory process;
- covering up or failing to report for supervisees' serious and recalcitrant errors and failings;
- being unavailable during crisis situations (e.g., a client threatening suicide or harm to others) with no backup plan; and
- being unprepared or unsuited to be a supervisor.

Research conducted by Ellis et al. (2013) produced a discouraging picture of several hundred supervisees. A stunning 93% of this sample reported currently receiving inadequate supervision that included such supervisor shortcomings as being frequently distracted, refusing to address issues, not committing to the process, and perceiving the process as a waste of time. Thirty-six percent reported currently receiving harmful supervision that included supervisors who made physical threats, were traumatizing or cruel, who engaged in a harmful dual-role relationship, and who humiliated supervisees publicly. Over half of the sample reported receiving harmful clinical supervision at some point during their training.

It is also disheartening to note that more than half of the trainees surveyed in another sample of supervisees perceived ethical breaches by their supervisors in the course of training; these acts included inadequate performance evaluation, session boundary issues, and disrespectful treatment (Ladany et al., 1999). Negative experiences with supervisors can have profound and adverse impacts on future career goals, suggesting that the consequences of bad supervision experiences are global and long lasting (Ramos-Sanchez et al., 2002).

The following cases reveal how some actual cases of insufficient and harmful supervision played out:

Case 10–29: Bucky Newbie told his supervisor that the student he saw for the first time in the university counseling center seemed "rather down."

The supervisor responded, "All students are somewhat depressed when it gets closer to finals time. Don't worry about it." Three days later, the client made a serious suicide attempt.

Mr. Newbie was in his first year of supervised training and may not have adequately perceived or described the significant nature of the client's condition to the supervisor. He seems unprepared to work with a suicidal client or any client presenting with severe symptoms. Brushing off Mr. Newbie's concerns with no further exploration constituted grossly insufficient supervision.

Case 10–30: Un Prep had taken a course on cognitive assessment but had never before administered the Ultra Sophisticated Learning and Education Scoring System (USELESS). He felt uneasy when his supervisor insisted that he administer that tool to a client scheduled for assessment 2 days later. Prep explained that he lacked familiarity with administration, scoring, and interpretation of the USELESS. His supervisor responded, "Just take it home tonight and practice on your roommate."

Prep's supervisor did not pay sufficient attention to his trainee's reservations. By failing to heed Prep's concerns, the supervisor abdicated an educational responsibility. By suggesting a superficial practice option, the supervisor put the client at risk of facing an incompetent assessment by an unqualified and admittedly unprepared examiner. The supervisor also conveyed a casual and inappropriate attitude toward the ethical principles of psychological assessment.

Sometimes, the supervisor may not have acted unethically, but the supervisee has not gained skills or confidence and feels forced to be less than honest.

Case 10–31: Supervisee Jimbo Tryhard felt dissatisfied with the progress of several of his clients and experienced considerable self-doubt. Tryhard's supervisor, Dr. Bea Little, always reacted in a critical tone whenever Tryhard attempted to disclose his concerns. Because Dr. Little would have a direct impact on his success in the program and his chances of obtaining a job after graduation,

Tryhard switched to playing out the supervisory sessions by reporting and exaggerating only positive aspects of his sessions.

Tryhard may have reacted in an overly sensitive manner to Dr. Little's criticisms, but the supervisor also failed to establish a candid and beneficial relationship with his supervisee. Although a challenge to accomplish, supervisors must seek to create alliances that help supervisees to feel safe enough to admit mistakes and work through them. Unfortunately, supervisees who feel devalued, humiliated, ignored, or criticized in a nonconstructive way will not likely protest, especially if the supervisor is otherwise respected in the work setting.

Case 10–32: Urlee Hit revealed her struggles with alcoholic and abusive parents to her clinical supervisor, Dee Cipher, Ph.D. Thereafter, every time Ms. Hit reported difficulties with a client or the program, Dr. Cipher suggested that Hit's current concerns and shortcomings seemed linked to her childhood trauma.

The supervisory relationship appears badly contaminated by Dr. Cipher's focus on and lack of sensitivity regarding Ms. Hit's disclosures. While mental health professionals may at times react to clients based on past events in their lives, Dr. Cipher's interpretations appear to undermine the supervisee's confidence and create tension in the supervisory relationship. If Dr. Cipher believes that Hit's own issues frequently get in the way of treatment, she should recommend that Hit seek counseling.

Supervisors sometimes forget whose needs are being served, as the next two cases illustrate, resulting in clearly insufficient—if not harmful—supervision.

Case 10–33: Jane Dumpee eagerly anticipated her upcoming supervision by Queenie Topdog, Ph.D., a highly respected clinician known for tireless dedication to her profession. At first, Dumpee enjoyed hearing about Topdog's work, even though such discussions took up almost half of the supervisory hour. However, as Topdog's self-revelations became more personal, Dumpee

became concerned because her own needs for case review went unmet.

Case 10–34: The minute Melanie Chic arrived for her clinical supervisory session, Leery Fox, Ph.D., commented on her appearance (e.g., “That color doesn’t do anything for you,” or “That sweater is absolutely stunning”). He often lost track or interrupted the flow of her attempts to focus on her clients’ issues with remarks such as, “Speaking of drinking too much, have you been to the new jazz bar on 4th Street?”

Supervisors differ in terms of how they model their clinical skills; some may utilize primarily a didactic style, whereas others more personally open and disclose their own experiences (Farber, 2006). Supervisors, however, who use their status for personal gratification, entertainment, power, or dependency needs exploit those who have entrusted their professional development to them. Even though neither of these two cases apparently involved intentional abuse, both supervisors abdicated professional roles in favor of their own agendas. Although we cannot be sure about Dr. Fox’s motives, his behavior may also border on sexual harassment.

Case 10–35: Dee Sirable found her supervisor to be attractive and admitted to herself that she dressed and groomed carefully on their meeting days. Despite being married with young children, Ambus Cade, D.S.W., found Ms. Sirable to be attractive as well. Soon, their meetings were held over dinner, sometimes in Sirable’s apartment. Flirting and self-disclosures overwhelmed supervisory duties, and an affair lasting several months commenced. When Dr. Cade’s wife confirmed her suspicions and issued an ultimatum, Dr. Cade terminated the affair.

Despite the consensual nature of this ill-fated liaison, crossing sexual boundaries in supervision is dangerous territory with potentially devastating consequences for both parties. In the actual case, when an offended “Ms. Sirable” told everyone about the actual nature of her relationship with Dr. Cade, they were both let go from the program. (Sexual involvement with

students and supervisees is discussed in more detail in Chapter 9.)

Supervisor–Supervisee Conflicts

Conflicts with supervisors may not always involve unethical or irresponsible behavior on the part of either party, but when they do arise, the quality of actual supervision erodes. Moskowitz and Rupert (1983) found that almost 40% of their sample of supervisees reported major conflicts with their supervisors. Clashes may arise from differences in theoretical or therapeutic approaches, supervisory style, or personality issues, all of which have a destructive negative impact on the supervisory alliance (Dodds, 1986; Ramos-Sanchez et al., 2002).

What happens if the supervisor engages in unethical behavior and attempts to bring the student into the tainted circle? Or, what if a supervisor instructs (or requests) that a supervisee engage in unethical behavior? Sadly, such incidents occur, creating a difficult conflict for the supervisees, who feel dependent on their supervisors for support or references.

Case 10–36: Herman Blab, PhD, enjoyed telling his supervisee, Ali Ears, about his own current clients. He divulged not only their problems but considerable identifying information and often who they were by name. A few were people Ms. Ears knew, and she began to feel uncomfortable. Dr. Blab seemed to enjoy these conversations, sometimes asking Ms. Ears what she thought about the case. When Ms. Ears gently suggested that names not be used, Blab exclaimed, “This is part of your training, and I know you will keep all this confidential.”

Case 10–37: “Let’s just keep this our little secret,” Horn Swaggle, Ph.D., said to Will Agree, his supervisee. “I have to catch up on a ton of work and I know you have exams coming up, so how about you cancel your clients for 2 or 3 weeks. Just make up some excuse, and I will do what needs to be done at my end.”

These supervisors not only are neglecting their training responsibilities and shortchanging

their trainees, but also are modeling bad practice by trivializing the needs of clients and implying sloppy or dishonest behavior as easily justifiable.

What Supervisees Want (and Do Not Want)

Surveys reported that expertise and facilitative characteristics (trustworthiness, empathy, and genuineness) were the most favored characteristics describing what supervisees need and want in a supervisor. Many supervisees also welcomed assistance with personal growth issues more than the teaching of technical skills. Communication of expectations and clear feedback also ranked high among supervisees, whereas sexist or authoritarian treatment, unavailability, and interpersonal conflicts were rated as especially detrimental to the value of supervision (Allen, Szollos, & Williams, 1986; McCarthy, Kulakowski, & Kenfield, 1994).

Ladany et al. (2013) found that trainees rated as most effective those supervisors who encouraged autonomy (e.g., self-directed decision-making and self-reflection); strengthened the supervisory relationship (e.g., showing empathy, respect, and open-mindedness); facilitated open discussion; had positive personal and professional qualities; demonstrated knowledge and skills; and offered constructive and challenging feedback. Ineffective supervisors were described as deprecating, less involved with their supervisory duties, condescending, dominating, and lacking empathy. In addition, ineffective supervisors possessed insufficient knowledge and skill development, offered inadequate observation and feedback, provided primarily negative or punitive feedback, and possessed negative personal characteristics.

Lack of timely feedback lies at the root of numerous complaints growing out of supervisory relationships. This becomes especially common when supervisees abruptly receive notification of an unfavorable rating or termination.

Case 10–38: Near the end of a 12-month clinical internship, Sheldon Outtaloop was stunned by

an evaluation from his supervisor describing him as insensitive and rude in his relationships with colleagues. He felt fearful that these comments would hurt his chances to find employment. Mr. Outtaloop complained that this critical evaluation was unethical because he had heard nothing of such concerns earlier.

Routine feedback sessions and written evaluations should be built into all supervisory relationships (APA: 7.06a; ACA: F.4, F.6.a; NASW: 3.02–3.03). When discussing serious criticisms with supervisees, one should invariably offer these in writing, paired with a dialogue about expected changes with a remedial plan (Harrar, VandeCreek, & Knapp, 1990). One could argue that if Mr. Outtaloop is truly insensitive, he might not have heeded supervisory criticism. Nonetheless, he was entitled to feedback and was justified in asserting the inappropriateness of saying nothing about shortcomings until the final evaluation and then provided no opportunity to attempt remediation of his defects, thus denying him due process.

Terminating Impaired or Otherwise-Unfit Supervisees

Supervisees concede to engaging in ethically questionable practices. The majority of the supervisee sample in the Worthington, Tan, and Poulin (2002) survey admitted to at least one negative behavior, such as not disclosing unfavorable feelings toward their supervisor, failing to complete client documentation in a timely manner, gossiping about supervisory conflicts, and not discussing negative feelings toward clients. Whereas supervisors have at least partial responsibility for not nurturing open and honest communications, one hopes such matters can be resolved. Mistakes and errors will be made by supervisees, many of which are correctable. However, not every student capable of passing the academic course work has the interpersonal and emotional strengths necessary to function effectively as a mental health clinician.

Not until the supervised practice phase of training begins do personality style, character issues, temperament, and personal

psychopathology come into full consideration in supervisee evaluations. This becomes a difficult ethical dilemma, requiring well-documented evidence of both the trainee's deficiencies (as compared to problematic behavior likely amendable to repair) and efforts taken to intervene or remediate the complaints (Lamb & Swerdlik, 2003). Only when sensitive attempts to resolve the problems have failed, when no biases or unfair discrimination exist, and when institutional policies regarding termination from the program have been scrupulously followed should the supervisee be dismissed.

In a survey of graduate students, almost all (95%) reported awareness of peers with impairments in professional functioning, and half knew of ethical improprieties committed by their peers (Mearns & Allen, 1991). Next is one example.

Case 10–39: Trainees in Tim Quicktrip's group were unimpressed when Tim bragged that he cut client sessions 15 minutes shorter than what appeared in his reports, and that when clients did not attend, he created therapy notes as if they had. His supervisor was informed by several peers, and Quicktrip was warned to desist from this unacceptable behavior. But, subsequent closer supervision revealed that he returned to his old tricks shortly thereafter.

Supervisees whose ethical and professional slips may create an ongoing pattern, especially if they are reinforced in some way, need the earliest possible intervention. Tim Quicktrip's "reward" was more discretionary time for himself, although his dishonest behavior appears to be engrained.

Case 10–40: "Hey, doc, I know I've asked before and you always say 'no,' but I really, really, really need your help this time," Darrell Lect pleaded. "This is an emergency. I have a chance to go on a 3-week tour with a band, and I just *have* to do it. Can you sign in some supervisory hours for me? Just this once? I won't ask again. Promise."

Mr. Lect has his priorities flipped, and given that he has previously asked his supervisor to

fudge for him, the signs that he should qualify as a mental health service provider look dim. It is possible that this supervisor has not been firm enough in the past, but now the supervisor needs to draw a line in the sand to see what choices he now makes or start a procedure that will remove Mr. Lect from the program.

Even students and interns have expressed concerns that impaired peers have been inadequately addressed (Oliver, Bernstein, Anderson, Bashfield, & Roberts, 2004; Rosenberg, Getzelman, Arcinue, & Oren, 2005), although procedural barriers have been described that make effective intervention difficult (Gizara & Forrest, 2004; Vacha-Haase, Davenport, & Kerewsky, 2004). Sadly, even highly problematic students can ultimately become licensed practitioners (Jensen, 2003).

Additional Modes of Supervision

To help diffuse some of the inherent role entanglements and abuses in supervision, models other than "one on one" have been proposed. These include group supervision, vertical supervision, the use of multiple supervisors, and telemetry-based supervision (see ACA: F.2.c). On the downside, a diffusion in responsibility can occur if trainees are fanned out among several sources of supervision. Some combination of models, however, may help mitigate the deficiencies and risks inherent in the one-on-one supervisory model.

Case 10–41: Callie Charmed found herself unexpectedly sexually attracted to a male client. She had no intention to act on the attraction but felt uneasy and confused about it. She kept her concerns to herself because she was dating a fellow graduate student in her group supervision session.

Group supervision may lessen the resource drain and provide opportunities to hear diverse views. However, supervisees may feel less willing to disclose their difficulties or perceived errors in the presence of their peers. It is hoped Ms. Charmed will seek an appropriate individual for a private consultation and learn that sexual attraction toward clients occurs quite

commonly along with ideas about how to manage such feelings. Other potential problems with group supervision include a reduction of individual attention and intragroup conflicts (Enyedy et al., 2003).

Cost-effective technological advances offer the potential for “cybersupervision” via chat rooms, e-mail, texting, Skype, videoconferencing, and other computer-mediated communications. A distinct advantage is elimination of geographic barriers and ease in scheduling. For example, the development of Remote Live Supervision, an Internet-based one-way-mirror setup, may enhance the potential to conduct adequate supervision from a distance (Rousmaniere & Frederickson, 2013). This type of access allows coverage of certain kinds of issues and cases where no sufficient supervisory services exist close by. Rural and international supervisees may be served where no prior availability existed. Supervisees should be screened for their appropriateness if they are far removed geographically from the supervisors’ location. Reasons for declaring a good fit should be documented (Stretch, Nagel, & Anthony, 2013). Students who are dependent, emotionally liable, unreliable in any way, or possess any other cognitive or knowledge deficiencies are not likely good candidates for distance supervision.

The already-complex role of the supervisor is convoluted even further when relying on electronic devices. Potential regulatory issues can complicate matters; that is, the supervisor may not hold a license in the state where the patient or trainee sits, elevating the potential for legal risks. In addition, the use of unsecured telemetry can compromise clients’ confidentiality and violate protective regulations under HIPAA. The considerable advantages of personal, face-to-face interaction and nonverbal clues between supervisors and supervisees may be missing (Kanz, 2001). Additional questions include those regarding who is responsible and available to act should the supervisee make a serious error. Who is responsible to intervene in an emergency?

Regardless of the mode of supervision, clear understandings of the contract between supervisees and supervisors regarding the

nature of their relationship are needed (Sutter, McPherson, & Geeseman, 2002). Mutual understandings should be made explicit and thoughtfully articulated. Such arrangements not only obligate the supervisor but also are much desired by supervisees (Nelson, 1978).

Research Supervision

Depending on the work setting, research experience is critical if graduate students are to become competitive applicants for employment. Institutions where faculty conduct research usually offer opportunities to become involved with their educators’ work, sometimes as a paid assistant. Even research experience as an undergraduate is highly desirable for applicants for advanced training in many kinds of programs, including most traditional clinical psychology programs.

Students and their research supervisors are locked into a symbiotic relationship, although it is grounded in the particular context of a scholarly community (Löfström & Pyhältö, 2014). Each must depend on the other, and the stakes are high. Researchers not only need help with various facets of their projects but also appreciate having others around with whom they can discuss their work. After all, their students may constitute the primary source of interest in the investigator’s projects. When a study goes well, everyone is advantaged. If one or the other falls down on agreed-on responsibilities, does sloppy work, or engages in some form of scientific misconduct, everybody loses, including the scientific community should any ill-generated data seep into the research record.

Supervising research can feel less engrossing than supervising therapy because the conduct of research does not typically involve discussions of feelings or personal disclosures. However, with the focus on competence, integrity, and mutual trust, ethical problems can easily arise. These include abandonment, unfair authorship practices, incompetent or inadequate supervision, and abusive or unfair behavior on the part of supervisors (Goodyear, Crego, & Johnston, 2008; W. B. Johnson & Nelson, 1999; Sullivan & Ogleff, 1998).

Case 10–42: Simi Gradbound enthusiastically agreed to collaborate on a research project with Professor Desert because she needed to list research experience on her résumé. Dr. Desert also indicated that they could present the paper at a regional professional meeting, which would prove even more helpful to the student. Gradbound collected and analyzed the data and turned the material over to Dr. Desert, who, by prior agreement, would draft a manuscript. In the meantime, Dr. Desert received a large grant and was elected chair of the university personnel committee. Each time Gradbound would drop by to ask how things were going, Desert would apologize profusely and promise to get around to the project as soon as he could. The deadline for the regional meeting passed, and Gradbound graduated without completion of further work.

Suffering neglect by one's mentor is one of the most frequently cited sources of student discontent (W. B. Johnson & Huwe, 2002). The research project obviously fell to a low priority on Desert's list, but remained of primary significance to the student. Gradbound rightly felt abandoned and may blame Desert for any difficulties she experienced in gaining admission to a graduate program.

Case 10–43: Professor Aldo Frawd encouraged his research supervisee, Lionel Twist, to eliminate all outlier cases in his data set because they would elevate the error term and "only confuse things," adding, "If we don't get a significant finding, we won't be able to publish this article. Extremes don't tell us much about the phenomenon anyway."

Mr. Twist finds himself in a compromising position and may become professionally corrupted. Frawd's attempt to rationalize away misconduct may well persuade an admiring supervisee who also needs a publication to advance his own future. Mentors are often drawn to protégés who remind them of themselves and who they can groom to pursue a career very much like their own (W. B. Johnson, 2003). However, some research mentors may have more interest in creating clones of themselves than in fulfilling their professional obligation to help students find their own scholarly

voice and a strong commitment to the value of truth seeking. (See Chapter 16 for more information about collaborative relationships with students and scientific misconduct.)

Finally, students may not have the same commitment to the conduct of responsible research as do their supervisors. Yet, they are often left on their own to collect data.

Case 10–44: Curb Sitter was hired by a faculty member to interview people in the downtown area about attitudes toward a new development that would create major changes in the look and current spirit of the community. Mr. Sitter was behind in his studies and looking forward to an upcoming trip to visit his girlfriend. To serve his other needs, he decided to fill out most of the interview schedules himself.

The faculty member may never know that the data he will present at a town hall meeting are mostly bogus. In the actual case on which this story was based, the faculty member was suspicious when the responses reused the same words and phrases. He confronted the student, who tearfully confessed his misconduct. The main lesson for supervisors is to recognize the often-underrated power of those assigned to collect routine data (often relegated to students just starting out and sometimes to undergraduates). Analyzing and disseminating ill-gotten data is a serious disservice to science.

The same concerns apply for inadequately trained students who unknowingly collect data inappropriately. Careful supervision of research assistants is an imperative scientific and ethical responsibility, although we do acknowledge that the supervisor cannot always be present to observe directly. Clear rule setting and communicating the importance of clean data as well as encouraging assistants to convey any mistakes or issues that interfered with their task without fear of censure are strongly advised. (More about students' participation in research projects appears in Chapter 16.)

Employee Supervision

Mental health professionals have responsibilities for training and monitoring the behavior

of their employees with respect to any duties delegated to them. Employees who handle grade books, confidential records, data sets, incoming requests from consumers, or billing must understand the ethical requirements that attend their duties and behave in a trustworthy manner. They must also be prepared to deal with other situations that might be unlikely to arise in more traditional work settings.

Case 10–45: An anonymous caller to a marriage and family therapist's office reached Noel Numbers, the bookkeeper. The caller spilled out her fear that she was about to abuse her child. The caller refused to give her name but wanted to talk to someone. The therapist was not available.

If the anonymous caller does not get some professional help, a tragedy could result. Mental health clinicians should prepare their full- and part-time office staff to refer such callers to the abuse hotlines or to another agency or hospital emergency room at which trained personnel may be available. In some work settings, or for some therapists specializing in crisis management, crisis hotline training for the nonprofessional staff might be considered.

Case 10–46: After beginning work as an administrative assistant to a group of therapists, a young man discovered that several of his acquaintances from the same small town were clients of therapists in the group. His work routinely involved transcribing reports and billing people he knew personally.

Whereas solo practitioners are less likely to have staff support, those in group practice with multiple clinicians or in institutional practices (e.g., clinics, hospitals, schools, or guidance centers) should ensure that support staff training is adequate. While it is possible to respect the privacy and confidences of personal acquaintances in many situations, employers should also assess the ability and sensitivity of all potential staff members prior to hiring. This becomes especially important in communities where social circles will likely overlap, such as university towns, distinct cultural communities, or

rural settings. The new assistant may have the capability to adequately handle the situation, but the counselors hiring him hold ultimate responsibility for his behavior and should take special precautions to protect clients' privacy. For example, safeguards might include placing sensitive files in secure locations unavailable to the staff.

There are times when it may simply be inappropriate for mental health clinicians to delegate certain client calls or other nontherapeutic tasks to others, as the next case illustrates.

Case 10–47: Teenevyle is in turmoil. Allegations of raids on the city treasury by several top officials have created headlines in the town's newspaper for weeks. The mayor's wife has entered counseling with Dr. Sanctuary because, she alleges, her husband has taken to drinking and has made threats to kill himself. He has refused therapy, but his wife calls frequently, asking to speak to Dr. Sanctuary immediately.

This explosive small-town crisis requires taking measures regarding how messages from this particular party are received, who transcribes the notes, and who has access to these sensitive materials. Similar situations can arise for clinicians treating any high-profile clients or their family members.

PROVIDING REFERENCES

Practitioners and educators are often called on to evaluate the qualifications of colleagues, supervisees, students, and employees. We include a discussion of providing references in this chapter because the requests involve a relationship a referee has with the individual requesting support. Such evaluations, whether sent as hard copies, electronically, or conveyed over the phone, have an influential role in the applicant selection process, giving the referee considerable power over the future of those requesting support (Purdy, Reinehr, & Swartz, 1989; Templer & Thacker, 1988; Williams, 2004). On the other hand, serving as a referee—especially if any negative commentary

will be offered—has become increasingly risky (P. J. Taylor, Pajo, Cheung, & Springfield, 2004; Weiss, 2004). Referees might even have to defend themselves from charges of defamation, negligence, or breach of confidentiality, sometimes for what they considered to be an innocuous remark (Peshiera, 2003; Schall, 2013). Complicating matters further, the recipient organization may consider bringing legal action against the referee if a significant shortcoming known to the referee remained unmentioned and led to damages perpetrated at the new site. Referees ought also to assume that the person discussed will eventually either view or learn the gist of the contents, even if a confidentiality waiver was signed. Some services exist that will contact ex-employers posing as a prospective employer to learn how the ex-employer is described and, for a fee, pass the information along to the applicant.

Although legal actions are not commonplace, referees are left squeezed in the middle of a multidimensional dilemma. Students and employees expect a positive evaluation, whereas graduate schools and employers want an honest, factual appraisal enabling them to make an informed decision. Applicants will feel upset if the outcome is unfavorable, and the recipients will be upset if they accept an applicant who fails to live up to what they were led to expect.

An ethically appropriate referral states verifiable facts, positive or negative, that have relevance to the position the applicant seeks. An ethically acceptable—and legally safer—reference should never be motivated by malice or retaliation (“Legal Issues Raised,” 2004; P. J. Taylor et al., 2004). Addressing specific performance and relevant examples as opposed to vague generalities constitutes the best protection against liability from an unhappy applicant or recipient.

Research on the reference process revealed some odd circumstances that work against referees who want to provide complete candor. Unless a referee views the candidate in a highly positive light, truthfulness carries the risk that the candidate will face a summary rejection. Studies have demonstrated that a negative comment, even if couched in a letter predominantly

positive in tone, will likely result in eliminating the candidate from further consideration. Why? Because most letters are totally positive, creating a sort of “letter inflation” (Hardin, Craddick, & Ellis, 1991; Miller & Van Rybroek, 1988; Schall, 2013). Therefore, it seems probable that a less-than-enthusiastic letter damns the candidate by dint of faint praise, and even a minor criticism may stand out like a glazed ham at a Ramadan fast breaking.

A positive letter should never be used to pass forward an incompetent or corrupt employee or a difficult or unethical student to a new employer. This is unfair to the hapless employer or graduate program selection committee who trusted the veracity of the referee’s statement.

Obviously, a reference seeker should always approach the intended sources prior to using their names. Asking whether the potential referees feel they could provide a helpful reference in relation to a given position is a fair question. If the reaction hints at hesitancy or reluctance on the part of a potential referee, the option of asking someone else remains open and probably should be taken.

Many referees have reservations. How can negative assessments best be presented? Consider the following four descriptions:

Professor Snuff wrote a two-sentence letter regarding a student seeking graduate training: “Save yourself a headache and burn Ms. Bonk’s application. This woman should not be allowed to breed.”

Dr. Slapdown’s letter regarding Rose Clueless contained general references to problems, such as, “Ms. Clueless has shown disrespect toward me,” and, “A colleague told me that Rose drinks too much.”

Dr. Golightly wrote a generally positive letter but also described clear examples of Mike Breezebrain’s absentmindedness and the trouble it caused other supervisees in the clinic. Once, for example, he misplaced the group appointment book and could not recall where he put it. It surfaced a day later on the bottom shelf in the coffee room refrigerator. Another time, Mr. Breezebrain did not show up for his morning appointments,

thinking they were for the following day. Dr. Golightly concluded his letter with, "Mike is a nice guy, but he couldn't find his rear end with both hands and a full-length mirror."

Dr. Fact carefully detailed a number of events suggesting strongly that Fred Firestarter probably had an antisocial personality disorder, although Fact never used an actual diagnostic term in the letter. Each entry stressed the applicant's behavior and was anchored in verifiable facts should such documentation ever become necessary. For example, Fact and others had witnessed Firestarter's verbal outbursts and once setting a trash can on fire after stalking out of the office. An administrative record existed of an investigation of improper use of university stationery to perpetrate a fraud.

These four letters form a hierarchy from totally unacceptable to an appropriate way of relaying negative evaluations. Dr. Snuff provides no basis for his terse, boorish, and lethal assessment. Was Ms. Bonk truly without merit, or might Professor Snuff be the one with a problem? The letter's recipients may never know, but Ms. Bonk will not likely survive such a paper bomb. Snuff is behaving unethically because he offers no factual or interpretable information. Snuff's letter was also defamatory. An employer who told a "job detective" that an ex-employee was only suited to work in a brothel or strip joint was sued for \$82 million (Cadrain, 2004).

Dr. Slapdown's letter is almost as bad in that we do not know the basis of the disrespect or if a secondhand report about alcohol abuse is factual. Nevertheless, Ms. Clueless will likely be written off as a result of Slapdown's letter.

Dr. Golightly's letter was fine up to a point, grounding his concerns in behavioral examples, until, that is, the last sentence. Although perhaps intended as a cute wrap-up, he stated a probable untruth and violated professional decorum. Silly things mentioned in reference letters circulate on the Internet. Examples include, "When she opens her mouth, she does so only to change feet," and "He doesn't have

ulcers, he causes them," or, "Works well when under constant supervision and cornered like a rat in a trap." We strongly discourage such quips or sarcasm, as they can come back to haunt the referee.

Dr. Fact presented clear and supportable data, which allowed the recipients to reach their own decisions about Mr. Firestarter. Although it is highly unlikely that Firestarter's application will succeed, if this student ever challenges Dr. Fact in the future, the evidence is solid.

Generally, one never has an obligation to provide a recommendation, and therein lies one way to avoid any liability if the evaluation would be negative. Concerns about applicants who abuse alcohol or drugs, who have exhibited unethical behavior, who lack motivation, or who demonstrate irresponsibility comprise the primary cluster of people for whom referees refuse to write letters (Grote, Robiner, & Haut, 2001). Schall (2013), in his excellent resource, offered additional reasons for refusing to write letters. These include not knowing the individual beyond recorded grades (and not inclined to learn more), dislike for the individual, a grounded suspicion that the individual has serious personal problems, knowledge of academic dishonesty, and an inappropriately made request (e.g., nags, manipulates, offers a bribe). Ideally, writers should warn applicants if a letter will be poor or neutral and offer examples regarding why (Range et al., 1991; Falender & Shafranske, 2004).

An exception to a choice to decline a recommendation or endorsement occurs in response to a request for documentation of supervision hours or training program completion. The supervisor or training director has an obligation to supply necessary certification forms when requested to do so, even if the trainee's work qualifies as barely passing. In such instances, the documentation may take the form of simple confirmation. For example, "Mr. Barely completed 1,000 hours of clinical experience under supervision;" or "Ms. Threshold received her master's degree having passed the prescribed course of study." The key ethical issue here involves whether that trainee successfully completed the specified program.

Should one ever agree to write a letter *without* indicating to the requester that it will contain fault-finding content? What if one feels compelled to alert the intended recipient to extremely troubling facts about the requester? These questions lead to the complex issue of loyalties. Hardin et al. (1991) advised that a decision must be made regarding alerting colleagues or if a more neutral letter will give the student a chance to continue training and possibly improve. Regardless of the referee's final decision, keep mindful that it is absolutely critical to keep unfavorable remarks well grounded in fact and concrete, observed, and verifiable behaviors as opposed to relating suspicion and innuendo.

What if one receives a telephone call requesting an assessment of a student or colleague? Can one more safely give a completely honest report over the telephone? Some say phone conversations are considerably more reliable than written letters (e.g., Dowdall, 2013). Unless the conversation is being taped without informing the referee, the chances of substantiating a defamation charge is lessened. Nevertheless, the criteria should be the same as for letters—responsible sharing based on observation and known facts.

Case 10–48: Chuck Chum, Ph.D., called his old friend Bernie Pal, M.S.W., for a spontaneous assessment of one of Pal's colleagues who has applied for a position in Chum's department. Pal gave a generally positive appraisal but also divulged some detail about the colleague's missing finger due to a childhood accident, funny-looking hairdo, and morbidly obese husband.

Dr. Pal should have stuck to a job-related discussion despite the fact that he was talking to an old friend. Pal's colleague may have been unfairly disadvantaged by off-hand remarks that were unrelated to the purpose at hand. We also caution that it is unwise to say anything in private that might ultimately be repeated to the candidate unless one is willing to have the candidate learn about it.

Some have issued a warning against agreeing to refer anyone over the phone simply because a

conversation cannot be reconstructed should it ever be challenged.

Case 10–49: An angry graduate student confronted Dee Nye, Ph.D., in her office, complaining that his internship application was turned down. When he asked around at the internship site, he was informed by a contact there that Dr. Nye described him as "somewhat irresponsible." Dr. Nye was taken aback because she never implied any such thing and gave an overall positive assessment to the site director over the phone.

Making calls to individuals who are not among the referees named by the applicant, known as going "off list," has ethical aspects as well. On one hand, Vaillancourt (2012) asserted that a committee relying exclusively on the candidate's list is asking for trouble given that almost anyone can find three people who will say something positive about them. However, Vaillancourt also warned that hiring committee members deciding to go rogue can find themselves in trouble as well. She encouraged asking candidates for permission to call others and even asking candidates if others might offer unfavorable comments and why. It is always possible that referees are avoided for their poor behavior, such as sexual harassment or conflicting personality styles, and might retaliate by giving a biased statement. To be totally fair, any negative assessments coming from off list should be cross-checked with others if possible.

Applicants are placed in an awkward dilemma whenever hiring committees ask for permission to contact others not on the list provided. A "no" answer likely elicits a response of "What is the candidate hiding?"; a "yes" answer means that someone may actually make that one negative comment that could sway the decision.

Another ethical abuse that occurs too commonly involves the agreed-on reference letter that never materializes. The referee who promised to supply a letter never gets around to doing it. Even the somewhat better intentioned referee who sends off a letter 2 weeks late may still seal the candidate's rejection. Job, postdoctoral, or graduate school applicants may not

discover such omissions until decisions have already been made. Or, they may never know that their bids were unsuccessful because their incomplete files were never reviewed; instead, they assume they were unworthy of acceptance. The unwritten or past due letter constitutes a particularly merciless act, even when that was never an intent. An initial agreement to be supportive becomes an act of betrayal instead.

Finally, too-busy or less caring referees can cause harm by creating letters that contain typos and grammatical errors or take shortcuts by duplicating a one-size-fits-all letter when letters addressing specific issues are requested. Recipients will simply assume the referee does not care whether the applicant is successful.

SEXUAL HARASSMENT

Not all that long ago, Western society expected women to passively endure uninvited expressions of sexual interest and suggestive remarks made by the men who occupied positions of power in the workplace. Recipients who took poorly to such behavior risked sanctions that ranged from ostracism to dismissal. Early complaints under Title VII of the Civil Rights Act of 1964, which prohibited employment discrimination on the basis of sex, were often dismissed simply as inharmonious relationships between the sexes, an unfortunate social experience, or a mere consequence of attraction between the sexes (Koen, 1989). (Sexual intimacies with students and supervisees is discussed in Chapter 9.)

Current law protects both men and women from a sexually harassing or otherwise-hostile work environment, and the gender of the victim and alleged offender do not matter. The victim can even be anyone affected by the offensive conduct of someone else being harassed. However, 84% of all reported incidents come from women (Equal Employment Opportunity Commission [EEOC], 2011). As women increasingly achieve positions of authority, they also find their own behavior making them vulnerable to harassment charges. Still, most incidents of sexual harassment probably go unreported, perhaps partially due to the

grievance procedure itself. Sexual harassment places recipients in a potential no-win situation by forcing them to keep quiet or enter into an arduous process that could end up costing them their jobs and reputations.

In 1980, the EEOC (1980a, 1980b) defined sexual harassment and issued guidelines for employers. Sexual harassment consisted of unwelcome sexual advances; requests for sexual favors and other verbal or physical conduct of a sexual nature that force submission as an explicit or implicit condition of employment or academic standing; and statements or conduct that interfere with an individual's work or academic performance and that create an intimidating, hostile, or offensive work or learning environment. Clearly agreed-on specifications of what behavior constitutes the tipping point at which harm becomes inflicted are difficult to specify. Except for the more extreme vituperations or lewd acts, perspectives on behaviors vary depending on the motivations of the perpetrator, the interpretation of the recipient, the nature of the relationship between the parties involved, and the context in which the incident occurred.

Whereas flirting and other sexually oriented behaviors that are (or appear to be) welcomed by the recipients are not covered by the definition of sexual harassment, the recipients' responses may not reflect their authentic reaction. The next case is illustrative.

Case 10–50: Professor Jerry Built, Ph.D., often told his technical equipment supervisee, Dyna Graph, that he would dole out the supplies issued as a vital part of her work responsibilities only if she were “nice to him.” When the supplies were not forthcoming, he would say that they would be made available when she treated him more affectionately. According to Ms. Graph, “being nice” meant complimenting Dr. Built on his appearance and being flirtatious. She resented feeling forced to perform in this manner as a prerequisite to performing her job, but feared that expressing herself may lead to more problems, possibly the loss of her job.

Men and women have different attitudes toward the acceptability of sexually oriented

behavior (Rubin & Borgers, 1990), and men seem more tolerant of behavior seen as harassing (Kearney, Rochlen, & King, 2004; Reilly, Lott, & Gallogly, 1986; Rubin, Hampton, & McManus, 1997). Some forms of sexual harassment may have an ostensibly benevolent intent, taking protective and affectionate actions toward those who hold to traditional women's roles. Others arise from hostility, to dominate and to show antipathy toward women who appear to usurp men's power (Glick & Fiske, 1997). Most acts of sexual harassment take place in private, so credibility becomes an additional murky factor (Binder, 1992; Feldman-Schorrig & McDonald, 1992). Allegations submitted to the EEOC are decided on a case-by-case basis where exceptionally vulnerable or damaged victims may come across as hysterical and unreliable and smooth perpetrators may be convincing.

The plaintiff does not have the burden of proving tangible economic detriment. However, the plaintiff must demonstrate that the harassment was sufficiently severe or pervasive to create an abusive working environment. Cases have also applied and defined the "reasonable woman standard" as a way of attempting to determine a representative woman's response to assist the court in deciding whether a claim is frivolous or trivial (Thacker & Gohmann, 1993). This standard shields employers from having to accommodate the idiosyncratic concerns of the hypersensitive or vengeful complainant (Feldman-Schorrig & McDonald, 1992). The reasonable woman standard also provides a means of precluding any trauma that could be caused by a thorough psychological examination of a plaintiff to determine the merits of an allegation (Thacker & Gohmann, 1993). Other changes in federal and state laws allow victims to receive compensatory and punitive damages for substantiated claims of sexual harassment. Current ethics codes reflect the EEOC definition and reasonable woman standards (APA: 3.02, 3.03; AAMFT: 3.7; ACA: F.3.c; NASW: 1.11, 2.08). Even though the victim is usually subordinate to the accused (Bergman, Langhout, Palmieri, Cortina, & Fitzgerald, 2002), two codes specify that anyone found to

penalize those coming forward with an ethics complaint has also committed an ethics violation (APA: 1.08; ACA 1.2.f.).

The next case illustrates how demands for sexual favors, and the fear of reprisal for rejecting them, can interfere with job, academic status, and emotional well-being. The ongoing behavior of the supervisor violates both ethical standards and the law.

Case 10–51: Sherman Tactile, Ph.D., habitually rested his hand on his clinical supervisee's lower back for a prolonged period of time. When she tried to turn her body or stand farther away, Dr. Tactile would either alter his position so that he could resume his touching or would say, "Come back here so I can explain this to you," or "Why are you such a distant and unfriendly person? Cold people don't make good therapists." The supervisee complained to Tactile's superior upon completing her traineeship.

Intimidations can also occur in a more diffuse manner, as illustrated by the next case involving gender harassment, defined as comments or behavior directed at one sex but not the other (Fuller, 1979).

Case 10–52: Professor Tim Traditional, Ph.D., announced to his classes that he is admittedly "old school and likes to flirt with the ladies." He added that if anyone found his small pleasure a burden, they had better just put up with it or drop his course.

Here, women students were placed in a separate category and put on notice. The net effect was to categorize them as potential targets and to deliver the message that they were unworthy of the contemporary mores that favor equality and respect between the sexes. Professor Traditional's stance contains the elements of gender harassment that need not involve direct references to sexuality.

Not all gender-related behavior can be reasonably defined as harassing, but it does result when the behavior causes discomfort or humiliation (e.g., referring to all women as "skirts") or is used as a means of power containment (e.g.,

only inviting male students to collaborate on research projects). To those who would declare Professor Traditional's behavior as a simple residua of an earlier generation and therefore quite harmless, we would ask the following: If a woman asked Dr. Traditional to write a letter of recommendation, how powerful do you think it would be? Do you think Traditional would ever nominate a woman for an outstanding student award?

Case 10–53: When Zena Freeman asked Macho Mann, Ph.D., for assistance with problems she was having understanding certain concepts in her organizational psychology class, he commented that women did not belong in the course because they were not suited to the field. Mann refused to respond to her specific questions. Instead, he continued to refer to the general unsuitability of women for work in the business world and cited her difficulties in comprehension as evidence.

This case does not involve direct sexual references or touching, but the effect was to keep the woman in a subordinate position through exclusion or ridicule. This also seems to be an example of how faculty members and supervisors can exploit their power over students (Carr, 1991).

The next two cases illustrate the need for ethical sensitivity to professional interactions in the workplace regardless of how one defines and interprets sexual or gender harassment. The first incident came to our attention from a middle-aged supervisor, who concluded ultimately that her trainee must be gay, never recognizing that her own behavior might well be unwelcome to any young man.

Case 10–54: Thelma Flitty, Ph.D., was fond of her supervisee, Jack Frost. She always gave him a big hug when he arrived for supervisory sessions, winked at him when he made funny comments, took his hand when he seemed unsure of his therapy decisions, and hugged him again when he left. "You are cute as a button," she told him, "I could just eat you up!" Dr. Flitty was taken aback when, during one of their sessions, Jack said, "I

feel very uncomfortable with the way you behave toward me."

One cannot know for sure whether Dr. Flitty has a sexual interest in Mr. Frost or was acting like a doting mother. Either way, Flitty treated Frost differently from her other supervisees, and she remained oblivious to how she came across, as evidenced by her reasoning that Jack overreacted. This response is similar to how men used to discount their own harassing behavior. Many women may not yet be used to being perceived of as bothersome when they are showing interest in a man, assuming instead that they are coming across as complimentary or nurturing.

Finally, consider this more complicated situation.

Case 10–55: Bobby Breakup and Rhonda Rupture are supervisees in the same counseling program. Their affair was a brief but intense consensual relationship before Breakup abruptly called it off. Rupture complained to her supervisor that Breakup took sexual advantage of her and was making it painful and awkward for her to remain in the program.

One may empathize with the discomfort of working alongside the source of emotional pain, but is a dissolved workplace fling grounds for a valid sexual harassment case? Legal standards may well be insufficient to reach a reasonable decision (Pierce & Aguinis, 2005).

In the end, we are all mere humans with the ever-present potential to make mistakes. The best defense against interpersonal entanglements is to follow Aretha Franklin's motto: R-E-S-P-E-C-T.

WHAT TO DO

- Do your best to cooperate with other professionals to advance the best interests of clients, supervisees, and students.
- A display of courtesy and civility while relating to other professionals is usually the most appropriate demeanor, even when one has reason to feel annoyed with them.

- Recognize that supervisees, employees, and students stand at an inherent disadvantage in any disagreement or conflict with their supervisors, employers, and educators, respectively.
- When preparing letters of reference, be honest and direct, grounding evaluations in behavioral indicators and objective, verifiable evidence rather than opinion and innuendo.
- Try to resolve disputes informally whenever possible, and attempt to prevent disputes by clarifying mutual expectations at the outset of any collaborative arrangement.
- Exercise caution and diligence in training and monitoring the behavior of employees and supervisees, and provide timely feedback to ensure conformity with ethical practice.
- Both male and female mental health professionals must familiarize themselves with the subtle and more obvious forms of sexual and gender harassment and their legal implications.

WHAT TO WATCH FOR

- Try to avoid difficult individuals in the workplace if at all possible. Confronting or otherwise angering them often ramps up their negative behavior.
- Use caution when a client who is consulting another mental health clinician wants to also become your client.
- Remain aware that individuals may react in ways you did not intend to sexually toned comments or behavior in the workplace.

WHAT NOT TO DO

- Do not offer services in a manner that causes confusion or conflicts with a client's preexisting or ongoing relationships with other professionals.
- Avoid displaying *personal animosity* in a professional arena.
- Avoid sexual harassing comments and behavior in the workplace.

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11

Self-Promotion in the Age of Electronic Media

Advertising may be described as the science of arresting the human intelligence long enough to get money from it.

Stephen Butler Leacock

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WHAT TO DO

The public's image of mental health professionals is often distorted, incomplete, and sometimes downright erroneous. The accuracy of information reaching the general public about emotional well-being, mental illness, and the therapy services is sometimes baffling, sensationalized, or deceptive. Many people are unable to differentiate accurately among clinical psychologists, psychiatrists, social workers, counselors, and marriage and family therapists. An array of fringe psychotherapies and other self-proclaimed mental healers contribute to the befuddlement. Most people do not understand or are skeptical of our behavioral research, believing it is all just common sense (Kaslow, 2014; Lilienfeld, 2012).

Mental health professions have not been effective or proactive in educating the public in about how and why their members' services are beneficial. Members may even be ambivalent about attempting to do better (Palmiter, 2012; Salzinger, 2003). The reason may be found in vestiges from earlier admonitions to avoid superficial glitter and, instead, use considerable restraint when putting oneself in the public eye. However, advanced information technologies offer an unprecedented opportunity to readily and inexpensively disseminate credible educational material. For example, reliable resources and solid information are offered by the federal government, professional organizations, and nonprofit agencies. The American Psychological Association (APA; <http://www.APA.org>) and other mental health organization websites display numerous educational articles on a variety of topics of interest to the general reader.

Technology has also led to a rapid evolution in the way people disperse and absorb knowledge that shapes how they think, what they believe, and what they buy. Ethical risks and pitfalls lurk close by, with many consequences that are yet to be attended to.

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CHALLENGES IN MARKETING PROFESSIONAL SERVICES

Advertising spins all around us, and mental health professionals want to be in the loop. A successful private practice obviously requires attracting clients, and it is not difficult to find marketing advice (e.g., APA Practice Directorate, 1996; Hemmings & Field, 2007; Winegar & Bistline, 1994). Indeed, failing to engage in some form of advertising will likely result in a failed practice (Barnett, Zimmerman, & Walfish, 2014). Despite the self-serving purpose of advertising one's services, it is possible to do so aggressively and with integrity and truthfulness (Barnett & Klimik, 2012; Knapp & VandeCreek, 2008; Koocher, 2004). However, some therapists have used confusing, anxiety-provoking, or frankly deceptive practices while presenting themselves to the public and may unduly influence potential clients who suffer from cognitive or emotional impairment.

Advertising mental health services poses challenges because the "product" is difficult to characterize succinctly compared to, say, ice cream, hamburgers, or automobiles. Furthermore, advertising success is impossible to predict with any assurance, given that therapy involves participation in a unique relationship. Compare this to tangible products and services, such as a medication you take for a headache or the services of an auto mechanic. Enough measurable evidence will result from assessing how you feel afterward and how your car runs, allowing you to gauge whether expectations have been met.

THE HISTORICAL SHIFT

Because our professions have commercial or business aspects, and because professional regulatory bodies are arms of state government or professional organizations, tension exists

between maintaining appropriate conduct and avoiding restraint of trade. Thus, when it comes to advertising services and making public statements, today's stance involves taking sufficient precautions to uphold professional and ethical values. The "cannot"s of yesteryear have all but disappeared (Shead & Dobson, 2004).

To better understand where we are today, we have to take a quick peek at our past. Until the last few decades, the helping professions considered advertising to be déclassé at the least. Some professions tried to ban most advertising, claiming that it provided no meaningful distinction of value. The justification held that an advertisement cannot reflect true skill or competence, and one should instead rely on referrals from presumably well-informed colleagues. Until relatively recent times, advertising was required to have a "professional tone," which generally meant it should be discrete, formal, terse, and narrow in scope. The preferred format was more an announcement of availability than an active effort to recruit clients.

Enter the Federal Trade Commission (FTC), an independent agency within the federal government. Founded in 1914, it consists of two main branches. The Bureau of Competition focuses on antitrust issues, while the Bureau of Consumer Protection investigates charges of false or deceptive advertising. A wave of consumer activism, stimulated by the work of Ralph Nader and other consumer advocates, became prominent in America during the 1960s and 1970s. This climate became an important factor in the decision of the FTC and the U.S. Department of Justice to bring about changes in the ways professional associations attempted to regulate their members (Koocher, 1977, 1994a, 1994b).

By the early 1970s, the Bureau of Competition began approaching professional organizations with concerns about practices barring the presentation of what it considered useful consumer information through advertising. From the perspective of the FTC's Bureau of Competition, three prime directives seemed to apply.

1. Truthful advertising is good.
2. False or deceptive advertising is bad.

3. Attempts to block truthful advertising are as bad as false and misleading advertising.

In 1972, the FTC and the Antitrust Division of the Justice Department initiated complaints against a variety of professional associations, making it clear that professions do not enjoy some special form of antitrust exemption. In addition, at least some rules of professional associations that directly reduced or eliminated competition were unlawful. The FTC actions specifically concerned professional ethical codes that prohibited soliciting business by advertising, engaging in price competition, and otherwise engaging in competitive practices (Koocher, 1977).

The FTC deemed the APA's flat ban on the use of client testimonials in the 1981 ethics code as "inherently suspect." Similarly, the FTC opposed the APA's prohibitions against making claims of "uniqueness" because these might conceivably be true in some cases. The APA was forced to make emergency changes in 1990 by removing prohibitions against using testimonials from patients; claims of unusual, unique, or one-of-a-kind abilities; appeals to clients' fears unless services are obtained; claims of the comparative desirability of one service over another; or direct solicitation of individual clients. In addition, a sentence previously barring psychologists from "giving or receiving any remuneration for referring clients for professional services" vanished. Even though this principle was intended to prevent fee-splitting or kickback arrangements (see Chapter 12), the FTC interpreted it as having the potential to prohibit participation in legitimate referral service businesses and some managed care operations (Koocher, 1994b). Another sentence also disappeared in the 1990 ethics code: "If a person is receiving similar services from another professional, psychologists do not offer their services to such a person." The APA intended this sentence as a kind of noninterference clause to prevent piracy of clients already receiving services elsewhere. In addition, it reflected a belief that clients simultaneously receiving services from different therapists might receive compromised care as the result of conflicting advice.

The FTC, on the other hand, viewed the sentence as creating a barrier to consumers' free choice.

If the overall goal of the FTC focus was to make useful information available to the general public, then one can understand how clinging to vestiges of sameness in public statements solely to maintain a sense of professionalism would not survive. However, some limits on advertising do serve legitimate public interests. This is especially true in professions, such as that of mental health service providers, who may unduly influence consumers because of the consumers' compromised cognitive or emotional status.

The FTC did not intend for mental health practitioners or other professionals to necessarily adopt the market tactics of miraculous weight loss pills and carnival barkers but rather focused on universal advertising prohibitions. Potential harm that could result from hucksterism and advertising abuses remains a valid focus of specific tailored restrictions by professional associations. However, claims to "professional dignity" and the imagined need for "uniformity" were no longer a legitimate basis for limiting advertising by professionals.

In the end, however, runaway modern technology conspired to essentially deregulate the ways mental health services can be advertised. Enforceable ethical standards cannot keep up with the scores of available avenues to connect with potential clients. Nevertheless, the APA ethics code does maintain some mandates to guide ethical practice in advertising.

1. We must avoid making false or deceptive public statements, including any related to one's practice, research, or professional credentials (APA: 5.01).
2. We must maintain the integrity of statements made by others on our behalf (APA: 5.02). In so doing, advertisements must be identified as such, and we retain responsibility for those we engage to promote our work.
3. We do not compensate those in the media for publicity in news items (APA: 502.b).
4. We must uphold the accuracy of any workshops or nondegree educational programs we offer (APA: 5.03).

5. When we offer public advice (including broadcast and Internet communications), we must clarify the scientific basis of the advice and make any professional roles with respect to the advice recipients clear (APA: 5.04).
6. We do not solicit testimonials from current therapy clients or other persons whose particular circumstances make them vulnerable to undue influence (APA: 5.05).
7. We do not personally, or through agents, attempt uninvited in-person solicitation of business from actual or potential clients whose particular circumstances make them vulnerable to undue influence (APA: 5.06).

Other ethics codes echo similar mandates, in particular those involving truthfulness in self-promotion and avoidance of misrepresentation (American Association for Marriage and Family Therapy [AAMFT]: 8.4, 9.1-9.8; American Counseling Association [ACA]: C.3; National Association of Social Workers [NASW]: 4.06–4.07).

Nothing in ethics codes should preclude meeting with collateral contacts of current clients. For example, ethics codes do not consider the request of a child's therapist for parents to attend a family session to be a prohibited solicitation. Similarly, the invitation of an adult's therapist for a spouse or significant other to a session with the client's permission would also be appropriate in many circumstances. It is also acceptable to offer disaster relief and community outreach services.

Did the FTC involvement with professional service advertising interaction improve ethics codes? We believe some enhancements resulted from focusing on substance rather than style. On the other hand, we also believe the FTC failed to fully accept the principle that the relationships between mental health professionals and their clients are qualitatively different from those in many other professions. The lamentable result is a greater reluctance on the part of ethics enforcement groups to tackle legitimate complaints in this arena.

MODES OF ADVERTISING

The Older Standbys

Before the Internet explosion, listing oneself in the classified (yellow) pages of the local telephone directory seemed an important way to attract clients. Hard-copy directories are still used by some practitioners, with the potentially problematic feature being a relatively long shelf life. Therapists must stand prepared to honor promises made in any advertisement (e.g., specific fees) for an extended period. They also must pray a typo is caught before copies are distributed. The unfortunate psychologist whose ad contained an extra space had to live with "*The rapist accepts child clients*" for a full year.

Business cards remain an advertising staple ever ready to pass out to anyone who might be interested in who you are and what you do. However, the next case tells how not to use them.

Case 11-1: A client who was just offered a role in a TV series expressed appreciation to Hymen Brash, Ph.D., for helping with his performance anxiety. Dr. Brash immediately asked for a favor in return. He gave the client a stack of business cards and told him to hand them out to the other actors on the set. The client indicated discomfort with the request, but Brash replied, "It will be good practice for you to be more assertive, and we scratch each other's backs in the process."

Clients should never be pressured or coerced into helping their therapists obtain business or to do any favors in return. Clients may recommend their therapists to others and may request a business card, which is appropriate. Word-of-mouth referrals remain a viable means of attracting new clients, but these should derive from the satisfied clients themselves.

Direct Solicitations

Do restraints imposed by professional association restrictions on advertising violate commercial free speech? Commercial speech stands

protected under the First and Fourteenth Amendments of the Constitution, similar to political speech; however, the courts have ruled that authorities can reasonably demand substantiation in the face of alleged false or deceptive advertising. The FTC's thrust has focused on expanding access to truthful information in the marketplace while allowing some exceptions, such as "in-your-face" solicitations.

We remain concerned regarding personal solicitations of the in-your-face variety. While there is nothing wrong with a therapist's announcing general availability to the community through advertising, direct solicitations of *individual* clients has considerable potential for abuse and distress to the object of the pitch. They may pit the therapist's advantage directly against the potential client's insecurities and fears. They may capitalize on a client's ignorance or social naiveté. The therapist's special expertise and knowledge are generally accorded a degree of respect or deference, predisposing clients to follow their advice and recommendations, even if this means changing long-standing patterns of behavior. Therapists must recognize this social influence and consider its use carefully.

Case 11-2: Max Pusher, M.D., a psychiatrist well known for his syndicated newspaper column, was invited to teach an extension course at Thunder State University dealing with anxiety, tension, and depression. A huge audience was attracted by his name and reputation. Dr. Pusher was accompanied by several assistants wearing colored armbands, who passed out brochures about Dr. Pusher's private clinic and other workshops he offered. In addition, some of the assistants approached selected students, saying, "You look troubled. Perhaps you could use an appointment or two."

This approach upset many of the students and certainly would play on the insecurities of others. This seems little more than a means to recruit clients in the guise of a public lecture.

Case 11-3: Drambuie Stalker, Ph.D., disclosed to a colleague that she attracted a

number of her clients by frequenting bars late at night looking for patrons who appeared to be depressed or distraught. She would strike up a casual conversation to discern their situation and share her card with those she thought needed counseling.

Dr. Stalker's stealth approach may not be as easy to classify, although trolling for clients in bars seems both crass and sleazy. We also wonder if she is putting herself in harm's way.

Some tolerable exceptions pertain to the general prohibition on solicitation of individual clients. These usually apply when the individual is not a psychotherapy client, but an agency, business firm, or other organizational entity. Consider the following examples:

Case 11–4: Effie Casey, Ph.D., an industrial and organizational psychologist, has developed a well-validated practice assessment program to evaluate pharmacists. He prepares a factually accurate descriptive brochure and mails it to potential employers of pharmacists and colleges of pharmacy, offering his consultative and evaluative services.

Case 11–5: Karen Kinder, Ph.D., is trained as an early childhood educator and school psychologist. She has developed a kindergarten screening instrument with good reliability and predictive validity. She has appropriate information printed in pamphlet form and mails these with cover letters offering to conduct training workshops to superintendents of schools and directors of special education in school systems throughout her locale.

While the clients approached by Dr. Casey and Ms. Kinder are indeed contacted as individuals, they are not in the same relative position of vulnerability as an "unaffiliated" individual in emotional distress. Employers, schools, or other organizations will generally stand in a better position to know their needs for such services, and the nature of the services offered is quite different from individual offers of psychotherapy. (For the sake of illustration, we are assuming the programs developed by Casey and Kinder are properly validated and reasonably

useful. Issues related to assessment in general are discussed in Chapter 7.)

In some circumstances, therapeutic services might also be offered in the manner described in the next case.

Case 11–6: Ethyl Fluid, L.M.H.C., plans to approach a variety of large corporations to encourage their purchase of alcoholism counseling services for their employees using an EAP (employee assistance program) model. She will offer to provide a team of adequately trained clinicians to staff an in-house clinic at each company's plant. Employees would be seen for counseling on a self-referral basis, with appropriate confidentiality safeguards. The program advantages Dr. Fluid cites include convenience for employees, with a possible reduction in alcohol-related work problems and absenteeism. She presents this plan in letters to chief executive officers and human resource directors of the companies.

Assuming Dr. Fluid is observing other ethical obligations related to providing the treatment she proposes, this type of solicitation presents no problem. No outrageous claims are made, and each company is free to evaluate its own need for the program as well as other alternatives. Client freedom is ensured, and no one individual is pressured.

Referral Services

In some parts of the country, professional associations operate a service by which callers can specify a needed type of consultation or intervention and be given the names of potential providers. In some cases, similar services are offered by for-profit entities, private practitioners, community agencies, or clinics. The three fictitious referral services mentioned next all have one feature in common: They provide clients with the names of psychotherapists. Presumably, they also advertise their services in directories, the media, or elsewhere. The same advertising obligations binding therapists as individual or group practitioners should also bind the operators of such referral services.

Case 11-7: The Northeast State Psychological Association offers a referral service to its members for the benefit of the public, developed in response to frequent telephone inquiries from people seeking services. Any members of the association who are licensed, who carry professional liability insurance, and who have no ethical complaints pending against them may be listed. A file containing provider information, including the availability of a sliding-fee scale, foreign language skills, specialty training, and the like, is maintained. When a person calls seeking a referral, a message is taken and referred to a doctoral-level psychologist hired as the coordinator of the service. The coordinator contacts the caller to establish the nature of the request and provides three names of psychologists whose skills, location, and availability fit the client's needs. The service is paid for from general membership dues.

The program run by the state psychological association for members and prospective clients is intended as a public service. Clients are advised that the service is not endorsing any particular provider but rather providing a list of qualified practitioners who seem to meet the client's stated needs. Clients unable to pay normal therapy fees are referred to those who offer sliding-fee scales or to community clinics.

Case 11-8: Psychotherapy Assistance is a psychotherapist-finding service run by three therapists in a large metropolitan area. It attempts to match potential clients with therapists on the basis of many factors, including fees charged, areas of specialization, treatment style, and so forth. Therapists who wish to receive referrals are interviewed by the service operators regarding their practice. All must be appropriately licensed and carry liability insurance. Clients who call are given a diagnostic interview and charged the usual and customary rate for the service. They are then given the names of two or more therapists recommended by the service, assuming psychotherapy is a recommendation. The only fees are those paid by the client.

Psychotherapy Assistance represents a fee-for-service matching program. A clinical service

is rendered in the form of an evaluation, and referral is then made to practitioners presumably known to the referrer. Supposedly, the matching is more individualized and based on clinical judgments of therapists, which is not possible under the more limited state association system. No fees are charged to the providers, which is an appropriate model lest the specter of fee splitting arise (see Chapter 12).

Case 11-9: Nadia Nerk is an unemployed real estate agent who has opened a storefront service known as "Shrink Finders." Clients pay Nerk a fee and are offered access to a set of video recorded interviews with psychotherapists recorded in her office. Clients may look through as many tapes as they wish and are given the names and addresses of any therapists whose tapes impress them. The therapists have paid Nerk \$100 for making their tape and an additional \$10 per session for each client visit based on a referral from her service.

The Shrink Finders service seems questionable on several fronts. The effort at a "catchy" name for the services and the video interviews raise the concern that superficial data are being promulgated as the basis for important decisions. There appears to be no effort to tailor the service to client needs or otherwise introduce professional judgment or advice. Most troubling, however, are the financial arrangements. Because the providers pay a commission to Ms. Nerk, this may pose an ethical problem for the therapists if the financial arrangement is concealed from clients.

While referral services can be helpful to clients and the public at large, their modus operandi determines their ethical propriety. Advertising and financial aspects of the operations may singly or together raise ethical problems. Any therapist considering involvement with such a service should explore these issues prior to signing on.

Finally, many therapists try to help colleagues make referrals free of charge by putting out calls on professional LISTSERVs or scanning online directories of provider organizations. (See more about informal collegial referrals in Chapter 10.)

Internet Advertising

With the era of the Internet and ubiquity of web-enabled cell phones, businesses now focus more attention on cyber-based marketing and creating ways to bring consumers to their websites. In February 2007, searching Google (<http://www.google.com>) under the term *find a therapist* yielded 3.5 million hits. By January 2015, the number increased to over 100 million. Websites of well-trained mental health professionals, con artists, and everything in between are found on the Internet. Consumers are left to try to sort it all out, often unaware that one can pay search engines to list their business near the top of any search or as pop-up ads sent to whoever has ever used a related search term.

The irony here is that *anyone* can be an advice giver to whomever on the planet manages to find them. Domain names and hosting services are inexpensive, and web pages are not difficult to create. These sites often dispense advice, usually associated with advertising fee-based services, although perhaps as many as a third do not appear to have any professional training or credentials. Troubling questions exist regarding the quality of many of the services offered (Heinlen, Welfel, Richmond, & O'Donnell, 2003).

Websites range from those offering plain-looking, simple referral information and links to reputable resources, to those with sound and animated graphics. At one site, a counselor who refers to herself as "Dr." but no credentials are listed, offers general advice for those suffering loss and promises all of the answers if you sign up for her workshops. Another with ambiguous credentials, using the slogan "where science and miracles meet," purports to heal a variety of conditions from posttraumatic stress disorder (PTSD) to weight loss. An elaborate marriage counselor's site features a dozen video clips on such topics as stress, overeating, and depression, along with how to contact him for his various fee-based services. Another asks the reader a series of questions and promises to help if any answers are "yes," through for-fee counseling by webcam, e-mail, or telephone. A radio therapist operating a small geographical niche market

uses her web page to attract face-to-face paying clients. A dating service founder (listing himself as a certified psychoanalyst) claims to use an extensive researched-based system to match people. The most complicated page we found features wild images of birds squawking and flapping their wings, music blaring, and an array of brightly colored buttons linked to all sorts of self-promoting offers. Some sites publish considerable information about psychodiagnostic and other assessment techniques and may pose threats to test security (Ruiz, Drake, Glass, Marcotte, & van Gorp, 2002).

If one maintains a website for marketing purposes, there is an ethical obligation to keep it truthful and current with respect to services, fees, and other relevant data of interest to potential consumers.

Advertising on Social and Other Electronic Media

We live in an age of rapidly evolving social media in which many people choose to communicate with others in their personal social and professional networks online. Mental health practitioners are free to insert themselves into the mix and attempt to use these media to their advantage, but should follow the same general ethical guides that apply to advertising with special attention to confidentiality.

Some social networking sites (i.e., LinkedIn) focus on professional contacts, while others (i.e., Facebook) have a much broader range of content and usage. If one chooses to utilize such sites for marketing purposes, maintaining professional decorum, an awareness of who has access to what information, and avoiding blurring boundaries with clients pose special challenges.

Case 11-10: Web Strew figured he could tell the world about his practice at almost no cost. He typed out a lengthy and glowing advertisement, promising, among other things, to help people make important decisions and ease psychic pain. He sent this message to every group he could join along with all the individuals whose e-mail addresses ever crossed his desk.

Dr. Strew's actions constitute a difficult-to-eradicate practice. Some assert that spammers clog the system with unwanted and junky material. Although he may find himself in violation of the Federal CAN-SPAM Act of 2003 (Controlling the Assault of Non-Solicited Pornography and Marketing Act, 2003), this legislative attempt to control spamming has not proven effective or enforceable in most cases.

Before one takes the first step to advertise online, remember it is possible for anyone to see what you put out there.

Case 11–11: Samson Tuffguy, Ph.D., specializes in treating “difficult patients.” A blog post describes his specialty as treating “those clients who you find unlikable, whose appointments you dread, and who are just more than you want to or are able to handle.” When one of his clients saw the post, he not only quit therapy but used his own Facebook page and Twitter account to blast Dr. Tuffguy.

To believe that only like-minded individuals would be interested in what you do, thus leaving you free to speak openly, is hazardous. Dr. Tuffguy should have worded his specialty more gracefully.

LinkedIn joins people with colleagues one knows and with others one does not know personally but who may have similar interests. When invitations are accepted, each party can view what the other is up to and what services they offer. Advertising via e-mail can be sent directly to one’s links. Detailed professional accomplishments are allowed, complete with hot links to, for example, “buy the book” or personal websites. There is plenty of room for mischief in the form of misrepresentation, but the wider opportunity to share one’s wares are in LinkedIn groups, many but not all of which are moderated. Most groups do not allow outright ads or hot URLs, but it is not difficult to promote oneself. One does risk critical responses, as illustrated next:

Case 11–12: Leonard Bookhype, L.M.H.C., bragged on a LinkedIn psychology group that his book was the ultimate answer to understanding why people engage in self-destructive behavior.

He listed a few teasers and strongly encouraged viewers to purchase his book. Several others chimed in on the conversation, one suggesting his thinking was flawed and three others calling it superficial pop psych.

Mr. Bookhype likely regretted his attempt to market his product to this audience. A better way to attract positive attention to oneself on LinkedIn and most other social media is to post thoughtful, professional responses in the ongoing conversations.

Twitter allows short messages, so the wording has to be compressed and to the point. The goal is to attract people to “follow” you and to retweet your messages to their connections and so on and on toward reaching the 230 million active users who tweet 500 million times a day. When advertising, even if not blatantly identified as such, the goal is for business to come your way. One can maximize one’s therapy practice by following local businesses and professionals, using hashtags to attract followers to you, and linking to your own website (Hanks, 2011). Twitter, like all social media, is also vulnerable to mischief.

Case 11–13: In an effort to promote his sagging counseling business, Bogus McDuff, L.M.H.C., created several Twitter accounts, all devoted to testifying to McDuff’s skills as a counselor.

Mr. McDuff’s tactic is cloddish and deceptive. Twitter does actively attempt to verify accounts but is able to attend mostly to celebrities and public figures.

Further in the chapter, we offer some easy rules to minimize ethical trouble when making online public statements. For self-promotion, we advise keeping it clean and professional.

Buying Publicity

Attracting publicity from media outlets serves many needs, ranging from a personal desire for acknowledgment to a practical way to acquire clientele. However, it is considered unethical to compensate the media or its personnel in exchange for publicity that viewers would

assume is news rather than an advertisement (APA: 5.02.b).

Case 11–14: Harvey Spend, D.S.W., paid a freelance author \$400 to write a flattering story about his “remarkable talents” as a counselor specializing in adolescents having problems in school. The article also boasted Spend’s volunteer activities at the local animal shelter. Dr. Spend allegedly told the writer, “Make me come off as a savior.” The final article was published in a local magazine accompanied by a photo of a grinning Dr. Spend holding two puppies.

Dr. Spend may be a competent counselor and his volunteer work may stem from sincere motives, but paying someone to write an article presented as an objective praising of a local citizen deceives readers.

Case 11–15: Rosemary Oregano, Ph.D., asked an acquaintance who was a writer for a regional agricultural magazine to do a story on the relaxation workshops she conducts on the grounds of her many large herb gardens in exchange for a fresh supply of herbs for a year.

Dr. Oregano is in violation of the APA code even though no cash changed hands. This kind of publicity would be acceptable only if the column is clearly identified as an advertisement (APA: 5.02.c).

Nothing in an ethics code precludes therapists, educators, or researchers from attempting to attract publicity through issuing a news release or making a personal contact informing the media of a story. Sometimes, media staff are interested in a therapy technique, research or book project, or an intriguing personality who just happens to be a helping professional. But, it is up to the media to make the decision without tempting them with remuneration or, as in the case of Dr. Spend, also controlling the content.

ADVERTISING CONTENT ISSUES

In general, it is appropriate to advertise in the print and broadcast media and online as long

as the tone and content of the advertisement are appropriate. Here are samples of the acceptable statements.

The following is the text that could appear in a local newspaper:

*Harry Childs, L.M.F.T.
Licensed Marriage and Family Therapist
M.A., granted by Western State University, 2003
Specializing in the treatment of parent-child
problems
Convenient office hours
Sliding fee scale
Hablo español
Health insurance accepted
Family therapy available
24-hour answering service
Call 555-0023*

The following is an acceptable text of a radio announcement: “Mary Okay, Ph.D., is a clinical psychologist specializing in marital therapy. She is opening her practice in Centerville at the Glenwood Mall, with ample free parking and convenient evening office hours. If you are having marital problems, she may be able to help. Call 333-555-2211 for an appointment.”

Assuming the facts are accurate and truthful and that Mr. Childs and Dr. Okay are indeed qualified to perform the services they list, there is nothing wrong with these notices. Any information of possible interest to a consumer, including facility in speaking a foreign language, application of special techniques (e.g., behavioral treatment of obesity, relaxation training, parent consultation, or hypnosis for habit control), convenience of office location, availability of evening hours, or other facts would be permissible.

One must be careful not to mix possibly misleading facts, however. In Chapter 12, we note how some services (e.g., school-based educational evaluations, child custody evaluations, or other forensic services) may not be covered by health insurance. Therefore, if Mr. Childs limits his practice primarily to child custody work, he should not mention that he accepts health insurance without caveats about coverage. Likewise, if Mr. Childs has no more

room for low-fee clients in his practice, then he should drop the reference to a sliding-fee scale. Such matters can be dealt with in a first session or telephone consultation, but leaving a false impression or obsolete information in the advertisement is inappropriate.

If a psychotherapist intends to advertise using any outlet, we recommend several precautionary steps:

- Consult with colleagues regarding the nature and content of your plan, as well as for a sense of community standards.
- Do not delegate the details of the advertising to others, in particular those with aggressive marketing strategies and little understanding of ethics in the mental health fields.
- Proofread or carefully monitor the final product before distribution or broadcast.
- Retain a copy of the advertisement, whether in print or broadcast, so that you will have documentation of exactly what was communicated should questions arise later.

Tackiness

Mental health professionals will occasionally engage in advertising practices that, while perhaps not unethical by today's standards, are seedy, hold their profession up to ridicule, or are otherwise in poor taste.

Here are a few examples of print ads not reaching the threshold of unethical but that do nothing for the image of mental health professionals:

*The name's Doc Lame
Psychotherapy's my game
Call for appointment this minute!
Jack Lame, Ph.D., 555-0212*

High-quality therapy for any emotional problem at rock-bottom rates. Ask about my bring-a-friend two-for-one special. Find me on Facebook. Chester Silly, Ph.D.

Although we changed names, the examples are genuine. Dr. Lame's and Dr. Silly's

advertisements fall short of maintaining a professional image.

Case 11-16: Martha Rookie, Psy.D., a recently licensed psychologist attempted to get her private practice off to a brisk start. She took out a full-page ad in the local newspaper to announce an "office open house," complete with a visit from "Psycho, the Crazy Clown," free balloons imprinted with her address and phone number, a "first session free" certificate, and a door prize of "20 free sessions for you or the significant other of your choice."

Dr. Rookie is an inexperienced psychologist in a big hurry and is making advertising blunders out of an impulsive effort to get her practice up and running. Such colleagues are typically amenable to constructive, educative approaches to their ethical misconduct. "Psycho the Crazy Clown" does little to enhance the image of the profession, while tending to make a mockery of people with emotional problems. In addition, the offer of free treatment sessions via a door prize drawing tends to belie the careful assessment and planning that should accompany any course of competently delivered psychotherapeutic services. Finally, the first session free coupons create a problem akin to the bait-and-switch routines used by unscrupulous salespeople. In the bait-and-switch scam, the potential client is drawn to the store or potential sale by an attractive offer but on showing interest is encouraged to switch to an item or service more profitable to the seller. In psychotherapeutic service delivery, a first interview is often critical to the formation of a working rapport between therapist and client. Often, the client will share emotion-laden material and form the bud of an attachment to the therapist, which may predispose the client to continue the relationship. In this sense, the offer of a free first session represents a type of bait, with implications the client will seldom recognize. There is nothing wrong with offering to waive the fee for a session. Many therapists will do this if they find it unlikely that they will be able to work with a client;

however, this is quite different from advertising no fee for the initial session as a hook to reel in clients.

The epitome of mixing tackiness with a slippery product endorsement can be found in an older issue of *Playboy* magazine.

Case 11–17: Barbara Keesling, Ph.D., who “earned a doctorate in psychology” from an unnamed university, appeared nude on several pages of *Playboy Magazine* while posing with her “self-help” books. The article described how Dr. Keesling found her way into psychology through work as a sex surrogate doing “hands-on counseling.”

The photos are still available online at *Playboy Plus*, but you must be 18 and pay to see them.

Fraud and Deception

Although professional associations are now largely blocked from addressing most types of advertising complaints, state licensing boards do have the authority to do so under the state’s interest doctrine. The FTC has not focused on state licensing boards and would not likely act against those taking well-reasoned steps to enforce greater restrictions than are allowed by professional associations as a matter of a “state’s interests.”

We provide the following illustrations of what many state licensing boards might consider unacceptable, including misrepresentation, guarantee or promise of favorable outcome, appeals to client fears or vulnerability, claims of unique or one-of-a-kind services, statements critical of competitive providers, and direct solicitation of vulnerable clients.

Case 11–18: A business card reads:

Hustle A. Droit, Ph.D. (c), M.A., C.Ht.
Health Psychology
555-0167

Experienced and internationally known for discovering “The Droit Cure.”

When asked to explain the abbreviations, Droit said Ph.D. (c) meant he was a

“Ph.D. candidate” (albeit from an unaccredited program in “psychology and transpsychology”), the C. Ht. stood for clinical hypnotist (a credential based on a correspondence course). He did possess a legitimate master’s degree and was licensed as a counselor but had never taken a course in health psychology. Mr. Droit said he took several workshops in mind, body, and spiritual healing techniques and defended his listing as “internationally known” by claiming his blog can be accessed from around the world. The blog offered a general description of an exercise regime he claimed would permanently alleviate stress. Visitors could pay \$20 for a download of the full routine.

A more common form of deceptive advertising is not as blatant.

Case 11–19: “You’ll just have to live with it! Is that what you’ve been told? It’s not true! New techniques available at the Southside Psychological Development Center will help you master your chronic problems, whatever they may be: bad habits, chronic pain, or relationship problems. Don’t delay, call today! 555-0099.

The Southside Psychological Development Center ad seems folksy and well meaning, but it also appears to ensure a favorable outcome. Aside from the inherent misleading quality of its tone, the ad implies success with recalcitrant problems and suggests the application of some novel or unique technique not available elsewhere. In fact, the center turned out to be a group practice of well-intentioned, but overzealous, therapists trained in behavioral techniques. The comparative desirability of their services and the new techniques were more representative of their hopes than of documented scientific claims. The ad has an additional flaw in that it does not name the individuals responsible for the operation. Qualified therapists should not hide behind a corporate or group practice title, and it would be preferable (and, in some states, legally required) to have the names of the therapists listed along with the name of the center. The final problem is the implication that effective treatment will be available at the Southside Center for almost any problem. It is

likely that the range of effective services to be offered at the center is actually narrower than the public had been led to believe.

Finally, hucksters are difficult to stop.

Case 11–20: Blarney Dupe hung around public places where vulnerable people might gather. Graveyards, courthouses, pawnshops, and hospital waiting rooms were the sites he chose to distribute his cards and brochures. Listed were several never-earned degrees, affiliations with nonexistent organizations, and his service offering of “sincere and compassionate counseling to relieve life’s pain.”

This type of fraud and deception is difficult to pursue because Mr. Dupe possesses no professional status. Disaffected clients would need to pursue a civil court action, although it is typical for this sort of individual to move on to another territory if found guilty and fined, only to continue the scam elsewhere. The likes of Mr. Dupe are a primary reason we encourage consumers to check their therapists’ credentials and licensure status. Membership in a recognized professional organization is not required to practice but does offer another layer of confidence for the consumer.

Case 11–21: Twin sisters, using the identities of legitimate mental health providers, were indicted by a grand jury and arrested for allegedly billing public agencies for psychological services. One sister’s company, the New England Psychological Consultants Inc., billed Medicaid, Medicare, and a school system for over half a million dollars. PsychSupport Inc., the company of the other twin, billed the University of Massachusetts Medical School in excess of \$30,000 for evaluations. The sisters were not licensed to provide any of the services (Anderson, 2014).

The blatant fraud perpetrated by this dynamic duo came to light when a licensed psychologist noticed her identity was being usurped. As other stolen identities were uncovered, the schemes unraveled.

Testimonials

The use of testimonials by “satisfied users” has a kind of inherent face validity that appealed

to the FTC. Unfortunately, like many forms of face validity, the true predictive potential of a testimonial endorsement becomes far more complex with regard to mental health services. If psychotherapy research teaches us anything, it is that any given psychotherapist will not enjoy equal success in treating all potential clients.

The FTC did allow the APA to bar the use of testimonials from “current psychotherapy patients” or from “persons who because of their particular circumstances are vulnerable to undue influence” (APA, 1990). However, the earlier testimonial debate is now largely moot, what with scores of websites allowing anyone, using their own name or a pseudonym, to say almost anything, positive or negative, about any mental health professional.

It can feel gratifying when a client values one’s services or offers praise for professional efforts, perhaps on a website posting reviews. But, there are many reasons for mental health professionals not to cite such laudatory comments in their *own* advertisements for professional services. Such statements may be taken out of context or reflect value judgments from which the public cannot reasonably draw valid generalizations. In addition, testimonials or public endorsements may compromise a client’s confidentiality or later prove embarrassing in ways not anticipated when initially agreeing to the quotation. Although most professional ethics codes revised under pressure from the FTC permit the use of testimonials from former clients, we advise our colleagues not to use them in their personal advertising services.

Case 11–22: Barney Ketchum, M.S.W., asks every client who appears to be satisfied with his services during the termination session to either write out or sit for an audiotape expressing his or her views of Ketchum’s skills as a therapist. He does not interfere with how clients express themselves, although he only uses the most favorable ones to post on his blog and website. He figures because he no longer treats these clients and their identities are not disclosed, he is simply engaging in a creative marketing practice.

We wonder how many clients would feel free to express reservations or to refuse Mr.

Ketchum's request. In addition, the therapist seems oblivious to the fact that he is asking his patients to potentially give up their rights of continued confidentiality should others recognize their voice or image. And, although most therapists know satisfied clients do become their best sources of future referrals, there is no proof the public will rely on commercially advertised testimonials in selecting medical or psychological care providers.

One type of advertising testimonial that has traditionally proved acceptable involves promotions of books or other products aimed at other professionals. Unlike the potential client who seeks the help of a therapist during a period of emotional distress, we assume a scholarly review of a book or assessment tool occurs in a relatively thoughtful and dispassionate manner. Yet, again, this issue has faded into the background because today anyone can post a review of almost any product online. Nevertheless, mental health professionals who write books or offer products should remain careful not to distort or mislead.

Appeals to Fear

Many psychotherapists might wonder why the FTC objected to a professional association's ban of advertising appealing to potential clients' fears. After all, some clients have emotional insecurities and may have greater vulnerability to inappropriate duress. From the FTC's perspective, global bans on advertising appealing to fear if services are not obtained seemed unacceptable on general principles. Many effective advertising appeals to emotions at some level (e.g., fear of tooth decay if you do not brush, fears of accidental injury or death if you do not use seat belts or text while driving, or fears of AIDS as a result of not practicing "safe sex"). In fact, social psychology teaches us that an "appeal to fear" coupled with a designated course of action can prove highly effective in evoking attitude change. Concern is warranted, though, when an ad reads like that in Case 11-23:

Case 11-23: Did you know stress can kill you? People drop like flies every day from everyday

stress. If you feel tense more than once a week, you cannot wait. Your life depends on it. Call me at 555-0126 today.

Unrelenting stress can, of course, lead to physical consequences. However, this ad appears to be incorporating the human condition to frighten people.

A more troubling example is the coupling of an appeal to fear with so-called in-your-face solicitation. Imagine the following scenario:

Case 11-24: Dinah Saur, L.M.F.T., arrives unsolicited at the home of a child who witnessed a playground shooting, urging the parents to subscribe to a course of therapy to prevent "inevitable posttraumatic stress syndrome" in their as-yet-asymptomatic child.

Using fear as an advertising tool without regard to the validity of its purpose is, in our view, unethical.

Citation of Organizational Membership Status

For many years, the APA prohibited mention in advertising of a psychologist's membership status. However, it was argued that because members and other professional associations have an obligation to follow the associations' ethics codes, and because many organizations hold their members accountable to such standards, membership may indeed represent a special qualification meriting public attention. The APA policy changed in 1979 to allow its members, should they wish, to list their membership status in public advertising so long it is not used in a way implying sponsorship of the psychologist's activities, competence, or specialized qualifications. Other codes also stress truthfulness in credential listings and avoidance of any misrepresentation (AAMFT: 9.4-5; ACA: C3.a, C.4.f; NASW: 4.06).

A variety of other credentials exist in the mental health professions, including membership in certain organizations with special entry requirements, a diploma from a postgraduate accrediting or certification body (e.g., specialty board

certification status), listing in the professional registers of various sorts, and honorary degrees or other titles. Some controversy exists regarding whether membership or receipt of such recognition constitutes a meaningful credential to potential consumers because the recipient may have acquired it via some grandparenting process or based solely on recognition of other more valid indicators of professional accomplishment (Koocher, 1979; see also Chapter 2). In general, one should advertise only those credentials deemed reasonably meaningful to the consumer population (e.g., state licensure, earned degrees, and valid specialty certifications). Honorary degrees and degrees earned in fields other than health or mental health practice should not form a basis for advertising offerings of mental health services.

Diplomate or board certification status presents a problem because of the proliferation of so-called vanity boards within different fields (Dattilio, Sadoff, & Gutheil, 2003; Foxhall, 2000; Packard, Simon, & Vaughn, 2006). Legitimate professional certification groups, such as the American Board of Professional Psychology (ABPP), the Academy of Certified Social Workers (ACSW), National Board for Certified Counselors (NBCC), and the American Board of Medical Specialties (ABMS) and its subsidiary the American Board of Psychiatry and Neurology (ABPN), all have several important features in common. These include close affiliations with recognized professional associations, nonprofit status, supervised experience, careful vetting of credentials, examinations or work sample review, and respected professionals serving on their governing boards (Dattilio, 2002).

Other frankly disreputable organizations sprang up to grant diplomas in so-called specialty or subspecialty fields not recognized by mainstream professional associations. Such organizations may offer their credentials chiefly based on personal attestations of the candidates, minimal review of credentials or questionable examinations, or simply payment of a fee. An article, "Expertise to Go," in the *American Bar Association Journal* described and dissected the antics

of one such entity, the American College of Forensic Examiners (ACFE) (Hansen, 2000). The article described the ACFE's founder as a man with a Ph.D. in philosophy who worked as a small-town policeman, a juvenile probation officer, and a children's counselor before teaching criminal justice full time. The university reportedly fired him over allegations of plagiarism. He decided to form an association of handwriting experts because he had a personal interest in handwriting analysis but no formal training in the field. Soon, he was awarding expert credentials to others.

The public may lack the ability to separate the wheat from the chaff when such diplomas or board certifications appear in advertising along with fancy-sounding names. We believe ethical mental health professionals should only cite credentials recognized by national professional associations independent of the credential's grantor. An important clue to such recognition will be a listing of the certification in professional associations' membership directories or in the regulations of state licensing boards.

Citing Degrees and Credentials

The most correct way to indicate an earned degree from an accredited educational institution would be to use initials following the holder's name (i.e., John Jones, Ph.D., or Mary Smith, D.S.W.). Simply using the title "Doctor" invites confusion because the doctorate may be in psychology, divinity, law, nursing, or medicine. In fact, many mental health professionals do hold graduate degrees in fields unrelated to their clinical or research work. In some professions, a licensing designation such as L.I.C.S.W. (licensed independent clinical social worker), L.M.H.C. (licensed mental health counselor), or L.M.F.T. (licensed marital and family therapist) may be the preferred mode of listing because the alphabetical designation of the master's degree tells the consumer little. In any case, one should list only the designations representing earned and completed academic degrees or professional licenses with relevance for the services advertised.

Case 11–25: Donnatella Anybody, L.M.F.T., Ph.D., holds a master's degree in family counseling and a Ph.D. in history. She advertises her family therapy practice using both degrees.

Dr. Anybody does indeed have an earned Ph.D. and deserves to take pride in her accomplishment. However, use of that degree to advertise her services as a mental health practitioner will likely mislead the public to conclude her doctorate falls in a field relevant to her practice. Such ambiguous listing with significant potential for misrepresentation is unethical.

Case 11–26: Anne Ticipatory, earned an M.A. in psychology and has begun work on a doctoral dissertation as the last requirement for a Ph.D. in that field. While working at a practicum site, she signs her case notes and reports as "Ann Ticipatory, Ph.D. (cand.)."

Ms. Ticipatory can see the light at the end of the long academic tunnel leading to her doctorate. Her university may even have formally declared her a Ph.D. candidate, thus authorizing her to begin dissertation research. Still, she has not yet earned the Ph.D. and the use of "Ph.D. Cand." or "A.B.D." (as in "all but dissertation") might imply some type of earned credential she does not hold. This type of listing is deceptive and is considered ethically inappropriate because only earned degrees may be listed. One certainly should explain the precise nature of professional training and credentials directly to clients, but abbreviations falsely implying actual degrees should never be used. It is hoped her supervisor will notice Ms. Ticipatory's listing and suggest correction.

Similarly, one must strive for factual accuracy when mentioning professional licenses. Most states have so-called generic licensing laws, but a few states have different levels of licensure. In a state with generic laws, psychological practitioners are licensed as psychologists. It is therefore inappropriate to list oneself as a licensed clinical psychologist or licensed school psychologist in such states. Some states license social workers at three or more levels (e.g., licensed social worker, licensed clinical

social worker, or licensed independent clinical social worker). No state licenses anyone as a psychiatrist; rather, psychiatrists are licensed physicians who go on to specialize in psychiatry. Thus, one might qualify as a "board-certified psychiatrist" but not as a "licensed psychiatrist." The best guide in determining how to advertise one's services involves looking carefully at the certificate or license itself and using only the specific title authorized. Other accurate elaborations are possible. Someone may handle such a situation by a listing "Mary Roe, Psy.D., licensed psychologist, practice limited to clinical psychology." This would be both factually accurate (i.e., official state-granted title) and ethically appropriate (i.e., accurately descriptive of specialty functioning).

Clinical psychology has grown to acquire a degree of status as a specialization within psychology. Many licensed practitioners, whose doctoral degrees were awarded in counseling psychology, school psychology, or other fields, have taken to identifying themselves as "clinical psychologists" in dealings with the public. The stated rationale of such individuals often focuses on licensing by their state to deliver so-called clinical services (by which most seem to mean health services), or they assert their education and training are similar or equivalent to that obtained in clinical psychology doctoral programs. Some psychologists attempt to distinguish between Clinical Psychology (as a proper noun) and clinical psychology, much as one would between Kleenex™ brand and generic facial tissue. Such reasoning places the clinician on a slippery slope. It is always most appropriate to list oneself only by the proper titles of credentials actually earned rather than those acquired by idiosyncratic or wishful interpretation.

Listing Workplace Affiliations

Many mental health professionals work in more than one agency or practice relationship. For example, it is not uncommon for a therapist to hold full-time employment at a clinic or hospital while conducting a part-time practice or consultation business. Many mental health

practitioners also serve on boards and committees of corporations, professional organizations, or private agencies or teach at colleges and universities. When presenting this information to others, however, it is important that such affiliations do not wrongly suggest sponsorship by, or approval of, an organization or agency. Clients must also understand whether the organization mentioned has any role in their relationship with the practitioner.

Case 11-27: Roger Facade, M.D., was in full-time private practice but volunteered a few hours a week to supervise a resident at the university hospital. In exchange for his time, Dr. Facade was given a largely symbolic appointment as an adjunct professor at the university. His new stationery included his new title with the university seal and used it for all his professional correspondence.

Case 11-28: C. U. Infer, M.S.W., worked at the Northeast Mental Health Institute, a prestigious nationally known facility, on a research project that was to last for 2 years. He was a licensed social worker and was permitted to see private clients in his office at the institute during hours when he was technically off duty from the project. Many clients assumed they were being treated by a clinical staff member of the institute under its auspices. When Infer moved away at the end of the project, several of his former clients were surprised to find that the institute had no records of their treatment and could not easily provide continuity of care for them.

Dr. Façade's misrepresentation is one of pride and possibly ignorance. While he has not demonstrably harmed any individual, he is attempting to trade on the reputation of the university to enhance his own status. In reality, his relationship to the university is rather limited and remote and does not have actual relevance to much of his professional work. Mr. Infer, on the other hand, may have misled clients, to their ultimate detriment. He is also trading on the reputation of an agency in which his actual affiliation is quite different from what the clients were apparently led to believe. Some clients may have chosen to use his services in

part because of the presumed coverage, backup, or expertise represented by the institute. It was inappropriate for Mr. Infer simply to remain silent. Rather, he has an obligation to disabuse others of incorrect impressions or conclusions they may draw.

Consider now the case of the "all-purpose" psychologist:

Case 11-29: An ethics committee received an inquiry from a group of local colleagues about Peter Pompous, Ph.D., and his possibly misleading advertising. The colleague wondered how one psychologist could run so many companies.

Pompous replied to the committee on stationery even more interesting than the inquiry letter. The stationery was headed: "Dr. Peter Pompous, Ph.D., Consulting Clinical Psychologist and Sexologist." Assorted institutional logos ran down the side of the page and listed the services Pompous offered. These included the following:

- Psychotherapy with Adults, Adolescents, and Children
- Individuals, Couples, and Group Counseling
- Hypnosis
- Lay Analysis
- Psychological Testing
- Neuropsychological Evaluation
- Personality Assessment
- Intellectual Evaluation
- Diagnostic Evaluation
- Vocational Evaluation
- Counseling
- Sex and Divorce
- Marriage Enrichment Courses
- Management Consulting
- Executive Leadership, Development, and Assessment
- Personnel Evaluations

Across the bottom of the page, the following institutions were listed: Mid-America Hypnosis Clinic, XYZ Learning Disabilities Center, Sex Counseling Institute, Affective Education Foundation, and Plainville Marriage Enrichment Center.

To begin, for Pompous to list himself with the prefix “Dr.” and the suffix “Ph.D.” is redundant and in poor taste. On further investigation, the ethics panel learned Pompous’s Ph.D. was earned in sociology and from a university not regionally accredited. He did hold a valid master’s degree in psychology, but the context in which he listed his doctorate was inappropriate. The organizations listed across the stationery turned out to have two things in common: They were all headquartered in his home, and he was the sole employee of each. When asked about his training relative to the services listed, Hartley proudly cited a long chain of briefly held jobs and short-term workshops he had attended that covered almost all of the services mentioned. Suffice it to say, his training was shallow in most of the areas mentioned, creating a substantial competence question (see Chapter 2). Although Pompous’s presentation of himself seemed rather cloddish and he appeared truly ignorant of his infractions, the potential for public deception is obvious.

Advertising Personal Growth Groups and Educational Programs

One type of counseling service often skirting the border between ethical and highly questionable tactics in terms of marketing issues is the so-called growth or enrichment seminars and workshops. When does a course or workshop become psychotherapy? Is there a difference between a seminar with a psychotherapeutic impact on an individual and psychotherapy conducted in the form of a seminar? While psychotherapy and related ethical matters are covered chiefly in Chapters 3 and 4, soliciting for therapy clients is not permitted. May one then solicit clients for a psychotherapeutic course? Consider these examples of more than semantic interest:

Case 11–30: Communication Associates, LLP, advertises a seminar, “Introduction to Personal Growth.” The format is described as lecture and experiential group participation, including “psychodrama, confrontation, gestalt, assertive, encounter transactional analysis, and training

techniques.” The ad appears weekly in a metropolitan newspaper.

Case 11–31: Psycho-Tron Laboratory Learning Systems, Incorporated, directed by Lester Clone, Ph.D., uses a business card with an optical illusion imprinted on it. Instructions on the card explain how viewing the illusion in a certain way is a sign of an inflexible problem-solving style in need of “cognito-effective reprogramming,” which can be obtained through an individualized course at Psycho-Tron.

It is one thing to give didactic or explanatory lectures about therapeutic techniques, but another thing entirely to apply techniques intended to have some psychotherapeutic outcome in the context of a course or seminar. To begin, certain therapeutic techniques, such as group confrontation, can have a harmful impact on some individuals. Without appropriate screening and follow-up, the sampling of seminar topics seems more like random indiscriminant episodes of play with therapy techniques. This may be educational, but it is also potentially harmful if targeted at the lay public as a commercial venture. In addition, the promises or claims alluded to, especially in the ad—from the Psycho-Tron Laboratory, are at best inane and at worst blatant misrepresentation. Communication Associates mentions training in their ad, but they target it to the lay public. Who do they intend to train and for what?

Those therapists oriented toward group enhancement of human potential must fully explore their goals. If these are therapeutic in nature, they should use appropriate professional cautions. Even advertisements for therapy workshops for other professionals can have shortcomings. In a content analysis of over 260 ads in psychotherapy publications, Cook, Weingardt, Jaszka, and Wiesner (2008) reported few citations of any evidence of treatment effectiveness beyond expert testimonials.

Product Endorsements

Endorsements by mental health professionals of products intended for sale to the general public

are not generally considered appropriate, particularly when the therapist earns rewards or compensation in some way for providing the endorsement. The rationale is twofold. First, a product's (e.g., a relaxation recording, biofeedback apparatus, assessment technique, etc.) merit should stand on a foundation of empirical research rather than personal testimony. Celebrity physician Dr. Mehmet Oz was called on the carpet during a U.S. Senate hearing for knowingly touting weight loss products as miraculous despite no scientific research supporting their effectiveness (Abcarian, 2014). Second, if the product is not psychological in nature (e.g., a brand of toothpaste, pet food, or soft drink), the therapist is using his or her professional stature in an irrelevant realm to endorse a product in a way that may be misleading. If a therapist were to have a dual career, performing psychotherapy by day and announcing television commercials in the evening, the circumstances might be ethically appropriate as long as the therapist's role (i.e., by day) was not mentioned or otherwise employed as a means of influencing the public to buy products in the evening.

Endorsements may be appropriate in the marketing of products of a professional nature to colleagues. These products might include testing equipment, computer software, or other items sold chiefly to qualified professionals. The key point is that the endorsement should be fair and accurate and any financial gain must be presented in a transparent manner (e.g., a psychotherapist promoting a self-help smartphone app that she created). Every effort should be made to ensure that commercial products offered for public sale are presented in a professional, scientifically acceptable, and factually informative manner.

Clinicians who use devices—in the case of mental health professionals, these may be biofeedback monitors or devices purportedly used to enhance some cognitive functioning—do need to make certain that any mention of such devices in professional advertising complies with policies of the FTC and Food and Drug Administration (FDA). In particular, regulators have enforcement concerns about product claims and promotional reminder ads (Schultz,

2008). "Product claim" ads typically include both the name of a product and potential therapeutic uses or assert a claim of success for a medical device. "Promotional reminder" ads typically cite the name of the medical device and other descriptive or price information, without giving the device's supposed benefits or uses. The FDA's Center for Devices and Radiological Health has begun to focus on the evolving use of smartphones to track health information as possibly triggering a requirement to evaluate some under medical device procedures. In 2014, the FDA did clear the first smartphone device to detect atrial fibrillation (Saxena, 2014).

THE ADVERTISING NOBODY WANTS: HELP, I'VE BEEN YELPED!

Mental health professionals are prominently advertised, whether they want to be or not, on sites where consumers can post comments about businesses and professional service providers. Any therapy client is offered an easy-access and no-cost opportunity to praise or disparage their therapist on such sites as Yelp, ZocDoc, or HealthGrades. Therapists can be blindsided by a negative review available for anyone with an Internet connection to see, and such unfavorable comments can result in a loss of potential business (Chamberlin, 2014).

When mental health professionals are found guilty of an ethics or licensing board violation, the "jury" is composed of their peers. They were afforded the opportunity to defend themselves and tell their side of the story. Accused therapists have the right to know the identity of the complainant. Indeed, unless the complaint was based on information already in the public domain, ethics committees do not accept anonymous complaints and will rarely proceed unless identified complainants agree to sign confidentiality waivers to allow the accused full due process. (See details of this procedure in Chapter 18.) Online review sites, on the other hand, allow for guilty verdicts without juries or due process because anyone can post devastating comments in relative anonymity. Some

complaints are no doubt valid, but it is impossible to know whether clients (usually ex-clients) perceived the behavior underlying an unfavorable review correctly, experienced negative transference, were bad matches in personality style, or overstated or lied for some reason. Not all reviews give enough information to sense the basis of the complaint. It is even impossible to know if the review, good or bad, was written by an actual client. Theoretically anyway, a damaging review could be posted by a rival, someone wanting to do the individual harm, or pranksters playing practical jokes on hapless strangers.

We accessed a wide geographical selection of actual “one-star” ratings appearing on Yelp. (Because we are not in any position to judge the veracity of the comments, we use no names and changed only enough words to protect easy discovery. The tone and essence of the complaints are fully retained.)

A frequent clustering of themes in our sample included incompetence, lack of caring or empathy, and financial exploitation.

I wasted my time on this poorly-prepared psychologist. I was not being helped. Instead I was being given textbook responses. The time I spent with Dr. X was money wasted. My friends did more to help me than he did.

Dr. F has many issues. He is rude. He claims he has worked in the field for 30 years but has not learned that he should be nice to his clients. He yells if you interrupt him. He's in it for the money. He does not care about the clients.

Concerns about the therapists' mental health were not uncommon.

This part-time child psychologist is a full-time narcissist. He's the crazy one.

A number of complaints were about the therapist talking or sharing too much while not listening.

Dr. Y's demeanor is jarring. He blathered about topics unrelated to therapy during my session. I could hardly get a word in edgewise. His office is filthy. His computer is an antique.

I came into therapy with my husband for marital counseling. As a result we became further estranged, and this was in large part due to our therapist. She shared inappropriately and in detail about her own failings as a wife and mother. I was shocked. She is one of those troubled people who studied psychology to try to figure themselves out.

Sometimes, the poster felt rejected and abandoned.

He couldn't care less about me. It was very difficult to meet with him because he was always busy. We finally scheduled an appointment. I had to take a taxi, and he was not even in the office! I called him, and it turns out he forgot about the appointment. He is very disrespectful.

And, some got right to their point without giving a clue regarding the basis of their ratings.

This therapist should lose his license. I cannot stress that enough. Find another therapist who is worthy of your time and money. You don't need this one.

We will not comment on these reviews because we cannot know if they are fair assessments or biased to the detriment of unlucky therapists. However, the next case using a bogus name reveals how *not* to respond.

Case 11–32: A client, using his actual initials and last name, posted a scathing comment about the “bottom-feeder-quality” therapy he received from Upsetta Peeved, L.C.S.W. Ms. Peeved posted her own response, describing her ex-client’s anger issues and suggesting he was possibly dangerous. The client contacted a lawyer to pursue a claim that Ms. Peeved violated his rights to confidentiality and made defamatory statements about his character.

Of course, it is understandable for therapists to feel upset and powerless, especially if the negative comments felt unfair. The urge to strike back or to defend oneself is natural. Whereas electronic media have left everyone vulnerable to public criticism, Ms. Peeved does not have the same luxury with regard to her

client, or even an ex-client. What was shared during therapy does not become irrelevant or fair game after a terminated relationship.

As frustrating and powerless as it may be, it is best to do damage control in other ways. Hostile confrontation will only make things worse and attract additional negative attention (Fisher, 2012).

Mental health professionals who publish books are also at the mercy of consumer reviewers. After putting in extended time and effort and hoping for some 5-star ratings on book rating sites, authors must be prepared for reviews by readers who were unimpressed, quarrelsome, or downright nasty.

How can one respond to negative reviews? Does Ms. Peeved (Case 11–32) have other recourses, such as getting the comment critical of her and her services removed? This is not likely. Yelp and other sites do not take responsibility for what is posted because they have no way to assess the validity of anyone's claim and apparently enjoy statutory immunity. Only if the content guidelines are violated or if ordered by a judge will Yelp remove a comment (Chamberlin, 2014). So, only if a comment is threatening, harassing, lewd, or bigoted, Yelp may consider removing it.

The *Psychotherapy Finances* article interviewed Keeley Kolmes and David Ballard (2012) for ideas about what to do with your Yelp page. Adaptations of their suggestions include the following:

1. Take “ownership” of your page. Even though bad reviews will not be removed, you do have the opportunity to post information about yourself, such as a professional profile. You can even explain up front why you cannot respond directly to bad reviews. This information will be seen before the reviews and costs nothing.
2. It is not unethical to ask colleagues you know think well of you to post positive reviews.
3. Find ways to bury bad reviews when others Google your name. This can be done by developing your own website and posting information, responding to blogs, writing articles, and keeping other social media presence. Try to keep the first page people

see when they Google your name positive and informative.

4. Keep everything in perspective. A single bad review may not mean much. If the same individuals keep posting negative material and become harassing or defamatory, consult an attorney.

One may be tempted, according to Kolmes and Ballard (2012), to engage in such practices as asking prospective clients to sign a statement to never post reviews about you, but such a pledge is not enforceable and creates other problems. Clients may feel coerced or put off, neither of which creates a healthy way to commence a therapy relationship. It is far better to encourage clients early on to discuss any disagreements or problems with you openly and for you to respond without anger.

Zur (2013) added additional ideas for responding to negative reviews. If the individual can be identified, a sincere apology or offer to refund may defuse the problem (although he warned not to admit to anything that may come back to wreak havoc on all concerned). Whereas responding in kind to a disparaging review is never wise, Zur (2013) offered one approach to consider; you might say, “Please contact my office to discuss your concerns.” Yelp authors are given the option to remove their reviews.

It may be helpful to reflect on the essence of the criticism to understand better what may have gone wrong and how the negative review might have been avoided. This is especially true if multiple negative reviews reveal a pattern suggesting something is worth attending to. Remember that even the best of the best are not immune from negative reviews, so at some point you need to just move on.

Finally, negative reviews have spawned a new industry of so-called repair companies and another legal specialty called “Internet defamation.” The costs involved, however, are beyond most individual’s ability to pay, and the outcome cannot be guaranteed. Less expensive aids include books such as *Me and My Web Shadow* (Mayfield, 2010), *Establishing, Managing, and Protecting Your Online Reputation: A Social Media Guide for Physicians and Medical Practices* (Pho & Gay, 2013), and *Wild West 2.0: How to Protect and*

Restore Your Reputation on the Untamed Social Frontier (Fertick & Thompson, 2010).

PUBLIC STATEMENTS

Stepping into the public arena is a form of marketing, even if unintentional. People will read about you, watch your YouTube video, frequent your column or blog, listen to your podcast, go to hear you speak or attend your workshop, and, if impressed, seek your direct services. In the process of being noticed, you may also enhance the public's perception of your field. It is possible, of course, for mental health professionals to degrade our image and themselves by displaying irresponsible or unethical behavior.

Embarrassing Ourselves

It is not unethical to be a fool or an abrasive lout, but such behavior becomes embarrassing when perpetrators are identified as mental health professionals. Public statements presented in a sarcastic or offensive manner can easily exceed the bounds of ethical propriety. Chapter 10 deals with these issues vis-à-vis colleagues, but consider more globally expressed remarks, such as these comments overhead in public lectures or meetings:

"Psychoanalysis really never helps anyone do anything except enhance their own narcissism."

"Social workers really aren't trained to do therapy and ought to be carefully supervised by psychologists or psychiatrists for most direct service work."

"Psychologists go into the field because they want to try to figure out what's wrong with them. Counselors go in to help others."

"Becoming a psychotherapist is a good career choice because most people are nuts."

These overgeneralizations, offensive comments, casual demeaning of people with problems, and similar remarks tend to cast a pall over the entire profession. When lecturing, testifying before a legislative or judicial body, or

making any statement for public consumption, one must consider the impact of one's words and style carefully, especially when the public identifies you as a representative of the mental health profession.

As ethics codes require, we must always show the public who we are, not who we want to be. Even highly accomplished figures have misrepresented facts about themselves, suggesting the trap is an easy one to fall into.

Electronic Messaging and the Digital Culture

Electronic communication via the Internet is a window to the world from the comfort of one's home, office, a park bench, or even while standing in line at the coffee shop. It is a pathway to communicate with one or many thousands of others simultaneously. And, it can be a trapdoor leading to trouble.

Online options appear almost infinite and include social networking with user-created content (e.g., Facebook, LinkedIn); publishing media (e.g., Blogger, Wordpress, Wikipedia); content sharing (e.g., YouTube, Instagram, Digg, Flickr); microblogging (Twitter, Tumblr); or discussion groups (e.g., Yahoo) and personal communications through e-mail and text messaging. Once content is sent, it can travel indefinitely as others pass it along. Anyone who surfs the Internet on a regular basis cannot help but notice the mean-spirited insults on blogs, electronic groups, and bulletin boards or in chat rooms.

Previously in this chapter, we discussed the issues relating to online attempts to promote one's services. In this section, we focus on casual participation in the digital world and the possible ethical mistakes that mental health professionals should avoid. The primary ethical challenges involve trust, boundaries, disclosures, privacy, and confidentiality (Bradley, 2009; DeJong, 2013). Lannin and Scott (2013) suggested that although mental health professions are still playing catch up with guidelines and policies related to use of digital communications, the ethical challenges inherent in smaller rural communities are

similar. Transparency becomes increasingly unavoidable, the chances of connecting unexpectedly in various forums are increased, and it is simply (or should be) assumed that many individuals know more about you than you have personally disclosed to them. Keeping these realities in mind may be helpful in deciding what to divulge and to whom. As of this writing, only the ACA ethics code *specifically* spells out precautions when engaging in social media activity (ACA: H.6).

The Digital Culture Divide

It is critical for mental health professions to think of electronic communications as a culture to be learned and understood before delving headlong into it (Lannin & Scott, 2013). At this point in time, a generational gap is likely operating that has an impact on how the ethical issues surrounding online communication are perceived and how they are taught to students. Mental health professionals over age 50 with already-established long-term careers are more likely to take a conservative stance on social media ethics and less likely to participate in it (Taylor, McMinn, Bufford, & Chang, 2010; Zur, 2012). Those senior professionals are also less likely to fully understand the mindset of their younger supervisees and colleagues for whom digital activity has been a way of life since they were toddlers.

Case 11–33: Supervisee Freddy Nimblethumbs had to stifle a laugh when his supervisor, Ante Bellum, Ph.D., told him to watch what he posted on “any of those places where people say stuff to the whole world.” “That’s like telling me not to eat,” Nimblethumbs quickly replied. Dr. Bellum scowled and divulged that she overheard that Nimblethumbs chatted about his training experiences and supervisors on his Facebook page. Nimblethumbs defended his online activity by claiming other supervisees do the same thing, that he never said “anything bad” and rarely “named names.”

We are not sure what the supervisee posted on Facebook, and perhaps it was innocuous enough. However, Mr. Nimblethumbs’s glib retort mirrors the analogy of Peter

Pirolli, a cognitive psychologist and expert in human-computer interactions, who compared humans searching the Internet to carnivores foraging for food (Winerman, 2012).

Lehavot (2009) suggested that students pause before posting on social media to reflect on any implications for their fellow students, faculty, clients, and ultimately themselves. The next case was loosely adapted from Lehavot’s (2009) work.

Case 11–34: A client googled her counselor, Jimmy Chettah, M.A., who interns at her college health clinic. She learned from his blog that he cheated on his fiancée and “got found out.” He added, “It’s just as well because she was getting on my nerves.” The client, who sought help for depression in the aftermath of her boyfriend’s affair with one of her friends, abruptly terminated counseling. She also complained to the head of the clinic and told anyone who would listen to stay away from “a hypocrite who should not be allowed to counsel anyone.”

We do know that the majority of graduate students and supervisees maintain a social presence online, and many have googled their supervisors and clients (Asay & Lai, 2014; Dilillo & Gale, 2011). Dr. Bellum’s position holds that extending information into cyberspace about the supervision experience and clients is inappropriate. These issues must be addressed openly in supervision by the “digital immigrants”—those, according to Zur (2012), who will never fully catch up or those who refuse to try—to reveal an understanding of “digital natives” and how their reality intersects with core ethical principles. To highlight this point, the season 18 finale of Comedy Central’s *South Park* featured fast-texting first graders taunting their less savvy fourth-grade schoolmates as “grandpas.”

It is possible for both digital natives and digital immigrants to take significant control of their online identities, but it is important to know how to do it and where the weak spots are, such as maintaining too-loose privacy settings and speaking without thinking about who could view what one posts and what the consequences might be. Therapists who fail in the responsible

use of new technologies and blur professional and social boundaries can endure embarrassment and other unwanted consequences (Devi, 2011; Gabbard, Roberts, Crisp-Han, Ball, & Hobday, 2012).

Impulsivity and Image

It may be enough to answer the question, How would my clients, students, supervisors, supervisees, colleagues, or prospective or current employers react if they could see what I am thinking about posting? It would be naïve to assume that others are unlikely to have access to anything posted online. Internet security, as Perlroth (2014) put it, remains largely held together with Band-Aid fixes and is poorly regulated.

The next cases, ranging from the blatant to the subdued, illustrate how impulsive or feckless postings result in untoward consequences.

Case 11–35: A school psychologist posted on Twitter, “Young black thugs who won’t follow the law need to be put down, not incarcerated. Put down like the Dogs they are!” Following a violent incident on the news, he posted: “Quick someone call David Duke before the NAACP gets here!” He defended himself by saying he was not a racist, just a realist.

The Southern Poverty Center protested such bigoted remarks and complained to the U.S. Department of Education. The media firestorm painted a disturbing image of school psychologists (Waller, 2012). The psychologist resigned.

Case 11–36: Ira Impromptu, M.S.W., frustrated with several of his clients for noncompliance with his treatment recommendations, wrote on his Facebook page: “I hate being a therapist today. My insane clients are making me insane!” He added an image of a man pulling out his own hair. The message was “shared” by intended recipients with yet others, resulting in considerable fallout when a client’s close friend happened on it and informed Impromptu’s client. The client stood outside the therapist’s office with a poster board on which he printed the message in huge letters to make sure

other clients knew of Impromptu’s foolish post. Three clients quit.

Although Mr. Impromptu saw himself as “just venting among friends” and never faced an ethics committee, a photo of the picketer taken by a passerby also circulated on Instagram. Mr. Impromptu’s reputation took a dive.

Case 11–37: Tyler Flamer, Ph.D., took issue with another psychologist’s comment on a mental health blog. Holden High, Ph.D., claimed success with predicting future behavioral problems by holding infants above his head and attending to their response. Flamer disputed such a claim and called Dr. High a litany of profane names.

Other posters, while not validating Dr. High’s questionable assertion, shamed Flamer with the uncivil manner in which he criticized Dr. High. Even when there is reason to believe a comment is ridiculous or in error, Dr. High’s suspect technique could easily have been criticized using professional language.

The next case, adapted from Chamberlin (2007), shows what can go wrong even when no objectionable material is at issue.

Case 11–38: Tom Candid, who needed only to complete his dissertation, applied for an internship in a private group practice. One of the members located Candid’s personal website and discovered that he posted his life story in intimate detail, noting “I do not believe in ever holding anything back about myself.”

Candid’s application was rejected despite the absence of unacceptable or disagreeable content. The group was concerned that his boundaries may be too loose, causing potential problems with inappropriate disclosures to his clients and placing the entire group at risk. When any position attracts many applicants, it may not take much to reject one.

Case 11–39: Cocki Tails, Ph.D., applied for a position at a mental health clinic and made it onto the short list. Her Facebook page had no privacy settings, and one of her interviewers accessed it. Her

photo album contained multiple images of Dr. Tails drinking with friends at bars, including one of her lifting a glass high while posing atop a piano.

Despite the relatively innocuous nature of the photos given that party photos are common postings on Facebook and that many professionals are known to drink at social events, Dr. Tail's application was laid aside. The expressed concern was not that she drank at parties but that posting the photos widely suggested less-than-professional judgment.

Mental health professionals may be held liable for certain kinds of content posted on private and public Internet sites or in e-mails. It must be remembered that unencrypted e-mail feels secure, but it is not. Legal problems can stem from disclosing one's own ethics violations or issuing disparaging comments about identifiable individuals who later sue for defamation. One must remain wary of violating Health Insurance Portability and Accountability Act (HIPPA) mandates, even when seeking consultations from colleagues in a closed group (see Chapter 6). It is also wise to ensure that your insurance company covers any complaint resulting from an electronic communication (Lannin & Scott, 2013). Online communications and other information you may not have supplied directly may also be discoverable in legal proceedings (Younggren, 2010).

Connecting Online With Clients

Questions have been raised regarding whether it is acceptable, perhaps even therapeutic, to "friend" clients or communicate with them online for reasons other than confirming appointments or other therapeutic relevant purposes. Agreement appears to exist that the blurring of boundaries whenever a therapeutic relationship picks up social overtones—even though the parties are not in each other's presence—attenuates objectivity and a focus on clients' needs (Devi, 2011). Transferences may be altered in ways that prove counterproductive, as the next case illustrates.

Case 11-40: Denny Display, L.M.F.T., figured that a connection with his clients would be strengthened if they could know him more fully as a human being. He "friended" every client who had a social media account. Whereas clients expressed enjoying the photos of his family and learning what Display did outside of the office, he noticed that their expectations during sessions changed in ways that posed burdensome dilemmas. A few clients acted as though they were now social friends, engaging in conversations that were irrelevant to the therapy goals, asking intrusive questions about his personal life, and inviting him to their social events. A few online commenters became increasingly surly toward other clients and even toward Display's nonclient friends, as if they were in competition for Display's favor. Things came to a head when Display's brother posted the comment, "You have some crazy-ass friends. Where did you find them?" With that, Display took down his Facebook page and spent considerable time explaining his ill-conceived idea to clients.

Mr. Display's intentions might have been sincere, but the fallout from his decision to open up his personal life to clients caused him headaches and did not serve his clients' best interests. Excessive self-disclosure carries numerous risks, as discussed more fully in Chapter 8.

Therapists would be wise to develop a policy regarding how they connect with clients by e-mail or texting as a special form of boundary setting (Kolmes, 2014; Zur, 2012). Whereas considerable time can be saved by scheduling and confirming appointments or answering basic questions, such communications channels can be misused. Some clients may want you to be available immediately and become agitated when you do not respond in a timely manner. You might inform clients that they should first call 911 in any emergency and you will be happy to receive brief nonsubstantive e-mail messages as long as they understand that such unencrypted messages are not confidential and that you do not constantly monitor your e-mail overnight or on busy days. Define *nonsubstantive* as scheduling or other nonsensitive matters.

Online Sleuthing

Once upon a time, discovering personal information about others one did not already know was a laborious task to be undertaken only for serious purposes. Enter the Internet and the almost-irresistible urge it provides to snoop around, find out what old friends (and enemies) are up to, and see what anyone is saying about you. Kolmes and Taube (2014) found that almost half of their survey respondents intentionally sought information about their clients online, and about a quarter came by client information accidentally. The question naturally arises of whether it is ethical for therapists to *intentionally* google clients, employees, students, supervisees, and anyone applying for a position. Such searches are not illegal, but are they unethical? In the case of clients, does this disrespect their rights to autonomy? As already noted, graduate students access information about clients and each other regularly. It is likely that today's web-savvy clients have googled you. (See also Chapter 6.)

It is always wise to remember that the validity of material floating around cyberspace is not always trustworthy or can be misapplied. For example, with so many people with the same names and similar demographics, unfortunate outcomes can occur.

Case 11–41: Jumputu Conclujun, Ph.D., googled his new client and discovered he had robbed a bank and served 6 years in prison. By the fifth session, the client had not revealed his criminal past, so Conclujun confronted him. The angry and embarrassed client stalked out and wrote a scathing comment on review sites. It turns out the robber and the client shared the same name and some demographics but were not the same person.

The Internet seems like an efficient way to seek consultation, and it often is. Some online lists and forums (e.g., LinkedIn specialty groups) regularly exchange ideas about professional issues and concerns.

The next case illustrates how not to do it.

Case 11–42: Tim Spout, Ph.D., posted a section of his session notes on a Yahoo group of therapists concerning a client who recently returned from Afghanistan and was not improving. The notes did not name the client but included his current job title and where he worked, the first names of his wife and young sons, and his diagnosis of PTSD.

Perhaps no one discerned the identity of Spout's client, but he was remiss in giving unnecessary detail. In addition, if Spout was not the list owner, he might not know the identities, professionalism, or confidentiality practices of all group members. When seeking consultation online, present only the relevant issues associated with the case.

This has probably happened in real time to all of us at dinner parties, on airplane flights, and also online. An individual you do not know found your contact information and discerned your status as someone who might be able to help with a personal problem.

Case 11–43: Ian Samaritan, D.S.W., received an e-mail message from an individual describing herself as a woman who was being abused by her husband and wanted to know what she should do. She also divulged that she had a young son who might also be at risk. Mr. Samaritan advised her to leave her home immediately and seek shelter. The couple later complained to a licensing board that Mr. Samaritan's advice resulted in causing child endangerment when the boy was left unattended for over 12 hours until the husband returned home.

Of course, Dr. Samaritan could not have known that the woman would take the advice so literally and run off by herself, and he was also unaware of many other pertinent facts about this complete stranger. In an actual situation, Samaritan was ultimately not held accountable, but he might have been. When someone approaches a therapist actively seeking professional help and follows what is perceived to be the advice, some jurisdictions might construe that a therapist–patient relationship was created (Gabbard et al., 2012).

Finally, it is a good idea to search regularly for your own name online to make sure nothing

needs your attention. Online social media identities can and have been stolen.

MENTAL HEALTH PROFESSIONALS AND THE MEDIA

We differentiate the best mental health professionals have to offer the public, namely information derived from a research or a strong practice base, from the clichés and psychobabble that permeate much of what the public absorbs as factual. We will not be suggesting that any media or other public forums be designated ethically off limits to mental health professionals. The challenge is not *whether* but *how* to interact with the media that raises ethical questions about social responsibility, competence, conflicts of interest, and the public image of the helping professions and social/behavioral research.

Media Portrayals of Mental Health Professionals and Researchers

Society clearly benefits when practitioners, educators, and social/behavioral researchers actively disseminate relevant information that teaches and enlightens. Yet, unfortunately, some within our ranks may fail to inform responsibly or even misinform. Misguidance can occur unwittingly, as when journalists or producers edit an interview with a blunt hatchet or interject their own, often enough erroneous, take on what data mean. Misinformation can be transmitted purposefully, as when authors who are also mental health professionals and their publishers aspire to sell more books than a sober and reasoned presentation of the facts would warrant.

In the 1980s, the APA placed specific expectations on its members with respect to public statements. Psychologists were explicitly admonished to avoid sensationalism, exaggeration, and superficiality when making any public pronouncements. Current codes are more reactive, requiring avoidance of false, fraudulent, or deceptive statements in any venue (including electronic ones) to which the public

has access (APA: 5.01, 5.04; AAMFT: 3.1, 5.9, 9.8; ACA: C.3.a; NASW: 4.04, 4.06). Given that “fraud,” “deception,” and “misleading” are thorny concepts because mental health professionals hold some conflicting and inconsistent theories, research findings are also often unclear, contradictory, or incomplete. So, unless another principle of an ethics code is violated, such as disclosing information shared in confidence in an open forum, it is more difficult to sustain an ethics charge, leaving the integrity of the public image of mental health professionals resting heavily on each practitioner’s willingness to remain as truthful and as dignified as possible.

Distortions of Psychotherapeutic, Diagnostic, and Research Concepts

Television and movie characters who would qualify for diagnoses as having homicidal dissociative personality disorders—often erroneously referred to as schizophrenics—populate the airwaves and theaters with a frequency suggesting to uninformed viewers that such frightening characters could be living next door. Indeed, television portrayals of people with a mental illness are estimated as 10 times more violent than the mentally ill in the general population (Diefenbach, 1997). In truth, the violence rates of hospitalized mentally ill individuals with no substance abuse problems are about the same as the general population (Fazel, Långström, Hjern, Grann, & Lichtenstein, 2009).

As for violent crimes, it is estimated that only 1 in 20 is committed by a seriously mentally ill individual (Fazel & Grann, 2006). The mentally ill are also often stereotyped by the media as unemployed and leading failed lives (Signorielli, 1989). In fact, compared to the general public, people with severe mental illness are more likely to be the victims of rape, muggings, or other crimes (Appleby, Mortensen, Dunn, & Hiroeh, 2001; Hiday, Swartz, Swanson, Borum, & Wagner, 1999). The most common victims of violence committed by seriously mentally ill individuals are themselves (Insel, 2011). Practitioners doing forensic work may also feel the consequences of how the false depictions of

the mentally ill affect their work, again because they create false impressions that may well have an impact on the decisions by juries, judges, and other adjudicators (Walker et al., 2010).

Other overrepresented, and usually inaccurately presented, mental conditions in the media include amnesia, homicidal mania, hysterical paralysis, and phobic disorders. More recently, obsessive-compulsive disorder (OCD) became the “diagnosis du jour.” There are exceptions to such extreme portrayals, but they are the exception. For example, *Silver Linings Playbook*, *The Rain Man*, and *As Good as It Gets* are among the more sympathetic dramatizations of people with mental problems. Also, *Shine* and *A Beautiful Mind* portrayed how individuals with serious mental disorders can be exceptionally talented and make significant contributions (Wedding, 2005).

A media version of a psychotherapy session usually boils down to a few exchanges between “client” and “therapist,” often concluding with a remarkable moment during which just the right insight occurs. Most portrayals of successful therapy focus on trauma or dramatic emotional breakthroughs in a way that grossly misrepresents the actual process.

Therapists are sometimes characterized as uncaring exploiters, as rogues with no sense of professional role boundaries, or as riddled with their own serious pathologies, occasionally even as murderers. The depiction of therapists as deceitful incompetents (e.g., *Prime*) is not uncommon. When viewers form opinions from such portrayals, both therapists and clients alike are harmed (Norcross, 2006). In a survey of 99 films with mental health professional characters (Bischoff & Reiter, 1999), male characters were more likely to be described as inept, and female characters were likely to be sexualized. In ABC’s *The Black Box*, the central character, a neuropsychologist diagnosed with a manic-depressive disorder, seduces a taxicab driver, then a surgeon whose patient is left waiting on the operating table before engaging in rough sex with her boyfriend—all in the first episode. The series was cancelled after one season. In the final season of the long-running CBS situational

comedy, *Two and a Half Men*, the social worker who is evaluating Alan and Walden for their fitness to adopt a young boy sleeps with both of them.

Greenberg (2000) expounds on Schneider’s (1987) “cinetherapists.” Dr. Dippy is weirder than his clients, Dr. Evil is a psychiatric version of the deranged scientist doing bad things to people, and Dr. Wonderful is benevolent and self-sacrificing. Extreme involvement in clients’ lives is a popular theme. Even depictions of therapists who may appear to the general public as exceptionally caring and available, placing few if any boundaries between themselves and their clients, raise and distort expectations regarding what ethical therapists do (MacFarlane, 2004). Examples here include *Good Will Hunting* and *Antwone Fisher*.

The public’s lack of scientific sophistication and the widespread belief in pseudoscience has been well documented, with the blame often placed on media misrepresentation (Hall, 2003). Occasionally, creepy portrayals populate screens and print media of social scientists as power-hungry mind controllers who seduce unsuspecting victims into their gadget-and-drug-stocked laboratories or eccentric scholars who dabble in the supernatural. Dr. Philip Zimbardo was rightfully disturbed by the German movie adaptation of his classic “Stanford prison experiment” (Haney, Banks, & Zimbardo, 1973). *Das Experiment* portrayed beatings, rapes, torture, and murder, acts that never occurred in the actual research (Murray, 2002).

Legitimate research results, when cited by journalists, often seem selected on the basis of curiosity or controversy rather than scientific quality or significance. Isolated or minor findings, if intriguing, may give the impression that far more was discovered than the data warrant. Typically, compact conclusions are presented with no effort to describe the limitations that should reasonably attend almost any research in the social/behavioral sciences.

Case 11–44: Fiona Mirth, Ph.D., delivered a paper based on a small part of a much larger National Institutes of Health (NIH) project at a

professional meeting seminar on understanding humor. Elderly schizophrenics taking one of three potent psychotropic drugs were asked to discern the point of several simple cartoons. One drug group performed better than the others at a barely statistically significant level. A reporter in the audience wrote a story appearing the next day in the city's newspaper with the headline, "Psychologist discovers pill to improve your sense of humor."

The psychologist was embarrassed and could only hope no one would attempt to act on the preposterous headline.

It is not always the journalists' misinterpretation of scientific findings. In an analysis of 460 press releases by 20 leading universities in the United Kingdom, Sumner et al. (2014) discovered that 40% offered exaggerated advice, 33% presented exaggerated causal claims, and 36% contained exaggerated inferences from animal research applied to humans. Resulting news stories simply passed along and sometimes further embellished the already-inflated material.

Display of Sullied Linen

It is unfortunate that exemplary and socially responsible mental health professionals do not seem to attract much media interest. Instead, feature items more typically parade flagrant violations of professional responsibilities or the commission of malicious, reprehensible, and bizarre acts. The next cases, using bogus names, involve serious ethical or legal offenses we ripped from the headlines.

Case 11-45: Hy Punt, Ph.D., owned a clinic serving abused children. The press discovered listings of individuals as members on his board of directors who had never heard of him. A mental health agency then terminated its contracts with his clinic when a young girl died while under his care. He then lost his state certification after being convicted of punching and kicking his girlfriend. In the meantime, investigations began related to the death of the little girl.

Case 11-46: Sik Imposter, Ph.D., trained as a social psychologist, used the name and

qualifications of a psychiatrist from another state and accepted a position as a staff psychiatrist in a state mental hospital. When Imposter became suspicious that his true identity was about to be discovered, he traveled across the country to the office address of the psychiatrist whose identity he had stolen and attempted to kill him as he exited a taxicab.

These cases create an alarming image of those who deliver mental health services. Psychologists, psychiatrists, counselors, and social workers are, after all, not exempt from the range of pathology and deviance affecting the population as a whole. To the extent that the public generalizes its perceptions and attitudes from these rare but publicized accounts, members of our professions would be seen as potentially fraudulent, exploitative, and even violent.

What if a publicized act by a mental health professional had nothing to do with his or her professional role or identity? In the past, debate focused on whether ethics committees should investigate crimes or other highly questionable acts *unrelated* to one's mental health career. The APA, for example, limits actionable offenses to scientific, educational, or professional activity. Private conduct unrelated to unethical acts or professional competence is explicitly excluded unless the act involved is the conviction of a felony (see Chapter 18). State licensing boards may hold somewhat different standards. In California, for example, the psychology licensing board may suspend or revoke the license of a convicted licensee only if the crime itself is substantially related to professional qualifications, functions, or duties (State of California, Department of Consumer Affairs, 2012).

Regardless, the public image of all mental health professionals suffers when private behavior become publicized, as illustrated by the following actual incidents, using bogus names.

Case 11-47: A young boy was seriously injured by a hit-and-run driver, Hooch Boozer, M.S.W. A heavily intoxicated Boozer was quickly apprehended. Newspaper accounts highlighted

Boozer's three previous arrests for drunk driving and identified him as a counselor at the local university.

Case 11–48: School psychologist Picky Pocket, Ph.D., gambled away thousands of dollars in a state-run casino. She was arrested for credit card theft and larceny after being caught red-handed stealing from teachers' wallets left in the faculty lounges of the several schools where she worked.

Case 11–49: An eight-page story in a major news magazine described the bizarre plot of a woman and her lover to kill her husband. The detailed story of the crime and murder convictions noted the woman's profession as a practicing psychologist and a dabbler in witchcraft.

Case 11–50: A school psychologist, Gettum Young, Ph.D., was found to have shared hundreds of videos and photographs of young boys in sexual situations, including rape by an adult, on his home computer,

Whether Boozer's irresponsible drinking and driving behavior compromised his ability to counsel students is unknown. However, along with Boozer himself, his institution likely suffered some loss in reputation. Dr. Pocket may have been a competent school psychologist, but her pilfering shattered the trust of the community as well as her job and her freedom. As for the psychologist–witch–murderess, this juicy story had very long media legs, much to the chagrin of others in the profession (see Pound, 2005). In the actual case from which Dr. Young's case study was adopted (Hutton, 2014), the psychologist faces years in prison, and the news accounts likely alarmed parents.

INTERACTIONS WITH NEWS AND ENTERTAINMENT MEDIA

In the 1980s, media psychology developed as a formal field to address growing concerns about ethical and professional issues when psychologists appeared on television and radio shows, wrote articles or advice columns for public consumption, and interviewed with journalists.

The concerns have since broadened to also include newer technologies.

Interviews With Reporters

Journalists (and radio and television producers) control what actually gets through to the public. This fact, as we illustrate, is worth remembering. Inevitable alterations occur in the form of small selected segments that fit today's sound-bite media needs.

It is natural to feel flattered when a reporter, blogger, freelance writer, or associate producer calls to express interest in you and your work. Your influence, popularity, and the demand for your expertise might increase as a result. Although many reporters select interview elements well, one must take as a matter of faith that the portions finally published will not violate the integrity of the interview. Unforgiving deadlines can sometimes preclude reporters from being thorough and fully accurate.

Occasionally, a piece written by a journalist has come to the attention of an ethics committee. In the majority of such instances, blame for the problem ultimately fell on the irresponsible or incompetent reporting. Journalists write through their own eyes and are not infallible. Or, sometimes, words are taken out of context, leaving an unfair impression in the readers' minds (Shapiro, 2011).

Case 11–51: Wilbur Nostix, Ph.D., was interviewed about his stand on corporal punishment of young children. Despite his many reasons for believing that spanking children only taught them that it is OK to beat up on someone smaller and more defenseless than you are, the reporter included the sentence, "Dr. Nostix did say 'hitting children is sometime necessary.'"

Although Dr. Nostix did, indeed, utter that sentence, he was quoting the opinion of another individual with whom he completely disagreed. He was furious with the reporter, but these kinds of mishaps cannot easily be rectified. Even if Dr. Nostix asked for a retraction and got one, it would be on a back page, and few would ever notice it.

This is not to say that a mental health professional cannot be held accountable for inappropriate disclosures to journalists.

Case 11–52: Groupie Squeal, PhD, was interviewed about his celebrity clients in a popular movie magazine. He identified his clients by name and offered personal comments about their therapeutic relationship, most of it self-serving. His response to an ethics committee inquiry was, “My clients welcome the free publicity.”

An ethics committee found Mr. Squeal professionally irresponsible. He was censured and admonished to leave the promotion of his celebrity clients to their publicists.

Before agreeing to accept an interview with a journalist, you might consider the following tips. First, inquire regarding the purpose of the story, including the journalist’s approach to it, and details about the media outlet if it is unfamiliar to you. If possible, provide tight, clearly stated summaries for the journalist in advance. Comment only on topics about which you have sufficient knowledge or experience. Better to say, “I don’t know,” or, “That is not an area I know much about” than trying to fake it. Remember that you cannot speak for your entire profession unless you are quoting from an official document. In the absence of solid data for your position, be modest and suggest other explanations. Be careful not to disclose any information shared in confidence. Although you may not be able to review how your contribution will be disseminated to the public, you can always ask. You should always make sure the journalist is keenly aware of the importance you place on the story’s accuracy.

Remember, members of the press work to fulfill their own agenda and view you as a means to their end. Any side comment or gesture (including groans, sighs, and facial expressions) are fair game. A colleague told us he blew his nose during an interview, and this was reported in the printed story.

Sometimes, journalists are interested in “psychological evaluations” of a specific newsworthy individual the mental health professional

has never met. Commentary in such instances is likely to be irresponsible. Journalists may also request detailed examples from your own practice or even referrals to clients they could interview. Of course, these requests should not be honored (Barnett et al., 2014; McGarrah, Alvord, Martin, & Haldemann, 2009).

Finally, we do not wish readers to conclude that the best course of action is to refrain from speaking to reporters altogether. A well-presented story can provide a genuine contribution to public understanding. We do recommend caution by asking the journalist some questions first.

Guest Appearances

Mental health professionals are often interviewed live on radio or television. This format can produce positive and educational interchanges or frustrations, such as getting cut off before the point was fully made, fielding stupid or inappropriate questions, or being repeatedly referred to incorrectly (e.g., as a psychiatrist when one is a psychologist). Sometimes, the guest is ambushed.

Case 11–53: Burt Trapped, Psy.D., was thrilled to be invited to appear on a major network magazine show. But, during the filming it became painfully clear that the host was biased against Trapped’s work. He felt blindsided and forced to defend himself throughout the interrogation. He considered walking out but realized he would then look cowardly, antisocial, and guilty. He stayed, and as he later put it, “I just looked pathetic instead.”

Sometimes, however, full responsibility lies with the guest, as the following case illustrates:

Case 11–54: Flamba Gambit, Ph.D., made occasional appearances on a local radio program to discuss relationship issues. Her authoritative manner and choice of words could be easily interpreted as implying knowledge grounded in scientific findings, although this was rarely the case. One of several complaints concerned her assertion that women who were raped unconsciously wanted it, and her research indicated this was due to “a

childhood fantasy of being simultaneously loved and punished by Daddy for being both a good and bad little girl."

Gambit's irresponsible statements may have caused some listeners emotional pain. On inquiry, the "research" Gambit cited consisted of no more than her opinion based on interactions with several of her clients who had been raped.

Media personalities who are also therapists face the "fishbowl" risk. Salerno (2005) wrote almost as much in his book on the darker sides of self-help therapists' very private lives as he did on the subject of self-help itself. In a more recent case, a popular media psychologist who was a regular on ABC's *Good Morning America* was accused of having a sexual relationship with a client. Before his case was even adjudicated, the sultry details were highly publicized as well as his alleged attempts to cover up the affair (Phillips, 2014).

Advice Programs With Therapists as Hosts

Years ago, a number of mental health professionals became media stars, interacting with real people who spilled out their personal problems or dysfunctional family issues for commentary by the celebrity host. The picture has since changed considerably, basically replacing dozens of therapists who hosted radio and television shows or offered advice columns with one megaenterprise and a few lesser personalities.

The primary media therapist left standing tall is the usually affable and sometimes blunt Dr. Phil McGraw. Love him or hate him, Dr. Phil is a household name. He has a top-rated TV show and an almost-circus empire consisting of a complex web page offering more advice and information, several best-selling books, and other businesses involving his wife and son. Although he once held an active psychology license, Dr. Phil describes himself primarily as an entertainer, maneuvering the shaky lines differentiating educative and informative from entertaining and exploitative.

Invited to discuss his career and work at the 2006 convention of the APA in New Orleans,

McGraw described screening and follow-up elements of his program. He told the psychologists in attendance that he makes no pretense of doing "10-minute psychotherapy" but rather attempts to get both his guests and people watching the broadcast to "get real and wake up and do something about their problems." He said he will not take on guests who are in therapy without first clearing the appropriateness with their therapist. He also has established a network of community-based practitioners and programs to whom he refers many guests in need of follow-up care.

Dr. Phil's critics mostly circle around concerns that those who send in letters and videos and sign consent forms (perhaps not realizing the primary purpose is to provide legal protection for the program) do not fully understand what they may be getting themselves into. It is important to remember that if one makes the grade and is invited to appear on the show, no one has put a gun to their head. Yet, even casual viewing of a few segments reveals discomfort among guests, some of whom are blindsided and clearly feel humiliated. Most guests do appear in need of help, and at the very end of the show, Dr. Phil usually attempts to put it all together with a plan to move forward, often offering professional assistance as "our gift to you."

The ethical dimensions of "media therapy" used to be hotly debated. Some believed this airborne mode of advice giving did more good for psychotherapists than any previous movement because the public received an inkling of what therapy and those who conduct it are really like. People who may have felt isolated or uniquely troubled or attached a stigma to seeking help might have benefited by learning others have similar conflicts and concerns. Critics, however, decried media therapists as "fast-food shrinks," embarrassing to their professions and possibly even harmful to the "quasi clients" or passive listeners and viewers. Despite the potential for educating the public, critics claimed media advice givers were hired not for their clinical competence or expertise as educators and scholars, but rather for qualities aligned with media business criteria, such as voice, verbal facility, and engaging or charismatic

personalities. The advice was viewed as especially suspicious because it was based on minimal information offered by a stranger.

Advice giving is currently allowed in a public forum as long as the person is deemed competent to give the guidance offered, does so in a responsible manner consistent with one's training, does not imply the existence of a professional relationship, and adheres to provisions of the ethics code (APA: 5.04). Earlier versions of the APA code specifically prohibited assigning a formal diagnosis in an open forum; no explicit prohibition against it appears in the most recent APA codes, despite the fact that we and others who have analyzed and interpreted the code (e.g., Fisher, 2003) view public assignments of diagnostic labels as unprofessional.

A newer iteration of media therapy involves showing actual clients undergoing therapy. The quickly cancelled reality TV documentary, Bravo's *L. A. Shrink* (think *Real Housewives* but with flamboyant therapists) followed three actual counselors (apparently only one who held a license) through their own angst-filled days sprinkled with troubled clients, who did not always receive respectful treatment. For example, one said to a client, "No, you don't have borderline personality disorder; you're a moody bitch." Discussion blog comments were often disparaging, such as "I always knew most shrinks were nutcases themselves." We may see more such shows featuring actual therapists with their clients, with professionals typically viewing this genre of entertainment as inappropriate (Friedland & Kaslow, 2013).

Popular Publications Created by Mental Health Professionals

Whereas other scientists, such as physicists and astronomers, have occasionally created works that struck a chord with the lay reader, mental health practitioners have a more receptive audience given the pervasive fascination with mental and emotional issues.

Books and articles written for the trade markets pose few ethical concerns when they are done conscientiously and stick to the facts. Many of these provide contributions

revealing a gift for making complicated psychological concepts and research findings accessible, interesting, and intelligible to the public. Examples from hundreds of possibilities include *The Emotional Life of Your Brain* (Davidson, 2012); *The Brain That Changes Itself* (Doidge, 2007); *The Examined Life* (Grosz, 2014); *Time Warped: Unlocking the Mysteries of Time Perception* (Hammond, 2013); *On Looking: Eleven Walks with Expert Eyes* (Horowitz, 2013); *Sexual Abuse in America's Military* (Hunter, 2007); *Predators* (Salter, 2004); and *Far From the Tree: Parents, Children and the Search for Identity* (Solomon, 2012).

In another genre, perhaps best referred to as creative nonfiction, psychotherapists tell stories about their clients' problems and their therapy sessions. The stories are told in a far more melodramatic fashion, usually animated with dialogue, than found in case reports used for training purposes (see Chapters 6 and 16). The pioneers—such as Robert Lindler's *The Fifty-Minute Hour* (1955), Oliver Sacks's *The Man Who Mistook His Wife for a Hat and Other Clinical Tales* (1970), Irving Yalom's *Love's Executioner and Other Tales of Psychotherapy* (1989)—were popular with lay readers and set the stage for more to follow. Intriguing titles appear to be prerequisite and include *The Men on My Couch: True Stories of Sex, Love, and Psychotherapy* (Engler & Resin, 2012); *The Mummy at the Dining Room Table: Eminent Therapists Reveal Their Most Unusual Cases* (Kottler & Carlson, 2003); and *Tales From a Traveling Couch: A Psychotherapist Revisits His Most Memorable Patients* (Akeret, 1995).

Although written in short-story form, some may assign ethically problematic features to the creative nonfiction genre. Most of the clients are extremely atypical, which may feed into the public's fear of people with emotional problems. Naïve readers may come to erroneously believe that being outrageous or at the far end of "odd" is mandatory before seeking assistance from a mental health professional. Whereas some authors writing in this genre, such as Irving Yalom, detailed how clients' confidentiality rights and identities were protected, this information is scant, unclear, or absent in others.

One of the more surprising offerings is Albert Ellis's (2010) *All Out*, a 668-page diary-style autobiography containing highly personal revelations. Ellis is the esteemed father of rational emotive behavioral therapy, which he claims to have used on himself to cope with his various personal struggles. Among Ellis's self-admitted demons was frotteurism, the act of rubbing one's pelvis or erect penis against unsuspecting strangers for the purpose of sexual gratification. Ellis preferred crowded subways and, despite some shame, described the practice as the easiest and cheapest sex he ever had with no fuss or obligations attached.

When the facts are misapplied or overlooked, ethically perplexing cases can arise.

Case 11–55: Gustav Slammen, Ph.D., wrote a popular article for a women's magazine on the psychological effects of being mugged and robbed in the streets. Based on his literature review and interviews with victims, he asserted that those who fight their attackers have a better chance of foiling the robbery attempts, recover more quickly from the emotional impact, and maintain more self-esteem compared to those who remain passive and give in to the thieves' demands. He concluded by encouraging readers to resist assaults vigorously should they ever be placed in such an unfortunate situation.

A psychologist charged Dr. Slammen with irresponsible scholarship. The complainant did not dispute the facts as far as they went. She noted, however, research supports that resisters are also at a far greater risk of being hurt or killed than nonresisters, and readers should have been made aware of this peril. The researcher claimed Dr. Slammen knew this fact because her work was cited in his article.

Among the long-standing favorite forms of "mass psychology" are self-help books, audiotapes, and various paraphernalia and contraptions purporting to assist with emotional and physical healing. Mahoney (1988) described the allure of therapeutic self-care products as a near-universal search for simple, guaranteed solutions to life's problems and challenges.

And, although the underlying motivations to develop products for this huge consumer market certainly vary, the potential for fame and fortune are surely among them. In his book, *SHAM: How the Self-Help Movement Made Americans Helpless*, Salerno (2005) took the self-improvement gurus to task, claiming them to be fraudulent due to lack of scientific merit and bent on preying on and bilking vulnerable individuals.

Self-care materials range from the diffuse "feel good" to very specific advice regarding narrowly focused conditions. Three common topic categories are: *how to improve* (e.g., self-concept, self-confidence, social assertiveness, parenting skills, physical fitness, sexual functioning, memory, and life satisfaction); *how to control* (e.g., smoking, weight, stress, anger); and *how to cope* (e.g., with depression, guilt, fears and phobias, shyness, insomnia, anxiety, problem children, loss of love, caring for elderly parents, and divorce). Many of these works, including some enjoying great success in the marketplace, are written by people with no discernible qualifications.

Even though the self-help market is engorged with vacuous potboilers and filled to the brim with cleverly named but contrived syndromes, well-trained and experienced mental health professionals are capable of creating self-administered programs that may prove beneficial for some purposes at a fraction of the cost of long-term, professional care. Despite the unquestionable potential for good, however, a number of ethical questions have arisen about what actually happens. Today, anyone can write a book and self-publish it online, as a hard copy, or both. This makes it impossible to evaluate what the public is exposed to. Consumers are often given instructions on how to solve difficult problems or manage their lives, but without a support system to sustain them through the process, to correct errors, to clarify misunderstood statements or directions, to caution against particular individual contraindications, or to alleviate any negative consequences resulting from following (or failing to follow) the program. It should also come as no surprise that publishers accept and advertise

books based largely on sales potential. The product, from a scientific perspective, is often inappropriate flamboyance, superficiality, and extravagant claims and conclusions not warranted by available evidence. Indeed, less than 5% of self-help books have been evaluated for safety or efficacy, meaning that the effectiveness as stand-alone therapies is unknown for most products (Norcross et al., 2013; Norcross & Simansky, 2005).

Although claims of newness or uniqueness are tried-and-true marketing techniques, most self-help books involve variations on simple behavioral, relaxation, imagery, and self-suggestion principles that have existed in one form or another for a very long time. Work should not be labeled as a "breakthrough" when they know (or should know) better. Readers may misapply the program or label themselves as failures when the advice does not work and give up altogether. Because the book was written by someone they likely believe to be an expert, consumers may more likely fault themselves than a defective product. Or, consumers may have a different problem for which a self-help program or any psychological approach is ineffective or even contraindicated.

Ideally, before selling instructions to people about how to deal with general or specific life problems, a responsible author would gather evidence regarding beneficial effects of the advice or program. An adequate evaluation requires the consideration of many variables, such as expectancy for improvement, format and program length, levels of task difficulty, involvement and role of significant others, reading level, long-term gains, and so on (Glasgow & Rosen, 1978, 1979). The feel-good self-care books would prove difficult to evaluate for any lasting improvement and should therefore never make promises.

We have seen a few books that do outline steps readers might consider if the advice proves unhelpful or if they have more severe symptoms than those their advice is intended to alleviate. Such disclaimers certainly earn kudos compared to their promise-blaring companions in electronic form or on brick-and-mortar bookstore shelves.

Do-it-yourself (DIY) tests, many of which have been around for a while to assess physical conditions (e.g., blood pressure, blood sugar level, pregnancy, HIV), are now appearing for psychological screening (e.g., attention-deficit disorder, early Alzheimer disease, depression) or emotional enhancement (e.g., an app to boost empathy) or memory enhancement. Many can be found online, often associated with the advertisement of the app or services for the problem purporting to be assessed or ameliorated. Ethical issues regarding DIY tests include insufficient regulation or professional oversight of test validity, potential for misuse and errors in interpretation, and absence of in-person support counseling (Kier & Molinari, 2004). Brain training sites, such as Lumosity, purport to improve overall cognitive ability (including memory speed, problem solving, and processing speed) through playing online games. However, a group of 70 neuroscientists purported that older adults would do better for themselves to take a hike than to sit in front of a computer playing brain games all day. Although players may get better at the specific games, little evidence suggests that general cognitive ability is improved (Underwood, 2014).

Prescribing Self-Care Products

Not every consumer who reads a self-help book found it while browsing in bookstores. According to Starker's (1988a) survey, the majority of respondents prescribed self-help books as supplementary treatments for their clients. Of these, almost half did so frequently. Almost all respondents believed the material was at least somewhat helpful, and reports of harmfulness were virtually nonexistent. Starker concluded the prescription of self-help books is common, the mood is optimistic about their efficacy, and little concern exists regarding their potential for harm (Starker, 1988b). Extensive surveys of clinical and counseling psychologists by Norcross and his colleagues have resulted in helpful lists of highly rated self-help books (Norcross et al., 2003, 2013; Norcross & Simansky, 2005).

Psychotherapists do need to approach the assignment of books with professional

objectivity and should read them first before recommending them. Clearly gimmicky works (e.g., those suggesting men and women originated on different planets, coupled with unsubstantiated generalizations about sex differences) are unlikely to prove helpful. Even for substantial self-help books, therapists should inform their clients about possible shortcomings and encourage them to discuss anything troubling or difficult to understand.

Assigning clients films to watch has gained popularity in recent years (Gabbard & Gabbard, 1999; Hesley, 1998; Paquette, 2003; Schulenberg, 2003; Sharp, 2002). Over two thirds of the psychologists surveyed by Lampropoulos, Kazantzis, and Deane (2004) used motion picture assignments in their practice, with the vast majority of these believing them to be effective in promoting treatment outcomes. Ramchandani (2012), while not opposing the use of films as educationally beneficial, did offer thoughtful caveats. Cinema often greatly oversimplifies mental illness. Filmmakers want stories that will sell, so even the better ones may promote or confirm stereotypes. Ramchandani (2012) suggested reflecting on correcting stereotypes and misinformation as well as what else the film offers, especially when they are used as educational presentations.

Carefully selected movies may efficiently help clients to find new ways of looking at themselves and their circumstance (Wedding, 2005). And, even though films are rarely intended to reflect the absolute, research-based truth, viewers know that. Compliance is rarely a problem because most people are willing to go to a theater or rent or stream a recommended movie. Although some films grossly misrepresent psychotherapists and the therapy process, many other films may be enlightening or supportive (Hill, 1993; Wedding & Niemiec, 2003). Therapists should remember, however, that when they prescribe movies, clients will take the viewing experience more seriously than had they casually selected them on their own. Therefore, therapists should view a film prior to prescribing it, evaluate its appropriateness for a specific client, and prepare for a follow-up discussion.

SOCIALLY RESPONSIBLE PUBLIC ACTS

We close this chapter by encouraging members of helping professions to openly champion those they serve. Individuals with mental health problems are often victims of discrimination or have insufficient access to desperately needed services. Harm can befall clients in ways falling well outside the purview of ethics codes, such as poverty, hiring and other discriminations, incompetent or inadequate care facilities, and the fallout resulting from public ignorance. The gains made by many other reference groups are immense by comparison. People with a psychiatric history, particularly if they were ever hospitalized, are still met with fear, mistrust, stereotyping, and avoidance, which limits their opportunities (Chen, 2015; Corrigan, 2005; Lund, 2014; Mayer & Barry, 1992).

Advocating for Those With Mental Health Issues

As part of the general ethic to promote human welfare, we believe in taking opportunities to educate others—both informally and formally—about the current status of psychological knowledge. The need for adequate services for the mentally ill is a primary social responsibility.

The helping professions are in the most legitimate position to replace misinformation with useful, solid data, including promoting images disconfirming inaccurate stereotypes. These include collaboration with public education and patient advocacy groups, monitoring negative portrayals of the mentally and emotionally disabled, and lobbying for increased availability of mental health services. Interestingly, and perhaps better late than never, Congress voted to eliminate the term *lunatic* from federal laws because laws should reflect current understanding of mental illness and not contain a pejorative word (Associated Press, 2012). The sole “no” vote was cast by Louie Gohmert (R-TX), who argued the term was useful to describe those who want to continue business as usual in Washington.

Horrible news stories about incidents perpetrated by unstable individuals highlight the need for better access to mental health services. It is often after the fact when we learn about unsuccessful struggles to find support for a mentally disturbed family member. Treatment unavailability was given a public face when, in 2013, Virginia State Senator Creigh Deeds attempted to find help for Gus, his 24-year-old son. Deeds obtained a court order to hospitalize Gus after observing intimidating behavior, but the time frame to identify a psychiatric hospital bed was only 6 hours. No bed became available, and Gus was sent home. The next morning, Gus inflicted multiple slices with a knife on his father's face before killing himself. It is wise to remind others, however, that only a small minority of the violent crimes are committed by individuals with mental illnesses.

Another shadow exists requiring personal reflection on our parts. Professionals who work with the mentally ill do, as one would expect, express attitudes that are more positive toward them than do members of the general public. However, mental health professionals' behavior may not differ substantially from the public's behavior regarding the amount of social distance they place between themselves and those with mental problems (Lauber, Anthony, Ajdacic-Gross, & Rossler, 2004; Phokeo, Sproule, & Raman-Wilms, 2004). It may motivate us to remember that stigmatization of the mentally ill comes full circle by substantially reducing the willingness or affordability among those who need it to seek professional services (Cooper, Corrigan, & Watson, 2003; Corrigan, 2004; Corrigan, Druss, & Perlick, 2014; Mann & Himelein, 2004). Ironically, mental health professionals may be complicit in impeding their own interests as a result of the stigma heaped on those whose career choice is to help them.

Public Disclosure at a Risk to Oneself

Difficult choices arise when one observes an unlawful, immoral, or illegitimate act but lacks the power to remedy the matter on one's own (Miceli & Near, 2002). "Going public" for reasons involving one's sense of duty can be risky.

Anticipated regret for keeping silent is also relevant during the decision to speak out or turn aside (Fredin, 2014). We refer to the actions of whistle-blowers, or "ethical resisters" as some prefer, often involving speaking out publicly as well as gaining the attention of (or seeking support from) the media. Whistle-blowers can even save lives, yet sometimes at their own personal expense (Alford, 2001; Johnson, 2003).

The overall spirit of the ethics codes by professional organizations holds as paramount maintaining the well-being of consumers and making positive contributions to the human condition. Members are admonished to always do the best they can, defined as following the ethics code principles when conflicts arise from any source. Of the four organization codes we cite throughout this book, only one appears to *require* taking risks in the public interest. NASW calls its members to social action of the sort that could result in a necessity to blow the whistle (NASW: 6). Members are expected to adhere to a list of responsibilities to the broader society, from local to global levels, and to take active roles in shaping public policies. Furthermore, they are encouraged to engage in political action leading to equal rights and access to opportunity for all, with special attention to those who are disadvantaged, oppressed, exploited, or discriminated against. (See Greene, Latting, & Kantambu, 2004, for a discussion of whistle-blowing as a special type of advocacy for social workers.)

The other codes are less explicit regarding proactive calls to public action. The AAMFT and ACA codes do not mandate disobeying the law when reasonable attempts to resolve matters that conflict with the ethical requirements are ineffective (AAMFT: Preamble; ACA: 1.1c), although the ACA (A.7.a) does specifically ask members to advocate for others "when appropriate" (left undefined). The APA also requires psychologists to make their commitment to the ethics code known whenever conflicts arise with the law, regulations, government agencies, or organizations and take "reasonable steps" to resolve the matter consistent with the provisions of the code, adding that under no circumstances

may this standard be used to justify or defend violating human rights (APA 1.02).

All codes place their members in an ethical dilemma because members are asked to first raise the issue directly with the appropriate parties. When the problem arises in the workplace, employers can always try to find a way to get rid of an employee who makes unwelcomed waves; thus, we advise treading gently, ideally with the support of others who agree with your position.

In its typical and better-known form, whistle-blowing occurs among those who hold a position as an insider in a government, agency, business, or institution. Unethical, illegal, or socially deleterious practices inside the work setting became cause for concern because of the whistle-blower's conviction that harm has been or will be caused to others or to the environment. The whistle-blower has usually attempted to remediate the situation through established channels inside the organization, but was ignored (Faugier & Woolnough, 2002). The employer's stonewalling, delays, excuses, or unresponsiveness eventually lead to sharing information with an outside source in the hope of eliminating the practice by external pressure (Miceli & Near, 1992, 2002). More recently, numerous staff members at Veterans Affairs hospitals are coming forward claiming retributions for not "cooking the books" (e.g., Parkinson, 2014).

The following are two of the few cases involving psychologists that gained media attention:

Case 11–56: Dr. Robert L. Sprague, a colleague of psychologist Stephen Breuning who conducted drug treatment research using cognitively disabled children and adults, became suspicious when Breuning was producing more uniform data than seemed probable. Sprague investigated on his own until he was convinced the research contained serious flaws suggestive of fraud. He contacted his program officer at the National Institute of Mental Health (NIMH). Breuning eventually admitted wrongdoing.

What Sprague thought would amount to making the painful decision to turn in his

colleague became a 3-year ordeal. Ultimately, Sprague himself was called into question, and he even endured threats by an official of Breuning's university. And, although cause and effect have never been proven, Sprague's long-standing NIMH funding was cut by 75% (Committee on Government Operations, 1990; Sprague, 1993).

The next case turned out better for the psychologist and resulted in corrected action, although the process was difficult to endure.

Case 11–57: The contract of Rose Hamway, a school psychologist, was terminated for "creating a hostile environment." Ultimately, the Office of Civil Rights found that the Tuscon Unified School District retaliated against her for advocating the rights of disabled students. She was awarded \$180,000 by the school district. In addition, the district was ordered to take corrective action regarding complaints and retaliation (Huicochea, 2012).

Most incidents coming to our attention involving mental health professionals do not involve matters of national or scientific significance. This also means more risk is incurred because the potential for exposure and public outcry is low or nonexistent. History has demonstrated that greater retaliation occurs when whistle-blowers do not have public support.

In the more typical case, the rights or welfare of some people were believed to be jeopardized, and guidance was requested regarding how to expose the dubious practices on the part of a local organization or agency.

Case 11–58: A staff psychiatrist noticed the death of a mental hospital patient went unreported, and the deceased was instead listed as "AWOL." When he questioned the administrator of the facility, he was simply told he was mistaken and was challenged to find a body.

Case 11–59: A psychologist at a Veterans Affairs hospital protested that his patients should not be summarily dumped onto the streets as the medical director ordered after the building where the psychologist worked was found to be unsafe. His

patients called the local newspaper in support of the psychologist. A front-page story was critical of the medical director, and the psychologist was fired for “insubordination,” only to regain his position after an arduous 2-year appeal process.

Case 11–60: A psychologist working for a managed care organization (MCO) became distraught when treatment she deemed necessary for the welfare of her clients were repeatedly denied. She was increasingly vocal about her concerns within the organization. Her services were promptly terminated under a “no cause” contract provision. The psychologist did author an article published in the local paper condemning the ethics of the MCO.

Not every practitioner represented in these examples went public, but all agonized over how to respond. The inherent risks in even these less publicized opportunities to blow the whistle include loss of employment or, failing that, demotion or transfer to some undesirable location or position. If the individual remains within the organization, he or she may be frozen out. Those known to be potential informants may have difficulty finding another job, or they may be accused of acting out of vindictiveness or revenge.

So, why would anyone put him- or herself at such risk? The main reasons include a strong belief in individual responsibility and a feeling of obligation to the community. Research conducted by Waytz, Dungan, and Young (2013) found the concepts of “fairness” and “justice” were the primary motivators of those who witnessed wrongdoing and took action, whereas “loyalty” was the defense for inaction. Unfortunately, there is no surefire source of support for those who upset a powerful organization in the course of upholding professional standards. Whistle-blower protection statutes are emerging at the state and national levels but do not necessarily protect everyone. A list follows of assessments the would-be whistle-blower might consider prior to acting.

Before making the decision to become a whistle-blower:

- Make sure you are in complete touch with why you are considering going forward. Is it

about doing the right thing because what is going on is illegal or harmful and not about anger or spite?

- Determine the accuracy, strength, and completeness of your knowledge and evidence. Keep a detailed log of every relevant event. If other parties are central to the case as witnesses, evaluate any assurances that they will stand by you.
- Determine which persons or public interest would be harmed should the matter remain unchallenged.
- Assess whether speaking directly with an offending colleague would be a positive or risky move.
- Assess the climate of the organization in terms of how likely it is to be responsive to your concerns and then decide how far up in the system you can likely go to evoke a favorable outcome.
- Look for any confidentiality issues. If you will be violating any rules or confidential information by contacting outside parties, the risk increases, requiring a particularly serious assessment of the consequences for both yourself and others.
- If your planned action will violate any laws or ethical duties by *not* contacting external parties, factor this into your decision.
- Evaluate the interest, commitment, and fair consideration you can expect from outside the organization.
- Assess whether alternatives to whistle-blowing might prove more effective and less risky.
- Carefully, informally, and confidentially (if possible) discuss your plan with highly trustworthy colleagues to obtain their assessment of the matter.
- Ask yourself if you are ready to risk your career status and compare that risk to how you would feel if you did nothing and others were harmed. Would you forever regret your inaction?

After making the decision to act,

- Determine the best way to proceed. Should you resign your position before speaking out?

- Be clear about what you expect will be achieved by speaking out in this particular situation.
- Seek one or more individuals or groups to support you.
- Stay on your good behavior. You do not want to provide ammunition for being discounted as a disgruntled employee or a crackpot.
- Develop a hierarchy of authority or interested parties in a position to act on the information and consider where in the sequence your “whistle” will be most effectively heard and heeded.
- Disclose facts and avoid to the extent possible pointing to specific individuals. Let the facts lead to the parties who created them.

Mental health professionals may run into instances of plagiarism, and many good reasons exist for reporting it to the appropriate party. Plagiarism steals the work of others, and getting away with it reinforces dishonest behavior. Strong evidence seems easy to gather in the form of a copy of the original and the purloined version. Fox and Beall (2014) offered advice based on their own experiences to ensure that negative fallout does not befall the whistle-blower. Included were the admonition to fully understand what plagiarism is and is not, careful documentation focusing on the material facts rather than attacking the character of the plagiarist, preparing for disinterest or lack of follow-up from the recipient of the charge, and even legal action. (Read more about plagiarism in Chapter 16.)

Do things always turn out badly for a whistle-blower? Gunsalus (1998b), Sieber (1999), and Keith-Spiegel, Sieber, and Koocher (2010) claimed that successful whistle-blowers are those we never hear about. Almost a third of the whistle-blowers surveyed by Lubalin and Matheson (1999) did not endure permanent negative consequences resulting from their actions. Koocher and Keith-Spiegel (2010) found the majority of respondents to a large-scale survey attempted either formally and informally to intervene in suspected scientific wrongdoing among their colleagues, and close to half reported no negative fallout;

in fact, 1 in 10 who intervened felt their status had been elevated. The chances of a successful outcome often depend on the skill and sensitivity with which the organization handles allegations of wrongdoing (Gunsalus, 1998a, 1998b).

As long as whistle-blowers remain the heroes who are shunned and ignored, our society remains in harm’s way. Whistle-blowing requires a personal constitution and sense of ethics, backed by considerable grit too few of us possess. As Rushworth Kidder (2006) put it: “Moral courage isn’t an esoteric branch of philosophy; it’s a practical necessity for modern life. Its presence or absence explains some of the world’s greatest successes and failures” (p. vii).

WHAT TO DO

- Advertisements should be truthful and factual, containing information the potential consumer will find helpful.
- Exaggeration, superficiality, and sensationalism should be avoided to the greatest extent possible when making public statements in any media or online forum.
- Speak or write responsibly because the public may rely on statements made by mental health professionals by virtue of presumed expertise.

WHAT TO WATCH FOR

- Consider your style of presentation of self and public statements carefully in any public context, whether or not advertising per se is involved.
- Keep in mind how the goals and purposes of those who report, produce, or distribute media are likely to differ from those of the interviewee.
- Recognition of the limits of one’s knowledge and experience is especially critical in media activities because large numbers of people can be misled or misinformed by incorrect public statements.
- With the ready availability of electronic distribution options, consider carefully the ethical dilemmas that could follow before

- posting messages relating to professional matters, colleagues, or clients and monitor your own social media participation.
- Resist the inclination to intentionally search online for those who have placed their trust in your integrity unless you have a compelling reason and your colleagues would likely agree with your reasoning.
 - Whistle-blowers often act on the basis of their moral courage and are to be admired. One cannot, however, be faulted for thinking through the consequences to oneself.

WHAT NOT TO DO

- Do not solicit testimonials from current clients.
- Do not engage in “in-your-face” solicitation of individual clients.
- Avoid making public statements purporting to speak for one’s entire profession.
- One should not generally make public comments on the emotional or psychological status of identified others.
- Do not post angry feelings online, even if you believe you have every right to strike back. If something is upsetting, take a break and consult with a trusted individual before responding. Often enough, no response is the best decision. The fire may die from a lack of fuel.
- Do not overshare (offer too much information) online.

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12

The Mental Health Business *Money and Managed Care*

When it is a question of money, everyone is of the same religion.

Voltaire

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Earning a living in the private practice of psychotherapy and assessment services has become increasingly challenging since the advent of managed care and growth of integrated health care services. Many early career mental health professionals worry about how to earn a living through clinical practice, while

senior colleagues worry about how to keep independent practices financially viable. To make any practice fiscally successful, one must pay careful attention to a variety of details not generally discussed in graduate school or training programs, despite the fact that both legal (HIPAA, The Health Insurance Portability and

Accountability Act of 1996) and ethical standards (American Psychological Association [APA]: 6.04; American Association for Marriage and Family Therapy [AAMFT]: 8.1–8.6; American Counseling Association [ACA]: A.10; National Association of Social Workers [NASW]: 1.13) require us to do so. Too often, graduate programs treat the business of practice as separate from the core aspects of the degree programs.

When finances do come up in the course of a mental health professional's formal training, specific discussion of actual practices involving billing, collection, and third-party reimbursement have historically been ignored (Lovinger, 1978; Totton, 2006; Waska, 1999). This may explain why client complaints and ethical difficulties frequently arise in connection with billing for mental health services. Often, the problems flow from miscommunications, procedural ignorance, or naiveté rather than greed or malice (Barnett & Walfish, 2012; Barnett, Zimmerman, & Walfish, 2014; Zuckerman, 2003). Depending on the nature of the professional training program, such discussions (when they do occur) may range from viewing payment for services as a simple business transaction to ascribing profound relational or psychodynamic meanings (Erle, 1993; Holmes, 1998; Monger, 1998; Shapiro & Ginzberg, 2006; Tudor, 1998; Valentine, 1999; Waska, 1999).

Scholarly articles on factors that influence fee setting in psychotherapy are rare. In part, this stems from a general reluctance by scholarly journals to publish papers that might be deemed as straying to the business of practice as opposed to scholarship. Actual fees can differ as a function of education and training, business experience, local competition, and even the psychotherapist's gender (Buck, 1999; Hill & Kaschak, 1999; Zur, 2014). In one study, the genders valued their services equally, but women in the sample weighed local competition as having a greater influence than men. The authors opined that this finding might result from greater numbers of subdoctoral female therapists in the community (Newlin, Adolph, & Kreber, 2004). Men have generally reported higher median full-time salaries than women

(Stetell, Pingitore, Scheffler, Schwalm, & Haley, 2001) and charged self-pay clients more than women did in the last published survey by *Psychotherapy Finances* ("Fee, Practice," 2000). In addition, another study reported that developmental and sociocultural expectations may keep female patients and female therapists from addressing financial issues openly in group psychotherapy (Motherwell, 2002).

If you attended graduate school much before two decades ago, the term *managed care* would have been a classroom novelty, if mentioned at all (Hixson, 2004). The notion that therapists might have to account to third parties (i.e., the client and therapist as the first and second parties) for their therapeutic decisions or prepare treatment plans for external review would have seemed remote and unreasonable. Few newly licensed mental health professionals prior to 1990 worried about their ability to secure listing on now-overcrowded rolls of approved insurance program providers. Today and for the foreseeable future, any therapist who hopes to build a financially viable practice must prepare to work with managed care or integrated health care systems (Fasone, 2002; Hixson, 2004; Rozensky, 2014).

WHAT TO CHARGE?

Determining the customary charges for one's services is a complicated task that mixes issues of economics, business, self-esteem, and a variety of cultural and professional taboos. When it comes to mental health services, the task is complicated by a host of both subtle and obvious psychological and ethical values (Auld, Hyman, & Rudzinski, 2005; Berger & Newman, 2012; Gabbard, 2005; Lanza, 2001; Motherwell, 2002; West, Wilk, Rae, Narrow, & Regier, 2003). Because we think of ourselves as members of the helping professions, discussing money may seem crass or pecuniary (DiBella, 1980), some sort of "dirty business" (Gabbard, 2005), or heavily laden with unconscious issues (Erle, 1993; Lanza, 2001). Comparison of fees is further complicated by differences in procedures, length of sessions, and other variables. For

example, rates can differ depending on whether the service provided involves psychotherapy, psychopharmacology, forensic services, neuropsychological assessment, or group therapy.

Psychotherapy Finances had produced useful fee surveys but has not published one since 2006 ("Survey," 2006a, 2006b, 2006c). Their surveys found that the fee for a single therapy session might vary by more than 100% over the range of clinicians in a given region. Variation occurs by region, practice site, professional degree, experience, and specialty, among other variables (Norcross, 2005). Psychiatrists have traditionally commanded the highest fees, although fewer and fewer of them practice psychotherapy as opposed to medication prescribing (Gabbard, 2005; Koocher, 2007). Psychological testing fees can also vary widely as a function of the time involved and intended uses of the data. Simple IQ assessment or educational testing might require only a few hours of work, but complex neuropsychological or forensic assessments may require 10 hours or more of data collection followed by substantial report preparation time.

In considering fees, matters are further complicated by the issue of what constitutes a "therapy hour." A session could range from an 8- to 10-minute medication check by a psychiatrist or psychiatric nurse clinician to 120 minutes or longer for a family or marathon group session. Some therapists offer their clients 60-minute hours, while for most others a treatment session will more often occupy 50, 45, or even fewer minutes. Likewise, group or family therapy sessions might extend 90 minutes or more, making clear direct fee comparisons across modalities and clinicians difficult.

Shortening the session may seem a way to increase cash flow by degrees, much as some food packagers keep the box size the same while decreasing the contents. However, the practice more often results from an effort to catch up on the hidden demands on the therapist's time. Record keeping, filing health insurance reimbursement claims, detailing treatment plans, and making telephone contacts related to cases have increased significantly over the past few years. In many circumstances, therapists may

spend 50 minutes meeting with the client, only to spend another 50 minutes completing therapy notes or other documentation necessary to seek third-party approval for additional sessions.

Some therapists may offer a sliding fee scale for clients who cannot afford to pay a customary charge, while others maintain a high "usual-and-customary rate" and provide an assortment of discounts. For example, a client who has remained in treatment for an extended period of time may pay a lower rate than a new client. Or, an individual whose treatment program necessitates 3 hours per week of professional time may have a lower hourly rate than a person seen once per week. From an ethical standpoint, the actual fee charged for services rendered is not as important as the manner in which it is set, communicated, managed, and collected. By definition, however, many clients may be regarded as somewhat vulnerable to potential abuse because of emotional dependency, social naiveté, psychosis, or other psychopathological conditions. It behooves the therapist not to take advantage of these factors.

Case 12-1: Arnold Avarice, Ph.D., was contacted by Sally Sibyl for treatment of her emotional problems. He diagnosed her as having a multiple-personality disorder. During the first 2 months of treatment, Dr. Avarice claimed to have treated Ms. Sibyl an average of 3 hours per day (some days as many as 5 to 6 hours) at a rate of \$175 per hour. Ms. Sibyl's wealthy family was billed more than \$30,000 for services during this time. When Ms. Sibyl's family questioned the bill, Dr. Avarice justified the frequency of his work with the client by noting, "I often had sessions with two or three different personalities the same day. She is a very disturbed woman requiring intensive work."

Most psychotherapists, including those expert in treating people with a multiple-personality disorder (also known as dissociative identity disorder), would question the necessity and appropriateness of Dr. Avarice's intervention. When called before an ethics committee, Dr. Avarice could not provide a treatment plan or detailed case notes for the many hours of treatment he claimed to have provided. Ms. Sibyl showed

little improvement and could not remember when or how often she had seen Dr. Avarice.

From the outset of a relationship with a new client, the therapist should take care to explain the nature of services offered, the fees charged, the mode of payment used, and other financial arrangements that might reasonably be expected to influence the potential client's decision. If the therapist has reason to question the ability of the client to make a responsible decision, then this also must be considered in deciding to accept the client or make some specialized referral elsewhere. Of course, parents or legal guardians may grant permission for treatment of minors or adults over whom they have guardianship. Providing consent should be regarded as a process rather than a single event. The flow of information and mutual discussion of the treatment process—including costs—should be ongoing as needed throughout the professional relationship. If therapists provide an estimate of charges, they must honor such estimates unless unforeseen circumstances arise. In the last situation, any changes should be discussed with and agreed to by the client. If it seems that financial difficulties may become an issue, they should be dealt with openly at the very outset of the relationship.

Occasionally, clients complain to ethics committees about pressure to enter treatment at a higher fee than they can afford. Such practices include both "soft-sell" and "hard-sell" pitches. An example of the low-pressure pitch might involve explaining, "If you really want to get better, you will find a way to finance good therapy. It's an investment in yourself." A more pressured or aggressive pitch might sound like, "You can't afford not to see me. I have been very successful in solving your sort of problem. Things will only get worse if you don't take care of them now." Aside from the implication of special skill explicit in both these pitches, they subject clients to unethical pressure by playing on their insecurities.

More appropriate ways to address the issue of the client who cannot afford the usual charges for services exist. Many mental health professionals offer a flexible fee schedule or sliding scale that varies as a function of client income.

Most professional associations also encourage their members to offer at least some pro bono services (i.e., professional activity undertaken at no charge in the public interest). For example, under its aspirational ethical principles, the APA states: "Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage" (APA: Principle B; see also ACA: C.6.e; NASW: 1.13.a). A variety of surveys have yielded self-reports that suggest many therapists do provide at least some services at little or no cost.

Many psychotherapists will offer a financially troubled client the opportunity to extend payment over a long period of time, but this practice will not prove helpful if the charges incurred remain beyond the reasonable means of the client. Some therapists have been known to tack on interest or "billing charges" to unpaid bills. This practice may also trigger regulatory complaints because state and federal laws generally require a special disclosure statement informing clients about such fees and obtaining their agreement in advance.

It is critical that the therapist consider these issues early in the professional relationship and raise them openly with the client in a realistic, yet supportive, fashion. If a prospective client seems unable to reasonably afford one's services, the therapist should be prepared to make a sensitive and appropriate referral. In this vein, it is important for all mental health professionals to keep abreast of hospitals, clinics, community mental health centers, training programs, and other resources that might offer more affordable services for those with financial difficulties.

Along these lines, therapists must consider their obligations to the client and local agencies in terms of treatment continuity and limited financial resources in the community. A practice known as "creaming and dumping" illustrates this point.

Case 12–2: Roberta Poore consulted Phil T. Lucre, M.S.W., for treatment of long-standing difficulties with her parents and coworkers. After only one session, it was clear to Mr. Lucre that Poore would, at minimum, require several months of weekly psychotherapy to begin addressing

her relationship problems effectively. Mr. Lucre's usual hourly rate was \$150, and he did not have a policy of reducing his fee for clients who could not afford it. Poore had limited insurance coverage that would clearly not cover the full cost of the services she would need. Mr. Lucre saw her for several sessions, but as soon as her insurance coverage and personal resources were exhausted, he referred her to the local community health center, where she could receive treatment at a reduced fee.

In this case, Mr. Lucre skimmed the "cream" (insurance benefits and personal resources of the client) and then "dumped" her in the lap of a community agency. This constitutes a disservice to the client, who faces a disruption in her therapeutic care, as well as a disservice to the community agency, which would have benefited from the revenue Lucre collected, while also providing continuity of care. When the possibility of service needs in excess of coverage becomes evident, the therapist should not take on the case but rather should make an appropriate referral immediately. If the therapist considers the treatment or evaluation plan early and discusses it with the client, including all relevant financial aspects, then the client would be in a position to express a preference considering the continuity issue as well.

The case of Mr. Lucre and Ms. Poore represents one type of abandonment of a client by the therapist, but what of the more general situation when a client cannot pay for services rendered? Should the therapist terminate services in midcourse of treatment, or does that represent abandonment of the client as well? The ethical therapist will attempt to avoid abandoning clients for financial reasons with two specific strategies. The first is never to contract for services without clarifying the costs to the client and reaching an agreement on affordability. The second is not to mislead the client into thinking that insurance or other such coverage will bear the full cost of services when it seems reasonably clear that benefits may become exhausted before the client's need for service. When a client becomes unemployed or otherwise can no longer pay for continued services,

the therapist should remain especially sensitive to the client's needs. If a client cannot realistically be helped under existing reimbursement restrictions and the resulting process might be too disruptive, it is best simply to explain the problem and not take on the prospective client. While it may be necessary to terminate care or transfer the client's care elsewhere over the long term, this should never occur abruptly or in the midst of a crisis period in the client's life.

Increasing fees in the course of service delivery can also pose ethical dilemmas. Commitments made to provide consultation or to conduct an assessment for a given fee should be honored. Likewise, a client who enters psychotherapy at an agreed-on fee has a reasonable expectation that the fee will not increase excessively. Once service has begun, the provider must consider the obligations for continuity of care due to the client. Aside from financial hardship issues, therapists must not abuse the special influence they have with their clients.

Case 12-3: Chuck Gelt began psychotherapy with Helen Takem, M.D., expecting to pay \$120 per session. After several weeks of treatment, Mr. Gelt shared some intense and painful concerns with Dr. Takem. These emotional issues included mixed feelings over relationships with Gelt's deceased parents, from whom he had just inherited substantial wealth. Dr. Takem pressed Gelt to contract with her for a minimum of 100 sessions at a cost of \$200 per session. She argued that, for this particular affluent client, the fee needed to be high or else he would not perceive the therapy as "valuable." The minimum contract for 100 sessions was needed, Takem reasoned, because Gelt was "ambivalent and tended to lack commitment."

Dr. Takem's proposed contract is clearly unethical as it requires new terms independent of demonstrated client need and without meaningful client participation in the decision-making process. In addition, the client's mixed feelings may inhibit his ability to see or raise a complaint about the inappropriateness of the dramatic boost in fees. At the same time, the client may feel reluctant to go through the emotional pain of sharing his concerns all

over again with a new therapist. The emotional investment made by the client during the first few sessions may contribute to making him less able to act as an informed, reasoning consumer.

When a client has participated in therapy for an extended period of time and inflation or other costs of conducting a professional practice (e.g., rent, utilities, insurance, and staff salaries) have risen, it is not unreasonable to adjust fees upward accordingly. This should, however, be done thoughtfully, reasonably, with advance notice, and with due consideration for each client's economic status and treatment needs (Barnett & Walfish, 2012; Pepper, 2004). Some clinicians, for example, will raise fees for new clients while maintaining ongoing clients at their preexisting rate. The ethical point to consider is that mental health professionals incur added responsibility because of the influential roles they occupy relative to clients (Buck, 1999). Raising the fee exponentially or without a meaningful economic rationale, however, is seldom, if ever, therapeutically defensible.

Similar issues are discussed in Chapter 11 with respect to promotional offers of "free sessions" or "special bonus offers" used in advertisements to attract clients. Clients may not realize the subtle emotional pressures that may accompany an initial consultation or "free visit." While there is certainly nothing wrong with not charging a client under some circumstances, this should never become a lure to initiate a professional relationship through advertising media.

Some mental health professionals require clients to pay certain fees in advance of rendering services as a kind of retainer. This would qualify as an unusual policy in a psychotherapy practice but is not unethical as long as the contingencies are by mutual agreement. The most common uses of such advance payments or retainers involve relationships in which the clinician is asked to hold time available on short notice for some reasons (as in certain types of corporate consulting) or when certain types of time-consuming assessments or litigation are involved (see a discussion in Chapter 13). A specific example might occur when a therapist agrees to undertake a child custody evaluation,

and the two hostile contesting parties (such as the Bicker family in Case 12–15) each agree to pay half of the fee in advance. In such cases, at least one of the parties will potentially become unhappy with the outcome, and in such circumstances, the unhappy party may refuse to pay for the services rendered because of displeasure with the findings. Another example might involve a family requesting a private neuropsychological assessment of their child in the hope of securing changes in the child's special education IEP (individualized educational plan). Such an evaluation may well require the neuropsychologist to invest 5 to 10 hours or more of data collection, plus similar amounts of time in preparing a report. In such situations, it is not unusual for the clinician to request a retainer or escrow payment prior to commencing work.

Payment for missed appointments is another source of occasional inquiries to ethics committees. It is not unethical to charge a client for an appointment that is not kept or that is canceled on short notice (Auld et al., 2005; Barnett & Walfish, 2012; Birnbach, 1999; Napoli, 1999; Ritt, 2000; Sommers, 1999). Again, the key issue involves giving advance information about this practice to the client (APA 02: 6.04; AAMFT: 8.2; ACA: A.10.c; NASW: 1.03). No one wants to have their schedule disrupted or lose time that they might have reallocated for other useful purposes. In addition, if a therapist has a waiting list and could well use the vacant appointment time, it is frustrating and costly to have a client cancel on short notice or simply fail to show up for the appointment. If the therapist intends to charge the client in such instances, however, it is necessary to advise the client of this at the start of the relationship and to make the conditions explicit, preferably in written form initialed by the client. When informing clients about such charges, it is important to advise them that insurance companies generally will not pay for missed appointments, as we discuss further in this chapter. In actual practice, it appears that few therapists charge clients for a missed appointment unless the behavior becomes a recurrent pattern. Zur (2014) provided an excellent summary of professional ethics codes related to fees in psychotherapy.

Case 12–4: Skippy Session saw Harry Biller, L.M.H.C., for counseling on a weekly basis for 6 weeks. During the first session, Mr. Biller explained his policy of charging clients for appointments canceled less than 24 hours in advance, and Mr. Session accepted those terms. A few hours before the scheduled seventh appointment, Session's father was killed in an automobile accident. Session telephoned Mr. Biller that he would be unable to keep the appointment and would call to reschedule. Mr. Biller did not charge Mr. Session for the canceled appointment out of deference to the unusual circumstances. Several months later, Mr. Session neglected to keep a scheduled appointment with Mr. Biller. When the therapist charged him for that missed appointment, Mr. Session complained, "That's unethical! After all, you never charged me the last time I missed one."

There may be many different reasons that Mr. Session missed his most recent appointment, ranging from "unconscious acting out" (Sommers, 1999; Valentine, 1999) to simple forgetting. He was informed about and did agree to Mr. Biller's terms at the start of therapy. Mr. Biller's compassionate waiving of his fee the day Mr. Session's father died may have been misinterpreted by Session. Mr. Biller is ethically entitled to charge for the second missed session; however, in the interest of maintaining the therapeutic alliance and for risk management purposes, it probably would prove wiser to discuss both the misunderstanding and the meaning of "forgetting" the appointment, postponing the implementation of the missed session fee until the next occurrence.

Fees certainly do have substantial psychological impact on a number of levels and may often become a therapeutic issue (Hixson, 2004; Newlin et al., 2004; Newman, 2005; Sommers, 1999; Valentine, 1999). Lovinger (1978) noted that the fee is all that the client has to give, aside from coming to the clinician's office. The client does not owe the clinician gratitude, respect, consensus, or anything other than a fee for services rendered. The fee may in that sense develop some special meaning via transference (Rogoff, 2006; Shapiro, & Ginzberg, 2006; Totton, 2006; Waska, 1999). This means that

the client may react to a fee change in the same manner as some duty owed in a relationship with another significant person in his or her life. It may become a means of addressing the anger held in relation to a demanding parent or represent a penance to atone for some imagined wrong to a spouse. Lovinger, like Freud (who, he reported, viewed fees as a frank matter of the therapist's livelihood for matter-of-fact discussions with his patients) suggested that a direct and candid approach is the best means to begin a client–psychotherapist relationship.

FEE SPLITTING

Fee splitting, often termed a *kickback*, refers to a general practice under which part of payment received for a product or service is returned or paid out because of some prearranged agreement or coercion. As occasionally encountered in medicine and the mental health professions, the client usually remains unaware of the arrangement. Traditionally, nearly universal agreement existed among medical and mental health professionals that such practices are unethical (APA: 10.02; ACA: A.10.b), chiefly because they may preclude a truly appropriate referral in the client's best interests, result in delivery of unneeded services, lead to increased costs of services, and generally exploit the relative ignorance of the client. Unfortunately, fee splitting may exist in rather complex and subtle forms that tend to mask the fact that it is occurring.

A continuum of types of fee-splitting or -sharing agreements exist, ranging from reasonable and ethical to clearly inappropriate. At one end of the continuum, we find employer–employee relationships in which one party hires another to perform services; at the other end, we find arrangements in which the person making the referral gets money solely for sending business to another. The employer–employee relationship provides an ethically clear context (i.e., I pay you a salary, and I collect fees for the work you do as an employee). Unethical fee splitting occurs in the case of making payment or kickback simply for

referring a new client. In between these two extremes, one can find a range of business practices with varying incentives that raise ethical questions. In addition, actions by the Federal Trade Commission (FTC), as discussed in Chapter 11, have legitimized some practices previously prohibited by professional associations' ethics codes.

Case 12–5: Irving Slynapse, M.D., a prominent neurologist, agrees to refer substantial numbers of his patients to Acetyl Choline, Psy.D., for neuropsychological assessment. Dr. Choline bills the client or insurance company and pays Slynapse 10% of all the money collected on clients he refers to her. Slynapse characterizes that 10% as a continuing charge for medical coverage and consultation; however, there are no regular appointments scheduled for consultation, and Choline never avails herself of that service.

Case 12–6: Weasely Proffit, M.D., has a large professional practice; he supervises several master's-level psychotherapists and rents office space to other doctoral-level mental health clinicians. His secretary bills all of the clients at a rate of \$150 per session. The supervisees are paid 25% of the fees collected, and the renters are paid 40% of the fees collected. The clients remain unaware of this distribution plan.

Case 12–7: G. Ima Helper, M.S.W., is well known for her many self-help books and media appearances. Her public visibility results in many self-referrals by clients in the community. Ms. Helper refers such clients to Helper's Haven, her private clinic, where they are seen for \$100 per session by master's-level therapists who are paid \$40 per session. The clients are led to believe that their therapists are supervised or receive consultation on their cases from Dr. Helper. In fact, therapists are not even employees (i.e., salaried) but simply earn a fee for each session held and have no contact with Dr. Helper, who has little direct involvement with the clinic.

Each of the cases cited has a number of unethical features in common. To begin, the clients are generally unaware of the proprietary relationship between the service

provider and the person making the referral. It is therefore unlikely that the clients would realize that the referrals originated because of motives other than their own best interests. In each of the cases, one party is also being paid for services not rendered. That is, Dr. Slynapse, Dr. Proffit, and Ms. Helper receive a commission in a manner concealed from, and to the detriment of, the clients. Clients may assume that referrals to therapists were based on the therapists' special abilities or competence rather than chiefly for profit. The more responsibility and liability the referer has for the case, the more reasonable it is to pay that person a fee. None of these therapists has objectively weighed the needs of the individual client and considered these in making the referral. A key point is the matter of professional responsibility. Some clients may actually end up referred and charged for services that they do not need.

Dr. Proffit's situation is potentially more appropriate than those of Dr. Slynapse and Ms. Helper. If Proffit has a long-term contract with the therapists who rent space from him and provides supervision, consultation, or case oversight, he may be legitimately entitled to a percentage of fees collected for those services. On the other hand, if he has no professional relationship with the therapists and no clear responsibility for their clients' welfare, he is not entitled to a fee. The key issue in determining appropriateness of such fees is the rendering of legitimate, reasonably priced services.

The case of Ms. Helper also raises the basic question of what one must disclose to a client about arrangements among clinicians. Helper may also be exploiting the other therapists in her clinic. The issue in the current context is that clients should be told any aspects of the arrangement that might reasonably be expected to influence their decision about whether to use the services. They have a right to know that Ms. Helper will not participate in their treatment in any way. In all of the cases in which a commission is paid to someone not rendering services, the client should also be advised. By commission, we mean any payment made simply for a referral, as opposed to a payment made

for some services rendered in a joint practice or professional collaboration.

Group Practice Cost Sharing

Many mental health providers work in group practices or collaborative arrangements by sharing certain costs, such as rent, secretarial services, utilities, and answering services. Many other therapists also have, or work as, assistants to other more senior clinicians and earn less than the full rate billed to the client. Although these types of arrangements may pass legal muster, we feel troubled when compensation is paid to some party simply for referring clients within the group or when percentages of gross income are charged against a therapist automatically rather than for services legitimately provided. In such instances, the clients' welfare is too easily ignored.

In the group practice described previously, for example, each therapist might be asked to make a monthly payment or split costs, based on actual or reasonably estimated costs and their use of space or other office expenses. This charge may differ somewhat depending on the nature of the group (e.g., incorporated partnership or informal arrangement). In the case of the assistant, it may prove more appropriate to pay the individual a salary or to base compensation on actual gross income less actual costs. Costs might include a reasonable charge for supervision (when allowed by law), administration, marketing, consultation, or office services, but these must be based on a mutually agreed-on set of actual expenses and be open to renegotiation as time-demand shifts occur. In all cases, the therapists must be free to make referrals outside the practice when this seems in their clients' best interests. No financial rewards or penalties should accrue to any party as the result of an inside versus outside referral.

One of the subtle difficulties involved in group practice arrangements or the use of assistants is the fair determination of costs and service use. Considerable opportunity for inflation of expenses or other manipulations exists. This is especially true when one of the therapists is

in a position of power over others by virtue of being the senior party, owner of the practice, or a licensed therapist employing individuals in training or unable to obtain independent licensure. In such situations, it behooves the therapist to avoid even the appearance of abuse and to be fully open with his or her colleagues.

Case 12-8: Debbie Doubter, Psy.D., has been invited to join a thriving group practice started 20 years ago by Wally Wealthy, Ph.D. She has been offered 40% of the fees collected for her services during her first year and 50% of the fees every year thereafter. Dr. Wealthy explains that he will provide close supervision and some training for her in the first year. In addition, he notes that 50% of the fees collected are his best estimate of the costs of rent, utilities, billing service, answering service, and coverage of her clients while she is on vacation. By joining the practice, Dr. Doubter will automatically qualify as a provider on several managed care preferred provider panels. Finally, Dr. Wealthy notes that his percentage includes some allowance for "return on investment." That is to say, he feels entitled to recover some money based on the years he has invested in building the practice.

In this case, Dr. Doubter must decide for herself whether she is comfortable with Dr. Wealthy's offer. It is not inappropriate on its face because Dr. Wealthy will indeed provide the stated services and will retain a significant degree of professional and clinical responsibility. Given the difficulties many young therapists face starting practices in today's economic climate, the 50% cut sought by Dr. Wealthy may seem acceptable to some.

Another subtle difficulty involves the tendency to refer clients to therapists one knows well. This can be an appropriate and responsible practice, as one tries to help each client obtain the most fitting services for her or his needs. It is critical, however, that the person making the referral do so without any anticipation of financial benefit or gain as the result of the referral. If it happens that the most suitable referral may well be to a colleague or employee and some indirect benefit

might be a result (e.g., overhead costs in a group practice kept lower by virtue of more patients being seen), this would not cause the same type of ethical conflict. The client should be informed, however, of the fact that a relationship exists between the clinicians and the reasons why a referral is being made to that specific clinician. Another alternative would be to offer the client a choice among clinicians that includes at least one with no linkage to the referring party.

Case 12–9: Finda Dockta, M.B.A., founded a psychotherapy referral service, Shrinks-R-Us, to “guide wise consumers to competent, effective, reasonably priced therapists.” Psychotherapists pay Ms. Dockta a registration fee, provide proof that they are licensed, carry liability insurance, and supply three letters of reference. The therapists provide her database with details on their experience, languages spoken, office location, and other relevant data. They also agree to pay her a 5% royalty on all net fees collected from clients she refers to them. Ms. Dockta markets the service heavily. Clients are not charged a fee and are informed that all costs of the service are paid by the clinicians based on their collections.

Some might say that Ms. Dockta’s program involves fee splitting, although the FTC would have no difficulty with it. Yes, she is getting a percentage of the fees (potentially for years to come, depending on the signed agreement with the therapists), but she is also legitimately earning those fees by providing useful referral information to consumers. The fact that providers pay for the service is not concealed. Although a state legislature may have authority to prohibit such activities within its borders (thus avoiding the FTC’s interstate commerce oversight), clinicians participating in such a service would not be subject to disciplinary action by national professional organizations or their state affiliates.

Special Business Agreements

Although technically not fee splitting, a variety of special business agreements common in the commercial world would be considered

potentially unethical in mental health or medical practice for reasons similar to the issues raised thus far in this chapter. These agreements would include so-called covenants not to compete or contracts with liquidated damages clauses.

Case 12–10: Lester Workman, Ph.D., spent 10 years building a favorable professional reputation and busy private practice in a suburban community. He began to attract more referrals than he could handle, but he was not sure whether the volume would be sufficient to warrant the addition of a colleague as a full-time employee in the practice. Instead, he hired Peter Partner, L.M.F.T., as a half-time employee at a salary agreeable to both for a 1-year contract. By the end of the year, Mr. Partner, who was young and energetic, began to build his own strong reputation in the community and wondered if he ought to consider going into practice independently.

In an ideal world, Workman and Partner will sit down and attempt to sort matters out in their clients’ best interests. If they are indeed to have separate practices in the same community, the choice of whom to consult should belong to the client. Clients in midtreatment with Mr. Partner, for example, should reasonably expect to continue their relationship with him. Unfortunately, however, such splits often result in considerable acrimony between the therapists, with clients caught in between. It would have been preferable for Workman to consider this potential outcome as a possibility from the outset should they terminate working together and include some reasonable professional plan in the agreement with Partner to meet clients’ needs. This agreement could include some fair allowance for the effort Workman put into building the practice.

Two types of advance agreement for the termination of such relationships cause serious ethical problems. In the first type, Dr. Workman might have attempted to sign Mr. Partner to a contract that included a “covenant not to compete.” Under such a clause, Partner would agree, for example, not to set up an independent practice or work for any other clinician

within a 50-mile radius of Workman's office for a period of time after leaving the practice. Whereas this might meet Workman's needs, it would deny clients their freedom to choose and is, therefore, clearly unethical. In some jurisdictions, state laws make such agreements among health care professionals illegal. The usual legal standard is "reasonableness." Although there are obviously many different perspectives on what is reasonable, the paramount ethical perspective would focus on the well-being of the clients. Clear differences exist between the obligations to a client who is psychologically vulnerable and the more usual circumstances in business and industry, in which such covenants are more appropriately used to protect trade secrets.

The second type of problematic contractual element Workman might have considered would be a liquidated damages clause. Such a clause might have asked that Mr. Partner pay Workman financial "damages" for each client he takes with him, either at a rate of a flat fee per client or as a percentage of future revenues. Paying a flat fee for each client who leaves with Dr. Partner might prove ethically acceptable as long as the cost of this fee is not passed to the client. Paying a percentage of future earnings or a royalty from the fees of the transferred clients is more clearly a fee-splitting situation and could be legally unenforceable in some states, even if Mr. Partner had agreed to it initially.

The message inherent in this discussion has three aspects. First, such issues require discussion and clarification prior to beginning the professional association. Second, the choice of a therapist should ultimately rest with the client. Finally, professional colleagues must exercise great care and at times suffer potential economic disadvantage so they do not abuse the relative position of power and influence they have over the clients they serve. Therapists should not profit unfairly at the expense of either clients or colleagues.

Selling a Practice

Selling a professional practice is another kind of special business agreement that raises ethical

questions. Suppose Dr. Workman wanted to retire after 30 years in solo private practice. Can he sell his practice? What does the practice include? Furniture, an office, some aging psychological test equipment, the name of the practice or clinic, and a group of clients make up a practice. One can indeed sell the furniture, real estate, and equipment. But, selling the clients, their files, and access to this information raises many significant ethical issues (Koocher, 2003; Manosevitz & Hays, 2003). Therapists cannot ethically transfer clinical responsibility for clients or confidential client records in a private practice without the clients' consent. Clients have the right to choose their therapist. In addition to freedom-of-choice (FOC) issues, the seller's clients may feel heavily influenced by the seller's recommendation that they continue to obtain services from the buyer. The seller is in a complex role with respect to these clients. That is, the clients are in some respects a commodity when they are referred en masse to the buyer. They have the right to expect that the referral to a new therapist is based on careful professional judgment of their individual needs (Pope & Keith-Spiegel, 1986). (Principles for valuing a practice, including ethical issues related to client lists and records, are described by Woody, 1997).

If the retiring Dr. Workman wanted to maximize his ability to transfer a thriving practice to another professional, the most ethical and effective way to accomplish this feat would be to spread it out over a period of years in what has been termed an "extended transition model" (Myers & Brezler, 1992). Ideally, Dr. Workman could attract a potential partner and forge an agreement (e.g., a legal entity, partnership, or professional corporation) that included a buy-out of the practice over time. As Workman's retirement drew near, he could offer clients the opportunity to transfer to his partner or elsewhere in the community. The agreement could call for the partner to maintain and administer the practice's records for the legally mandated interval (see Chapter 6) and might even include a continuing consulting role for Workman on an as-needed basis should special issues with former clients arise. In this way, the selling of

the practice actually becomes an evolutionary transfer that allows time, choice, and continuity options for the clients.

MAKING REFERRALS

What about the colleague who asks another colleague for a suggestion for a specialized type of consultant? One does not usually think of responding as potentially ethically problematic, but things can become knotty (Kaplan, 2005). The person asking for the referral has the right to expect the best recommendation available, regardless of any financial interests that might accrue to the colleague being asked for names.

Case 12.11: When Jack Switch, Ph.D., and Timmy Trade, M.D., see clients who they do not want to work with for whatever reason, they routinely refer to the each other as their first course of action.

This swapping arrangement may work well enough for the two therapists, but the needs of the clients are absent from this equation. Giving and taking on referrals should be made thoughtfully, taking the needs and resources of the client as the first priority. Cases presented in this chapter illustrate inappropriate referrals with respect to fee-splitting arrangements.

This is not to say that therapists should never make referrals to colleagues with whom they are very familiar or have close working relationships.

Case 12–12: Eugene Defer, Psy.D., works in a group practice with several other mental health professionals. He conducts an intake interview with a new female client in her mid-30s who requests a female therapist. Two women work with Dr. Defer in the group practice. He describes both women in terms of age and special clinical interests, suggesting that the client might choose to have an appointment with one of them.

Case 12–13: A client calls Ronda Refer, Ph.D., to help locate a therapist to evaluate a family member in a distant state. Dr. Refer does not know anyone in that geographic area but consults a professional directory to provide the client with the names and

addresses of some appropriately licensed practitioners in that general vicinity.

Both of the therapists described have behaved in an ethically appropriate manner. Dr. Defer has no specific financial interest in his referral to another member of the same practice group. While he may derive some diffuse benefit by keeping the client within the group, the client did, after all, approach that group in the first place. Defer has also shown himself responsive to the client's stated preference for a female therapist and has presented some additional data regarding options within the group, giving the client an additional measure of informed choice.

Dr. Refer is not familiar with anyone in the distant geographical area and knows relatively little about the client's specific needs. By using a professional directory to locate licensed or board-certified therapists, she reasonably ensures at least minimal confidence in the practitioners' competence. One must presume that the practitioners receiving such a referral will have the ethical sensitivity to make additional local referrals should the client need services they are not equipped to offer. Dr. Refer, however, should offer appropriate caveats to her client, such as, "Please tell your cousin that I do not know these practitioners personally; however, they are listed as fully licensed." Whenever a therapist does not feel comfortable making such a referral, the inquirer might then be directed to a community agency.

Alas, despite good and pure intentions, a referral can go askance, as the next case reveals.

Case 12–14: A counselor in Maine called Dr. Assist, a friend in California, requesting a referral for a client moving to the Los Angeles area. Dr. Assist asked a few questions about the client's situation and suggested Dr. Mismatch, an acquaintance with a good reputation in the community. The client acted on the referral and was very displeased with Dr. Mismatch. The counselor in Maine contacted Dr. Assist to complain that the former client had called to express anger toward her for passing on a faulty suggestion; in the client's words, Mismatch was "a dreadful therapist." The counselor in Maine also seemed irritated with Dr. Assist, implying that Dr. Assist's referral was ill-conceived.

Dr. Assist did her best and cannot be faulted despite the feelings of the faraway colleague and her client. To help allay the potential for fallout when referrals do not pan out, therapists should always remember to convey what may be too obvious at the time: Even when the referral is personally known, professional services turn on personal rapport. No one can guarantee that a professional relationship will work out satisfactorily. Because part of any therapist's reputation and professional responsibility are carried in any referral made, appropriate caveats should be offered as thoughtfully as the referral itself (Leigh, 1998; Shapiro & Ginzberg, 2003).

Behnke (2006) presented a poignant case involving a client who asked his therapist for a referral for his wife. The therapist referred the client's wife to his spouse, who used a different last name, without disclosing the relationship between the two of them. On learning the connection, the client was outraged, hurt, and clearly harmed, obsessing over what the two therapists discussed over the kitchen table. Disclosing the nature of a close relationship between therapists is usually essential, thus allowing the client the opportunity to decline.

Finally, hundreds of sites offer mental health referral services to consumers in every state, and Google or other search engines pull them up in less than a second. However, as we surfed for various types of services, we noticed that some so-called referral sites primarily funnel potential clients to individual therapists' private practices. When using the Internet to help someone with a referral we advise focusing on sites run by legitimate professional or state mental health associations. (More about referring clients can be found at the beginning of this chapter.)

THIRD-PARTY RELATIONSHIPS

Clients typically pay for mental health services in one of three ways:

1. Directly out of pocket with no reimbursement.
2. In whole or in part by a health insurance plan, health maintenance organization

(HMO), or preferred provider organization (PPO) plan.

3. Some other employee assistance benefit plan or public funds (e.g., through a school system, Medicare, or Medicaid).

Whenever some company, agency, or organization other than the therapist and client becomes involved in payment, we have a fiscal third-party relationship. There is no doubt that these third parties, their reimbursement policies, and the regulations that govern these policies have historically had a direct and powerful influence on practice and client care (Bachman, Pincus, Houtsinger, & Untzer, 2006; Gittelman, 1998; Harrison, Moran, Albrecht, Fitzpatrick, & Scrimshaw, 2000; Sperling, Sack, & Field, 2000; Sturm, 2004; Weisgerber, 1999). Although some well-established therapists refuse to accept third-party payments (Bennett & Lazarus, 2005), it is unrealistic for most mental health clinicians to expect that they will be able to earn a living without substantial interactions with third-party payment entities. Although many therapists will have no difficulties in their relationships with these entities, few will consider them an unmitigated blessing.

In historical context, insurance coverage for mental health services has attracted a range of interesting critiques. Some asserted that including psychotherapy benefits in health insurance coverage represented inequitable service to different income groups (Albee, 1977a, 1977b). Others raised threats to clients' confidentiality (Alleman, 2001; Austad, Hunter, & Morgan, 1998); concern about accountability and review criteria grew (Acuff et al., 1999; Alleman, 2001; Austad et al., 1998; Bersoff, 2003); and some even cited expensive litigation as a disincentive to coverage (Kiesler & Pallak, 1980). Access to such coverage has also led to many intra- and interprofessional squabbles about who ought to qualify to bill third parties for what services. We discuss professional competence in Chapter 2 and confidentiality problems in Chapter 6, so we now defer to a discussion of what we deem chiefly *political* issues in insurance reimbursement in favor of a focus

on the ethical problems such third-party relationships raise. Next, the topics of so-called accountable care organizations (ACOs), FOC options, and billing for services not covered are discussed as a lead in to a major discussion of fraud and the managed care organizations (MCOs).

Looking Toward Accountable Care Organizations

Beginning in the 1960s, federal health care policy in the United States focused on engaging medical care providers with a fee-for-service system. This has often incentivized the delivery of volume-focused services by independent clinicians who do not necessarily communicate well with each other. Providers are generally paid to deliver services with no particular assessment of outcome or quality. Thus, a depressed patient with obesity, heart disease, and type 2 diabetes may have a psychotherapist, a cardiologist, an endocrinologist, and a primary care physician who seldom (if ever) interact. The consequences can often yield suboptimal outcomes when the patient's depression treatment is impeded following advice on treatment of their other chronic conditions. Efforts are increasingly under way to realign reimbursement policy and financial incentives to increase patient-centered out-of-hospital care focused on quality outcomes through so-called ACOs (Franx, Dixon, Wensing, & Pincus, 2013; Maust, Oslin, & Marcus, 2013; Munjal & Carr, 2013).

Health insurers, led by the federal Medicare program, have begun to move toward increased integration, and health care systems have bought many medical practices. Mental health clinicians will increasingly have roles to play in this rapidly evolving system, but doing so will require sophistication and nimbleness with attention to primary care (Rozensky, 2014). This will include not only developing new competencies, but also keeping an ethical eye on emerging reimbursement schemes that may tend to limit patients' options with respect to choosing their providers and preferred modes of service. In the name of quality, we will likely

see some types of modified rationing or limitations placed on access to types of services and providers. Americans have access to insurance in many new ways, but the manner in which this access to coverage links to mental health service in the context of large ACOs will remain to be seen.

Freedom of Choice

The FOC issue refers to legislation and regulations that permit clients to choose their provider of services. As used in discussions of mental health services, FOC generally refers to whether the mental health professional is authorized to bill a third party directly for services rendered to a client or whether that therapist must first obtain the approval or referral of a physician or other gatekeeper. At least that was the historical battle. More recently, mental health benefits have come to be administered along with other specialty services so that a primary care physician (e.g., internist or pediatrician) must authorize a referral, whether to a mental health clinician, allergist, or proctologist. This practice is likely to increase with the advent of ACOs.

Psychologists pressed the FOC concept as a right of the client throughout the 1960s and 1970s, in an era when psychiatrists seemed in control of such matters. Psychologists argued that many of them had excellent qualifications to function as independent health service providers. Other arguments included the claim that the availability of psychologists improves consumer access to qualified care and increases competition among professional provider groups, with resulting cost benefits to consumers. Failure to recognize licensed psychologists as independent providers had been viewed by some as an unreasonable restraint of trade. As states granted licensing status to social workers, mental health counselors, and marriage and family counselors, these professions soon began to clamor for so-called direct recognition laws. Some authors have articulately addressed the unintended consequences of requiring a license to help (Crespi & Steir, 1997; Danish & Smyer, 1981; Hogan, 1977).

More recent developments of concern to mental health professionals involve limitations to access on closed provider panels and declining reimbursement rates as large numbers of clinicians alter the supply/demand characteristics of the mental health marketplace. MCOs frequently create a limited roster of clinicians approved to serve their policyholders. At times, categories of clinicians find themselves excluded or underrepresented on such panels. At other times, medical and mental health care providers have been abruptly dropped from the listing or denied entry for reasons that are unclear or seem unfair to one or another party. Access to membership on such provider panels remains a major professional concern, although not necessarily an ethical issue. Sometimes, however, clinicians find themselves ethically challenged when they fear that doing or recommending what is best for a client may compromise their provider status, as we discuss in a separate section.

Complaints may also come from specific providers or provider groups against their colleagues in kindred professions. When social workers, family counselors, psychiatric nurses, or unlicensed psychologists have sought entitlement to become independent vendors for third-party payments, they have generally cited the very same arguments advanced years earlier by psychologists (i.e., consumer's right to choose, lower fees based on increased competition, etc.). In general, the entitled clinician groups tend to oppose direct reimbursement of unentitled groups for a variety of economic and political reasons. Quality-of-care issues and cost containment are oft-cited reasons for limiting the size of the clinician pool to doctoral-level therapists. Others occasionally argue that these reasons are merely covers for the desire to reduce competition for a limited supply of clients or to avoid fee reductions. This may indeed present some moral or ethical issues, but assigning an ethical infraction to a specific individual in this context will prove difficult. One cannot usually identify specific individuals' malevolence or misconduct in contrast with their rights to free speech and attempts to influence the political process.

Such concerns seem best addressed as professional standards problems.

Billing for Services Not Covered

A common third-party problem with major ethical and legal implications relates to billing for services not covered under the third party's contractual obligations. Most third-party payers limit their health coverage to treatments for illness or health-related problems, usually defined in terms of medical necessity. One must invariably assign a diagnosis to the client to secure payment. Many services provided by mental health professionals are not, strictly speaking, health or mental health services. For example, relationship counseling, educational testing, school consultation, vocational guidance, child custody evaluations, executive coaching, and a whole variety of forensic functions may not be considered health services. As such, these would not normally be covered by health insurance.

Some insurance carriers also specify certain types of diagnostic or therapeutic procedures as uncovered services. Such treatments or services might be considered ancillary, experimental, unproven, or simply health promoting (e.g., weight control and smoking cessation in the absence of a medical diagnosis), but not treatment for a specific illness. Attempts to conceal the actual nature of the service rendered, or otherwise attempt to obtain compensation in the face of such restrictions, may constitute fraud. (In the first section of this chapter, we discussed the practice of billing clients for missed appointments. Because such billing results from services that have not been rendered, virtually no third-party payer will cover such charges.)

Exactly which services are covered under any given insurance policy is a matter of the specific contract language. Some therapists find themselves in the position of negotiating one fee if the client receives reimbursement by their insurer and a different fee if the service is not covered and the client must pay out of pocket. This practice can lead to client resentment and put the therapist in clear violation of certain contracts between providers and insurance companies. One strategy offered by some

therapists involves offering a reduced rate that represents a cash discount for clients who no longer use third-party coverage or declining to accept third-party payments entirely. A legally acceptable rationale would be passing on savings realized when the therapist no longer has to submit claims forms and case reports to the third party.

Case 12–15: Becky and Barney Bicker have been separated for 3 months and have filed for divorce. They are contesting for the custody of their two children. Their respective attorneys suggest a psychological consultation to prepare a forensic report for the courts on the best interests of the children. They are referred to Bill Lesser, Ph.D. Dr. Lesser assures the Bickers that their health insurance policy will cover his fee and proceeds with the evaluation. He subsequently files an insurance claim for his services without noting that it was conducted primarily for resolution of a custody dispute. He assigns the diagnosis “childhood adjustment reaction” to the Bicker children for billing purposes.

Case 12–16: Sven Gully, L.M.H.C., is trained in the use of hypnosis and relaxation techniques. He offers a smoking cessation program that regularly attracts clients. Potential clients often ask about costs and whether Gully will accept health insurance coverage for payment of his services. Gully knows that many companies will not cover hypnosis or will not pay for health-promoting programs in the absence of actual illness. He completes billing forms and lists his services simply as “psychotherapy” and assigns “adjustment reaction” diagnoses to his clients.

Case 12–17: Nomo Surance, M.D., has become well known as a psychopharmacologist and has placed strict limits on his practice. He only accepts patients who have ongoing psychotherapy relationships with licensed providers he trusts in the community and does not accept third-party payments. He will provide documented receipts that his clients can use to seek reimbursement but accepts payment only by cash, check, or credit card at the time of the appointments.

All of the clinicians described may be competent and caring professionals, but their business

practices may put them at odds with colleagues. Dr. Lesser and Mr. Gully have engaged in unethical conduct and flirted with fraud charges. Perhaps neither has carefully inquired of the third parties in question regarding whether the services are indeed covered and are simply trying to expedite claim processing. On the other hand, each should recognize that the specific services rendered in both cases may not qualify as mental health related or treatment of an illness. What appears expedient and helpful to the client (i.e., making services less expensive to the client in question) may constitute illegal practices and tend to increase insurance costs for other policyholders. The more appropriate behavior, when in doubt, would be to check with the third party for explicit advice and to inform clients accurately early in the relationship about whether their coverage applies. Drs. Lesser and Gully may believe that they have helped their clients, but they technically engaged in a “white-collar” ethical violation that costs all consumers money. If Dr. Lesser has concerns that health insurance will not cover his services and worries that the Bickers might squabble over paying for his time, he may reasonably consider requesting a retainer before initiating services.

Dr. Surance has set tight limits on his practice within a narrow scope of activity. He only provides medication for people who already see therapists in whom he has confidence, and he optimizes his income by not dealing with insurance companies or having to deal with billing and collection issues. Some might accuse him of being something less than a community-oriented citizen by limiting his practice in these ways. From his perspective, he’s making sure that he will have a minimum of clinical crises and economic headaches. Some people will not be able to obtain an appointment or afford his services, but he would say, “That’s not my problem.” One may not like this behavior, but it does not qualify as unethical.

MANAGED CARE

Managed care organizations take many forms. Some may be actual health care delivery

organizations, such as free-standing HMOs with their own physical facilities and employees serving as health care providers. Others may be networks of independent providers (so-called independent practice associations or IPA models). Still others may be HMOs that act as insurance companies and contract with a group of professionals organized as PPOs that agree to certain rules and reduced rates of reimbursement in exchange for patient referrals. Some large businesses and municipalities are self-insured. That is, these entities act as their own insurance company with the help of a program of claims and risk management, often run by an insurance company or MCO in exchange for a management fee.

In most models, the MCO manages a full spectrum of health care benefits. In other models, an insurance entity may “carve out” mental health benefits from overall health insurance packages and assign management of these particular benefits to an MCO organized chiefly as a benefits manager. A brief lesson on the micro-economics of health insurance, in the next section, can be useful in understanding the forces at work here.

The goal of the various MCOs is essentially the same: to control the increasing costs of health care. When health insurance is provided on an indemnity basis (i.e., costs of covered services are paid for or reimbursed up to policy limits regardless of the provider), few controls or incentives exist to limit spending. In such circumstances, economists would say that the moral hazards of insurance are not well controlled (Sloan & Hsieh, 2012).

The Moral Hazards of Insurance

Suppose we were to offer you “individual pregnancy insurance” at a very low price: complete coverage from prenatal care through delivery at a cost of \$1 per month or \$12 total per year per covered individual. Would you buy it? If your answer is, “Yes, where do I sign?” you are most likely a female or young couple considering becoming pregnant at some point within the span of coverage. If we decided that the policy would be available only to men, prepubertal

girls, and postmenopausal women, do you think we would have many buyers? Likewise, would you buy automobile insurance if you did not own a car or hold a driver’s license? These brief examples illustrate a basic moral hazard of insurance: Rational people are unlikely to buy it unless they think there is a chance they will need to use it (Hemenway, 1993; Sloan & Hsieh, 2012). If your chance of becoming pregnant is near zero, you are unlikely to buy the insurance regardless of how low the cost. Similarly, a rational person with no access to a motor vehicle is unlikely to purchase automobile insurance regardless of cost. Pregnancy insurance is indeed available, but it is bundled together in family-rate health insurance policies that take into account the fact that some members of some families will need the benefit, whereas others will not.

People who have insurance behave differently from people without it. This is another moral hazard that can be considered on an *ex ante* and *ex post* basis. The *ex ante* model refers to behavior prior to making an insurance claim. Simply stated, it means that people will be less careful in avoiding insured perils than they would without insurance coverage. Using the pregnancy model, a rational person who is capable of becoming pregnant will generally be less careful about contraception than she would be without any access to health insurance to cover pregnancy. In addition, an automobile owner whose insurance has expired might keep the car in the garage to avoid risk of damage until a new policy was in force.

The *ex post* model refers to behavior following the insured event. People with insurance will demand (i.e., consume) more and higher quality services than would an uninsured person. If your automobile’s fender is dented but the car is drivable and you are uninsured, you might choose to drive the damaged car rather than pay for the repair out of pocket. If fully insured, on the other hand, the rational person would most likely seek complete repair from the best body shop in town. If your health insurance provides full coverage, you will be likely to use more care available

to you rather than skipping some services to save money.

Insurance companies traditionally attempt to reduce the adverse effects of such moral hazards by devising ways to have policyholders share in the risk. Required deductibles, copayments, and variable coverage limits are examples of these strategies. Although the use of such techniques appears to be effective in the case of automobile and home owner's insurance, health insurance costs have not historically been well controlled in this manner. One reason is that health needs must often be dealt with as survival issues. One may choose not to rush to repair a dented fender or leaky roof or even to live with the damage rather than bear the expense of repair. Cost sharing reduces inappropriate utilization, but appropriate use is also reduced. However, it is not wise to postpone surgery for an inflamed appendix, ignore treatment for diabetes, or prematurely suspend cancer chemotherapy for economic reasons as the resulting harm may be irreparable later. In addition, our relationships with health care providers must be based on trust, confidence, and professionalism at a level of intimacy that is not usually expected from those we hire to patch a leak in our roof or fix a dented automobile fender.

It is in this context and amid demands from large group insurance purchasers (i.e., employers) that MCOs have evolved. In addition to policy limits, deductibles, and copayments, MCOs introduced case reviews, requirements for prior approval, and other steps intended to reduce unnecessary, redundant, or ineffective (but costly) medical care. By doing so, insurance plans can theoretically reduce the cost of coverage and thereby offer less-expensive benefit packages. In reality, the individual consumer has little impact on the system, and the large employers, major purchasers of coverage, often make decisions with bottom-line cost as the prime directive.

Paramount Ethical Dilemmas

The central ethical threat in managed care involves conflicting loyalties. Mental health professionals working under managed care

must balance the needs and best interests of their clients with an array of rewards, sanctions, and other inducements issued by the company. In its most common form, this conflict results in providing clinicians with financial incentives to alter or limit care. The limits on care proposed may prove efficient and appropriate and promote reasonable economies. On the other hand, limits curtail the freedom of both clients and service providers. In the worst circumstances, decisions that are adverse from a client's perspective may be orchestrated without the client's knowledge, input, or consent (Braun & Cox, 2005; Cohen, Marecek, & Gillham, 2006; Council on Ethical and Judicial Affairs, 1995; Inglehart, 1996; Kielbasa, Pomerantz, Krohn, & Sullivan, 2004; Mikalac, 2005; Moffic, 2004; Pomerantz & Segrist, 2006).

Sicker and Quicker

Many health and mental health clinicians have railed against MCOs, claiming that patients are turned out of hospitals "sicker and quicker" than in the past. Shore and Beigel (1996) noted that infringements on professional autonomy also have been a key point of antagonism between MCOs and service providers. The issue is an emotional one that often is not well understood by mental health clinicians. Karon (1995) observed that, although managed care programs are essentially vehicles intended to save money by eliminating unnecessary services, it is easier to save by simply cutting services. He worried that these are short-term approaches, with little interest in preventive mental health services. It is true that case review can potentially eliminate unnecessary psychiatric hospital admissions or psychotherapy in the same way second opinions can reduce unnecessary surgeries. However, review and decision making in the arena of mental health care are not often as clear-cut as problems in physical medicine (DeAngelis, 2006). Regulation of MCOs has become a significant public policy issue.

In this context, it is worthwhile to consider the case of *Wickline v. State of California* (1987).

Case 12–18: Ms. Wickline was a California Medicaid recipient who needed surgery for arteriosclerosis. When postsurgical complications arose, her physician requested an 8-day extension to the 10-day admission originally preauthorized. The reviewer authorized only a 4-day extension, and because the physician did not object and request additional time again, Ms. Wickline was discharged after a total hospitalization of only 14 days. She subsequently developed a blood clot that ultimately required amputation of her right leg. She sued, alleging that failure to grant the extra 4 days of hospital care requested caused her injuries. The trial court found the reviewer negligent and awarded \$500,000 in damages. On appeal, however, the decision was reversed on two bases. First, Ms. Wickline's physician had not protested the lack of a full 8-day extension. Second, the court concluded that the blood clot and resulting amputation would have occurred even if she had remained in the hospital.

This case is worth reviewing carefully because the court also went on to state that third-party payers could be held legally accountable if appeals made on behalf of the patient by the care provider were “arbitrarily ignored or unreasonably disregarded or overridden” (*Wickline v. State of California*, 1987, p. 1645). The message in this case is that third-party payers can be held liable for negligently designed or implemented cost-containment strategies. Mental health professionals should actively call that point to the attention of case managers when they believe an inappropriate and potentially harmful denial-of-service decision has been made.

In the case of *Muse v. Charter Hospital of Winston-Salem, Incorporated* (1995), a North Carolina appeals court held that a hospital was liable for punitive damages because of “wanton and willful” conduct. The hospital discharged a suicidal adolescent, against the advice of the treating physician, when the teenager’s insurance coverage expired. The severely depressed 16-year-old committed suicide a few days following the discharge.

A decade ago, a unanimous U.S. Supreme Court decision blocked lawsuits in state

courts for wrongful denial of coverage against employer-sponsored health plans (*Aetna Health Inc. v. Davila*, 2004). In that case, two beneficiaries of health care plans covered by the Employee Retirement Income Security Act (ERISA) of 1974 brought separate Texas state court suits, claiming that HMOs administering their employer’s plans had wrongly refused to cover certain medical services in violation of a Texas health care statute, and that those refusals had caused damages. Two justices noted that Congress and the Supreme Court ought to revisit what they regarded as an unjust and increasingly tangled set of ERISA rulings. However, the decision voided statutes in 10 states that expressly allowed such suits (i.e., in state courts). For clinicians and hospitals, the main result of managed care’s renewed immunity may translate to higher liability risk. Caregivers who prescribe treatment but do not provide it because health plans deny coverage may be forced to bear the full cost of liability if something goes wrong (Bloche, 2004). Although the *Aetna* case did not involve mental health issues, it may well apply to such cases. Therapists who encounter such third-party refusals should file a written protest with the company and provide a copy to their clients. Doing so demonstrates advocacy for one’s clients and calls your advocacy to the clients’ attention.

Becoming a Provider and Staying on the Panel: Between a Rock and a Hard Place

The MCOs have many bases for not admitting applicant providers to their service pools. They may already have enough therapists in a limited area or the denied applicants may have an ethics complaint, licensing board action, or major malpractice claim on their records.

In most cases, clinicians not admitted to or dropped from MCO provider panels have no clear grounds to appeal. As a result, many providers fear that if they “rock the boat” by raising active objections to decisions they believe are adverse to their clients or by speaking out against MCO policies, they may be terminated from the provider panel. Some MCO contracting strategies do little to reassure providers.

Case 12-19: On June 1, Psychotron Mental Services (PMS) mailed renewal contracts to thousands of clinicians in three states and caused major symptoms of professional distress. Most recipients received the mailing on June 7 and were told that renewal contracts must be returned no later than June 15. The lengthy contracts included a “hold-harmless” clause and a “gag rule.” Some providers, fearing economic losses, rushed to sign and return the contracts without seeking legal advice or raising objection.

So-called hold-harmless clauses specify that the clinician will not hold the MCO responsible for actions it may take that may result in harm to the therapist as a result of decisions they make regarding services to a client. For example, if the MCO denies a request to authorize psychotherapy services and the therapist continues treating the client without coverage to avoid abandonment, that therapist would be barred from recovering damages from the MCO. As another example, suppose the MCO denies services, and as a result, the client must end treatment and later commits suicide. The client’s family may then file a wrongful death lawsuit against the psychotherapist with or without the MCO as a codefendant. Hold-harmless clauses may be legally invalid as being against public policy. Nevertheless, therapists should refuse to sign such contractual conditions from the outset.

So-called no disparagement or gag rule provisions prohibit the provider from making “critical, adverse, or negative” statements about the MCO to clients or in any public forum. Such policies make sense in traditional business practices, such as in employee termination agreements. However, such agreements are out of place when applied to health care. Aside from the blatant abrogation of clinicians’ rights to free speech, such a rule might be deemed a limit on client advocacy and an attempt at intimidation. Such restrictions can interfere with the therapist’s ethical obligation to provide patients with information about benefits, risks, and costs of various interventions. Nonetheless, many clinicians who received the Psychotron rapid renewal contracts felt they had little

choice but to sign, especially in the face of the time deadline. Fortunately, many states have now banned such contract provisions outright.

Some MCOs have been highly aggressive and heavy handed in contract offers. Among the problems reported in contracts offered to providers by MCOs are clauses stating that the provider will be solely responsible in any legal actions undertaken by any party; take no legal action against the MCO under any circumstances; deal exclusively with the MCO; agree to abide by all of the MCO’s utilization review processes and decisions; agree not to bill clients for noncovered services without advance written consent; agree not to bill clients for covered services except for copayment and deductibles; agree to provide services when benefits are exhausted; and even agree to abide by future contract provisions that the therapist has not yet seen. Although many such provisions are unenforceable, no sane person would want to become the “test case.”

Signing a contract with provisions of this sort does a disservice to clients and service providers alike. In particular, agreeing to such clauses may void coverage in related cases by the therapists’ professional liability insurance and may compromise their ability to defend themselves in the case of a suit. It also represents an effort to shift unreasonable responsibility for MCO actions to the shoulders of unwitting or coerced providers. When you receive such a contract, have it reviewed by an attorney familiar with mental health practice. Often, state professional associations will be able to suggest such lawyers or refer you to clinicians in your locale familiar with that MCO’s contracts. If you are pressed to sign a contract in haste, be wary.

Practical Considerations

Some illustrative examples may help in understanding the nature of the struggles health and mental health professionals must increasingly address on a daily basis.

Case 12-20: Ralph Downter feels significantly depressed. His child died of leukemia a few

months ago, he is experiencing tension in his marriage, and he has just learned that the company he works for is headed for a "major downsizing." Based on a careful intake evaluation, Opti Mum, Psy.D., has formulated a plan for individual and couples therapy over the next few weeks. Dr. Mum knows that antidepressant medication may also be useful, but he first wants to gauge the client's response to treatment without seeking a medication consult. When Mum contacts the case manager overseeing Mr. Downer's benefits, Mum is thanked for his assessment and is told to refer the client to a specific psychiatrist for a medication consultation. The manager explains that it is company policy to try treatment with generic antidepressant medication before authorizing any verbal psychotherapy because "a lot of patients get better with just a little medicine."

Case 12-21: Polly Substance, age 13, was brought to the office of Over Thinkin, M.S.W. Her mother was concerned that Polly had been caught smoking pot at school. Her father has a history of problems with alcohol and has allegedly been physically threatening to his wife. Polly also has a history of learning disabilities and depression. Ms. Thinkin recommended family therapy at least once per week to begin addressing the multiple problems in the family. Comprehensive Regional Associated Programs (CRAP, corporate motto: "You're not sick until we say you're sick"), the managed care entity overseeing the family's benefits, will allow only four visits each for the mother and child during a 3-month period and insists on putting both on antidepressant drugs.

In both of these cases, the therapist's best clinical planning has been brushed aside by case managers with another agenda, presumably formulated by management with the intent of reducing costs. The preference of some managed care companies to prescribe medication instead of therapy is well documented (Protos, 1996), and most often these medications will be prescribed by an internist, pediatrician, or nurse practitioner rather than a psychiatrist (Koocher, 2007). In both cases, the ideal ethical conduct of the therapist would be similar. First, firmly but respectfully explain the reasons for the recommended treatment plan.

Cite supportive research and other factual data whenever possible. If the case manager does not agree, respectfully ask about the appeals process or to speak with a supervisor. Again, make the case in a thoughtful, rational manner, stressing the potential adverse consequences of not following it (e.g., failure to address the significant family relationship problems will undermine the chances for permanent change and may result in need for hospitalization or more extensive and costly interventions later). If there is still no favorable resolution, therapists should meet with their clients and present both their recommendations and the response of the benefits management company. Clients should also be told of their own recourse (e.g., complaints directly to the management company, complaints to their employer, or contacts with regulatory agencies) if they wish to pursue such options. The three ethical principles involved are holding the best interests of the client paramount, advocating for the client in a professional manner, and involving the client in the decision-making process.

Having stated the "ideal," it is important to recognize the constraints many psychotherapists feel. It is not unrealistic to fear that getting a reputation as a therapist who persistently appeals decisions or encourages clients to do so may result in a "no-cause termination." That is, the MCO may exercise a standard contract option to drop a provider without giving a specific reason. In addition, when a company is self-insured, employees may feel reluctant to pursue legitimate benefits assertively out of fear of retaliation, even when this fear is unjustified. As noted, some MCOs occasionally attempt to secure contractual provisions intended to prevent clinicians from speaking critically of company practices or advocating too vigorously for clients. There are also significant financial pressures.

Case 12-22: Tom Swift, Psy.D., was successful in doing focal short-term therapy. Pleased with his work, Giant Health Organization (GHO) sent him many referrals. A few months later, in a letter to all of its providers, GHO informed Dr. Swift that it planned to narrow its provider pool to those who

could provide up to 30 hours of service per week. Soon, GHO subscribers became the major portion of Dr. Swift's practice. Then, GHO began to offer special incentives, including cash bonuses at the end of each calendar quarter, for meeting a certain quota of cases "successfully terminated in fewer than eight sessions."

In this example, Dr. Swift has become the victim of an insidious seduction paradigm. He has become increasingly dependent on GHO as a source of income and is then propositioned with a bonus plan that places corporate profit goals ahead of client welfare. Even if Dr. Swift is a therapist of the highest ethical integrity, he will be sorely tempted by the new plan. One must also wonder how vigorous an advocate he might be for a client who needed more services or wished to appeal a GHO decision. After all, Dr. Swift could be obliquely threatened with a no-cause termination. We do not wish to infer that all or even the majority of MCOs would engage in such conduct; however, we do advise our colleagues to be prepared and forewarned of such strategies and the resulting risks.

Current health care trends suggest that mental health professionals may soon face a different kind of pressure and hospitals buy up medical practices and move toward formation of ACOs (Banham, 2013; Gottlieb, 2013). When therapists become employees of health care systems that focus on cost savings, they may face specific protocols for treating types of clients, reducing or eliminating the exercise of professional judgment and patient preferences.

Two common worrisome ethical questions raised by therapists who practice in MCOs are: If I go along with a managed care philosophy that only provides coverage for medication and short-term therapy, can my client charge me with incorrect or inappropriate treatment? If the company decides that the treatment I am providing is not medically necessary because it can stop providing payment with little notice and my client is unwilling to pay out of pocket, would I find myself at risk for abandonment charges?

The answer to both questions has a similar focus: professional responsibility, competence,

and planning. Under no circumstances should a therapist allow his or her care of a client to be dictated by a third-party payer. If an MCO dictates a "one-size-fits-all" (or even "one-size-fits-most") formula for psychotherapy, a therapist who agrees to that policy is headed for trouble. The policy implies that treatment is framed independent of a careful diagnostic assessment or plan matched to the client's needs. The nature of the treatment contract (see Chapter 3) highlights the importance of helping the client to understand and agree to the treatment plan and costs from the outset of the professional relationship. This includes helping clients to find out what mental health coverage their insurance provides, and that may include recognition that out-of-pocket costs are likely at some point.

One can certainly advocate for a client whose need for services is questioned, and it is easiest to do this when clear, competent treatment plans and records are produced. If a third party refuses payment and a client cannot or does not wish to pay out of pocket, the therapist should attempt a resolution consistent with the client's needs (e.g., offering a reduced fee or making a referral to an agency offering more affordable fees). There is no obligation to continue treating such clients indefinitely, although some reasonable interim coverage should be provided. No client should ever be abandoned in the middle of a crisis situation.

There are indeed some benefits to society in managed care. These include reductions in the cost of services and insurance, lessening the so-called moral hazards of insurance (from the insurance company perspective) and putting new pressures on clinicians to think carefully regarding all aspects of their treatment planning. None of these potential benefits is hidden. At the same time, there are great risks inherent in a system of health care delivery that potentially provides systematic incentives to withhold care (as in the case of capitation models, in which a set fee is paid to cover all the mental health needs of a set number of insured people regardless of how much service is provided) or raises unreasonable barriers to reasonable care.

Ironically, managed care and capitation models introduce a new kind of moral hazard by creating an incentive to provide less service.

Who actually saves money under managed care? Both nonprofit and for-profit MCOs exist. According to a survey commissioned by Blue Cross Blue Shield of America (BCBSA) in 2001, on average, 85.7% of commercial premiums for all health plans went to pay medical claims, while 11.6% went to administrative costs and 2.7% went to profits (Gale Group, 2003). Some mental health professionals believe that the for-profit MCO data are quite different. For example, a former president of the American Psychiatric Association has asserted that some MCOs take 40% to 70% of the health care dollar for overhead, profit, and huge chief executive officer and other executive salaries, leaving the actual amounts spent on direct care for the mentally ill in the range of 2% to 4% of the health care dollar (Eist, 1998).

Some disputes against for-profit MCOs have led the APA and its state affiliates to seek remedies in the courts. Litigation against Humana in Florida, alleging conspiracy to reduce, delay, and deny provider payments, led to a \$3.5 million settlement ("Eligible Psychologists," 2006). In a settlement with Cigna, more than 4,000 psychologists received nearly \$2.2 million ("Psychologists Receive," 2005). Such litigation may chasten MCOs to behave more appropriately, but only time will tell.

KEY ETHICAL PROBLEMS INVOLVING THIRD-PARTY PAYERS

Managed care evolved as a function of changes in the economic realities of the health care marketplace. At the same time, managed care raises a number of stressful concerns for mental health professionals and consumers (Kremer & Gesten, 2003); these concerns range from "autonomy" (i.e., infringements on the tradition of a professional's independent judgment) to "zeal" (i.e., the energy with which some care managers have attempted to cut costs). Managed care came about in response to dramatically escalating costs of health care

services, lack of meaningful economic controls on prices, demand by employers who contract for employee health insurance, and legislators who oversee payment under state and federal insurance plans. Not all of the concerns about managed care are ethical issues in the sense that they directly compromise one's ability to conform to professional ethics codes. Similarly, not all MCOs are sinister or malevolent. Many do a good job of controlling costs with reasonable peer review. When buying health care services, employers and subscribers must recognize that you get what you paid for. A low-cost plan will have more limited coverage and possibly less-professional management when it comes to case review decision making. In the end, the quality of services provided is dependent on the competence and integrity of the service providers. One should, however, always pay attention to the key ethical problems listed in Box 12-1.

FRAUD

As a legal concept, *fraud* refers to an act of intentional deception that results in harm or injury to another. There are four basic elements to a fraudulent act:

- One party makes representations to another, either knowing the claims are false or ignorant of their truth. This may be done by misrepresentation, deception, concealment, or simply nondisclosure of some key fact.
- The misrepresenter's intent is that another will rely on the false representation.
- The recipient of the information is unaware of the intended deception.
- The recipient of the information is justified in relying on or expecting the truth from the communicator.

The resulting injury may include financial, physical, or emotional harm. A variety of unethical acts might be considered fraudulent, including deception in some research paradigms or educational settings, lies about one's training or qualifications, or some types of promotional advertising (see Chapters 11 and 16).

Box 12–1 Ethical Challenges to Monitor When Dealing With Managed Care Entities

- With primary emphasis on cost containment, the needs of specific clients may be compromised. Providers may find themselves placed in conflicting roles when they try to offer what the client needs versus what is covered.
- Increasingly, providers (as individuals or groups) may feel pressure by third-party payers to agree to capitation schemes. Under such plans, clear financial incentives exist to reduce the amount of care provided, somewhat akin to the agricultural practice of paying some farmers to let land lie fallow. Such schemes will ultimately erode patients' trust, even when clinicians are justified in saying "no" to requests for incremental services.
- The reduction in clients' free choice under managed care is significant. Clients may be forced to accept a provider from a particular pool, requiring them to work with someone who has a previously negotiated arrangement with the MCO to which the patient was not a party.
- The same closed provider pools may lead to the creation of panels that are short on diversity (e.g., do not adequately include therapists skilled in working with ethnic minorities, people with sensory impairments, etc.).
- Confidentiality concerns are potentiated because of demands for detailed case data by MCO reviewers (see Chapter 6).
- Restrictive covenants, such as gag rules and hold-harmless clauses, can have far-reaching liability consequences for clinicians.

In this chapter, however, we focus on fraud as a financial matter. The next several cases all highlight one particular aspect of the problem in the sense that the "victim" is a third-party corporate payer, not a person as more often occurs in scam situations. Because the fraud frequently takes place in paper transactions or electronically, some offenders tend to wrongly regard themselves as less-than-serious violators.

Case 12–23: Carla Dingle, M.D., was indicted for fraud by a grand jury and asked to answer for her conduct to an ethics panel. She explained that she consulted at a private proprietary hospital on a fee-for-service basis by which part of each charge went to her and part to the hospital for administrative costs. To "simplify" the billing process, Dr. Dingle signed several dozen blank claim forms and left them and an e-signature for the billing office secretary to complete. She simply had not noticed that insurance companies were paying her for services not rendered. She claimed that hospital administrators must have improperly billed for extra appointments to inflate their income.

Case 12–24: Ernest Churchman, Ph.D., worked as a consulting psychologist for a nursing home run by a religious group. He offered his services free to the facility as an act of religious devotion and submitted bills for his services to a government agency, turning over all monies collected to the home. He was indicted for fraud when an audit disclosed that he had been paid for several thousand dollars' worth of services not rendered. Churchman had simply added two to five extra visits to the billing for each of the cognitively impaired clients he was asked to evaluate. He was apologetic when confronted, but noted that the home was in need of funds, and the money did not come out of the pocket of any patients, all of whom had government-sponsored insurance plans.

Case 12–25: Rhett E. McCarty, Ph.D., pled guilty in a federal court to scheming to defraud Medicare and Medicaid. Over a period of several years, Dr. McCarty received over a million dollars for sessions that never took place. He claimed he saw 19 clients every day except for Christmas, although the clients later claimed they consulted him once a week. In one case, McCarty received \$101,712 in payments for a client with whom he

had only a single session. He was sentenced to 3 years in prison without probation (United States Department of Justice, 2012).

Neither Dr. Dingle's poor judgment nor Dr. Churchman's well-intentioned diversion of federal funds is ethically defensible. Dingle should not have provided signed blank forms or an electronic signature password and remains fully responsible for any acts she delegated to others. Her carelessness and failure to monitor or review her accounts raises serious questions about her competence and awareness of professional practices. Dr. Churchman was clearly guilty of defrauding the government despite his perceived harmless intentions and rationalized sense of economic necessity. Perhaps neither seems as culpable as the greedy individual who deliberately swindles an anxious or depressed senior citizen out of his or her life savings, but the financial impact of fraud on third-party payers, taxpayers, and those who underwrite their services is substantial. Dr. McCarty on the other hand, seems simply a bold or stupid crook.

It is wise to retain duplicate copies or electronic records of all insurance claims completed. Such a practice will go far to prevent problems that result from alterations made on the forms after they leave the therapists' hands. In some cases, clients have been known to inflate listed charges, especially when insurance company procedures require the client (rather than the clinician) to turn in claim forms, and the insurer reimburses the client directly.

Most third parties insist on signing a contract with providers before agreeing to pay for their services. Blue Shield is an example of such a provider in many states. In the typical contract, a provider agrees to accept the company's usual and customary payment as specified in the contract in full satisfaction for the service rendered to the subscriber or client. The provider also promises not to charge a policyholder more for any given service than would be charged to another client. In other words, the provider agrees to accept set fees determined by the company and agrees not to treat policyholders differently from nonpolicyholders. In this way, the company attempts to provide good,

inexpensive coverage while preventing its policyholders from being overcharged or treated in a discriminatory manner. Ideally, the therapist gains access to a client population, timely payment for services, and the ability to treat covered clients at less expense to them.

Despite prior agreements between clinicians and MCOs, contractual violations occasionally form the basis of complaints. Intentionally violating contractual obligations generally constitutes illegal and unethical conduct. Three typical types of such contractual violations include the practices of ignoring the copayment, balance billing, and attempting to "boost your profile," as illustrated in the following cases.

Case 12-26: Some insurance coverage provides that the client must pay a small set portion of the mental health professional's fee, known as a copayment. Nell Sweetheart, M.S.W., often does not bother to collect \$10 copayments from her clients. She believes she is doing them a favor and that "no one will mind." She does not realize that she may be accused of fraud.

Dr. Sweetheart's failure to make a reasonable effort to collect the copayments has the net effect of misrepresenting her fee to the insurer. Assume, for example, that she bills the third party \$90 for a session and is paid \$80 on the assumption that she will collect \$10 from the client as a copayment. If she does not make a good faith effort to collect the \$10, she has effectively lowered her fee to \$80 while continuing to tell the insurer that it is \$90. This practice might be interpreted as fraudulent misrepresentation. Dr. Sweetheart may choose not to press collection of the fee against indigent patients for whom this is a hardship, but she must be prepared to demonstrate that she made good faith efforts to collect it.

Case 12-27: Sam More, Ph.D., is treating a client whose Blue Mace/Blue Helmet health insurance policy provides payment for outpatient psychotherapy. His usual charge is \$120 per hour, but his contract obliges him to accept an \$80 payment from the company as full compensation for each session. Dr. Moore bills his client for the \$40 net

balance between the Blue Mace/Blue Helmet payment and his usual fee for each session, even though his contract prohibits this practice.

Mr. More's behavior constitutes "balance billing," a clear contract violation and thus an unethical act. Some clinicians have been known to attempt to get around this issue by sending a bill marked "optional" or by telling the client, "You don't have to pay the difference, but I want you to know some of my clients do so voluntarily." Such pressure may constitute a subtle contract violation per se and does seem an abuse of the therapist's relative power position with respect to the client.

Case 12-28: I. B. Hire, L.M.H.C., knows that he will only be paid \$70 per session by Blue Mace/Blue Helmet, and he abides by his obligation not to balance bill or otherwise subvert the client's coverage. He also knows that no matter what fee he lists on the insurance claim form, \$70, \$90, or \$150, he will still be paid only \$70 rather than the \$90 per hour he usually charges clients who pay out of pocket. Hire also knows that, according to his contract, future increases in reimbursement by the company are based on his "billing profile," his usual charges filled in on claim forms for similar services. He knows that his future rates will be linked to this profile. As a result, he reports his usual hourly rate as \$150 per hour on all the claim forms, reasoning that he will eventually get a more fair rate than if he lets the company know his usual fee is actually only \$90.

Hire's behavior presents a more subtle form of contract violation. In some ways, it is actually fraud because he deliberately lies to the company in hopes of some future gain. Mr. Hire would probably rationalize that he is hurting no one because he will never bill the client more than his usual \$90 when coverage is exhausted. He is, however, lying to the company and violating his agreement to provide them with honest data.

If Dr. More and Mr. Hire do not like the insurance contract offered by the company, they have the option not to sign it. They might lose out on some income or clients because they do

not belong to the company's network, but professional disagreements over fee contracts do not lend themselves to individualized attempts at remedies as described previously. The acts of Moore and Hire are both illegal and unethical given the contracts they agreed to sign.

BILL COLLECTING

Fee disputes frequently lead to legal complaints against mental health clinicians (Knapp & VandeCreek, 2012; Knapp, Younggren, VandeCreek, Harris, & Martin, 2013; Woody, 1988, 2000), and this is also true in instances of client-initiated ethical complaints. The creditor and debtor relationships are just as much a part of the therapist-client relationship as in most other purchases of service. Inevitably, some clients will fall behind in paying for services or fail to pay for them at all. Because of the nature of clients' reasons for consulting mental health professionals and the nature of the relationships we establish, however, we have some special obligations to consider in formulating debt collection strategies.

When a client remains in active treatment while incurring a debt, the matter should be dealt with frankly, including a discussion of the impact of the debt on treatment. In most cases, however, the problems that arise occur after formal service delivery has terminated.

Case 12-29: Cindy Late complained to an ethics committee that her former therapist, Lucy Tort, Ph.D., had taken her to small claims court for over \$400 in unpaid bills. Ms. Late reported that she had been emotionally stressed and publicly embarrassed by having to appear in court to acknowledge in public that she had been treated by a psychologist. Dr. Tort advised the committee that Ms. Late had not responded to her bills or offers to work out an extended payment plan, noting that no confidential information was released; the court was only informed that Ms. Late had been a client and owed the money for services rendered.

Some therapists have argued that disclosure of client status to the court violates a client's

right to confidentiality unless specific informed consent is first obtained (Faustman, 1982). While that is an ethically considerate and conservative view, it probably is not unethical to initiate small claims actions in instances such as Dr. Tort's situation. An unpaid bill constitutes a broken contract between the client and therapist. The ethical standards of professional organizations recognize that such a breach of confidentiality to "obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose" (APA 02: 4.05b.4; ACA: A.10.d, B.2.e; NASW: 1.07j). Even such minimal disclosure might prove distressing to some clients because the court action is public and may even be reported in the community newspaper. Ideally, one should give the client ample notice that court action is being considered before it is actually initiated and include this as a limitation on confidentiality in the HIPAA notice given all clients (see Chapter 6).

Collection agencies represent quite a different matter from the small claims court, however, because the collection agent acts as an agent of the clinician. This mechanism of resolving a debt is more private than using a small claims court but has its own intrinsic hazards.

Case 12-30: Lucy Luckless, M.S.W., hired the Wee Willy Gettum Collection Agency for help with collecting a debt of nearly \$1,000 in unpaid therapy bills. Employees of the agency called the client at his place of employment and at home late in the evening and in the early morning hours. The agents shouted and called the client a deadbeat and cheat. They threatened to call the client's employer and to tack interest fees onto the bill. These tactics violated state and federal laws. The client complained successfully to both the local consumer protection authorities and to the social work licensing board.

In such instances, the therapist retains responsibility for the behavior of the collector and would need to execute a HIPAA business associate confidentiality agreement with the collector. While most states regulate the nature

and frequency of contacts by collection agencies, the mental health professional retains a degree of responsibility for any improper, abusive, invasive, or otherwise noxious collection activities initiated in their name. Debt collection practices may also trigger client complaints (see Chapter 13).

Psychotherapists stand in a unique position to cause clients emotional pain and should never take advantage of their professional status or power relationship to collect a debt. While "ethics" does not constitute an excuse to deprive therapists of their legal rights, we should use caution in exercising those rights vis-à-vis clients.

Case 12-31: Sara Caustic, L.M.F.T., was annoyed with Noah Vale, who had terminated treatment and left a bill unpaid for several months. Dr. Caustic continued to bill Mr. Vale monthly and began adding handwritten notes to the statements, such as, "Don't hold me responsible for the resentment you have toward your mother."

In this instance, Ms. Caustic inappropriately expressed her anger through the pointed use of sensitive material gained in her professional capacity. While it would not necessarily be inappropriate to give a client factual warning that some collection agency or court action might follow if a bill remains unpaid, threats of this sort are unprofessional and not often effective. If emotional damage results from collection practices, a malpractice suit may follow. In this sense, a therapist may have an obligation to assess the clinical risks associated with different debt collection strategies. As in any situation for which therapists employ other people to work in their practices, a degree of vicarious liability exists with bill collection activities. Debt collection should be businesslike and totally void of any psychological or clinical content.

Another way in which a psychotherapist may occasionally attempt to abuse a professional relationship to collect a debt involves the withholding of information.

Case 12-32: Noah Vale was so distraught by the notes from Ms. Caustic (Case 12-31) that he sought

treatment again, but from a new therapist. He signed a release of information, and the new therapist contacted Ms. Caustic to obtain data on the prior treatment. Caustic told the new therapist that she would not discuss the case or provide copies of any reports she had prepared until Mr. Vale paid his bill.

In this situation, Ms. Caustic continues to exercise her professional leverage irresponsibly. If she were asked to undertake new work on behalf of Mr. Vale, she certainly would have the right to decline. On the other hand, she may not ethically withhold materials already prepared or refuse to communicate with a colleague about a vulnerable client solely because of her own financial dispute with the client. In this instance, she is actually potentiating the harm to the client and compounding her own unethical and illegal behavior. Failure to release records under these circumstances may qualify as a violation of HIPAA and some state medical record access laws.

Therapists seeking to avoid such problems should routinely discuss any payment issues with clients as they arise. In addition, we should take care that legitimate efforts to collect fees never compromise our professional obligations to clients.

WHAT TO DO

- Inform clients about fees, billing, collection practices, and other financial contingencies as a routine part of initiating the professional relationship, ideally in written form. Repeat this information later in the relationship as necessary.
- Carefully consider the client's overall ability to afford services early in the relationship and help the client to make a plan for obtaining services that will be both clinically appropriate and financially feasible. Encouraging clients to incur significant debt is not psychotherapeutic. In that regard, therapists should be aware of referral sources in the community.
- Consider performing some services at little or no fee as a pro bono service to the public as a routine part of your practice.

WHAT TO WATCH FOR

- Pay careful attention to all contractual obligations, understand them, and abide by them. Similarly, therapists should not sign contracts with stipulations that might subsequently place them in ethical jeopardy.
- In dealing with MCOs, mental health providers should adhere to the same standards of competence, professionalism, and integrity as in other contexts. Heightened sensitivity should focus on the potential ethical problems inherent in such service delivery systems in which profit may trump client welfare.
- In all debt collection situations, therapists must remain aware of the laws that apply in their jurisdiction and make every effort to behave in a cautious, businesslike fashion. They must avoid using their special position or information gained through their professional role to collect debts from clients.

WHAT NOT TO DO

- Avoid relationships involving kickbacks, fee splitting, or payment of commissions for client referrals as they may be illegal and unethical.
- Do not allow any misrepresentation of financial transactions executed in your name by an employee or agent you have authorized (including billing and collection agents). Choose your employees and representatives with care and supervise them closely.
- Third-party payers may put pressures on therapists to meet their needs in ways that do not necessarily hold the rights of individual clients paramount. In such instances, ethical clinicians will act in the best interests of their clients.

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13

Mental Health Practitioners in the Legal System *Tort and Retort*

Whatever their other contributions to our society,
lawyers could be an important source of protein.

Dick Guindon, cartoonist

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Mental health and social behavioral science professionals have increasingly found themselves involved with the legal system as experts, defendants, and plaintiffs. Forensic clinicians play important roles as expert witnesses or consultants for many different types of legal matters. The specialization of conducting forensic mental health assessments (FMHAs) has incorporated important scientific and ethical advances during the last few decades (Allan & Grisso, 2014), leading to increased demand for such services. At the same time, unwary mental health practitioners who stumble unprepared

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into forensic contexts have increasingly found themselves at risk for lawsuits or licensing board and ethics complaints (Knapp, Younggren, VandeCreek, Harris, & Martin, 2013).

The professional and scientific literature on forensic behavioral science and mental health has also grown dramatically over the past few decades, including numerous books, handbooks, and a growing number of scholarly journals, such as the *Journal of Forensic Psychiatry*, *Journal of Forensic Social Work*, *Law and Human Behavior*, and *Psychology, Public Policy, and Law*. The legal arena also

serves as a model of an especially challenging work setting, as described in Chapters 14 and 15, replete with ethical dilemmas for clinicians, as illustrated in the *Specialty Guidelines for Forensic Psychology* (American Psychological Association [APA], 2013; Heilbrun, DeMatteo, Marczyk, & Goldstein, 2008). The reasons for this phenomenon are many, but include the evolving nature of mental health practice, the increasing acceptance and utilization of behavioral science data in legal proceedings, and the heightened accountability to which mental health professionals are held when clients believe they have suffered damages as the result of therapists' behavior.

The evolution of behavioral science and practice in forensic roles links directly to the increasing popularity of forensic mental health as a specialty (Allan & Grisso, 2014; Appelbaum, 2014; Drogin & Barrett, 2007; Weiner & Hess, 2006; Wettstein, 2002). Clinicians have recognized that forensic services do not fall under the same constraints managed care has imposed on health care services. In addition, research on topics such as competency assessment, child custody outcomes, dangerousness prediction, jury selection, and other areas have had a direct impact on the utility and acceptance of psychological testimony. Sometimes, researchers are surprised to find their published work cited inaccurately in court without their knowledge. With regard to mental health clinicians as defendants, survey research and case reports have proven useful in documenting the damages that some clients suffer due to professional negligence. As a result, the ability of aggrieved clients to seek compensation through legal proceedings has shifted accordingly in the direction of increased litigation.

We do not address the role of the mental health professionals as plaintiffs in this volume. Except for special considerations when a therapist sues a client for nonpayment of professional fees, addressed in Chapter 12, mental health practitioners have no different standing than any other profession when bringing suit against another person. This chapter focuses

instead on the role of the evaluator, therapist, or behavioral scientist as an expert witness and the issues confronting such experts as defendants in legal actions. Both circumstances can evoke considerable anxiety for similar reasons. In either instance, the consequences of the mental health professional's behavior can have great significance in people's lives. In addition, the legal system, its procedures, culture, and officiaidom differ considerably from the culture of mental health professionals. The ethical codes of mental health professionals and lawyers also differ greatly in focus and content, resulting in frequent misunderstandings.

THE CULTURE GAP BETWEEN MENTAL HEALTH PROFESSIONALS AND LAWYERS

Several key differences exist in training and culture between mental health professionals and lawyers that contribute to confusion between the two professions. Our traditional training as behavioral scientists and clinicians teaches us to believe that an individual who applies rigorous experimental methods can discover significant truths within ranges of statistical certainty. We seldom give simple dichotomous answers to questions, preferring to use probabilities, ranges, norms, and continua that reflect the complexity of individual differences. Lawyers train as advocates, taught to believe that the search for truth is best conducted in a vigorous adversarial cross-examination of the facts. They learn that seeking truth requires the "trying" or weighing of the facts on the scales of justice, and that clear, precise, and unambiguous decisions must be the end result. A criminal defendant must be found guilty or innocent. A civil defendant is either liable or not liable for damages. When damages are assessed, a specific dollar value is determined, even for such complex concepts as the value of a human life. The law seeks black-and-white answers to resolve disputes and reject the shades of gray that behavioral scientists relish. One cannot simultaneously act as a dispassionate scientist seeking to explain behavior in objective terms

as well as a partisan advocate seeking to win the day for one's client.

Mental health clinicians and behavioral scientists must be especially wary when treading into the legal system as they are about to enter philosophically alien territory. They will experience frequent opportunities and enticements to compromise their scientific integrity, overlook their ethical obligations, or otherwise put themselves at risk. Consider the following case examples:

Case 13–1: Wellin Tentioned, M.D., is recruited to serve as an expert witness by Prima Facie, attorney-at-law. Ms. Facie is representing a client injured in an automobile accident. She hopes that Dr. Tentioned's research on the effects of alcohol ingestion on reaction time will bolster her client's lawsuit. Facie will portray her injured client in the most sympathetic light possible, pay Dr. Tentioned an hourly rate far in excess of his usual hourly psychotherapy rate, and press him hard to state his findings in the way that most strongly supports her case.

Case 13–2: Carl Cathexis, Psy.D., treated Phineas Bluster in psychoanalysis five times per week for nearly 2 years. Dr. Cathexis offered Mr. Bluster a clinical interpretation and was taken aback by the rageful transference reaction it precipitated. Bluster stormed out of the office saying, "You'll hear from my lawyer; I'm going to sue." Bluster did not return for further sessions. A few weeks later, Dr. Cathexis received a letter from an attorney representing Mr. Bluster, accompanied by a release form asking for copies of all case records. Dr. Cathexis jots a note to himself, "Telephone Bluster and suggest he stop this acting out and return to treatment so that we can work through the transference."

In each of these cases, the clinician stands in a highly vulnerable position with a significant chance of slipping into ethical quicksand because of inexperience with the legal system. Dr. Tentioned risks becoming an unwitting partisan in attorney Facie's advocacy plan. If Tentioned agrees to consult as an expert witness, he must stand ready to assert and maintain

his scholarly and professional integrity. He can certainly feel empathy for the client and accept reasonable compensation for his professional time but cannot allow his professional judgment to be swayed by cajoling, sympathy, or monetary considerations. Dr. Cathexis risks allowing his potentially valid theoretical conceptualization of Mr. Bluster's behavior to cloud his judgment in what has clearly become a legal matter, regardless of whether Cathexis chooses to recognize it as such. His planned phone call will almost certainly exacerbate the situation and put him at still greater legal risk.

Many sources of potential curricula guidance for forensic mental health practice exist (e.g., APA, 2013; Bartol & Bartol, 2006; Bucky, Callan, & Stricker, 2005; Heilbrun et al., 2008; Krauss & Sales, 2006; Sparta & Koocher, 2006). Most agree that mental health professionals interested in forensic work should study topical introductions (e.g., philosophical issues, legal terminology, relevant case law, application of psychological skills to legal problems, and ethical issues); take seminars in practice specialties (e.g., criminal law, civil law, child juvenile law); and obtain initial experience in supervised practice. The key principle to keep in mind: When venturing into the legal arena, whether by choice or chance, specialized training or expert guidance is an *absolute* necessity. When in doubt, consult a skilled attorney who will represent only your interests.

THE FORENSIC EXPERT

As previously noted, the logic of jurisprudence assumes that truth may best be revealed when two parties confront each other with passionate debate on the merits of their respective cases. In contrast, the rules of science assume that a single party or same-side team employing rigorous scientific methods can test and eliminate erroneous conclusions (Anderten, Staulcup, & Grisso, 1980). Anderten and her colleagues also noted that the law requires us to base decisions on available evidence regardless of residual ambiguities. Science, and psychology in particular, does not require that all problems

investigated reach clear conclusions. Scientists must endure ambiguity with nearly infinite patience to avoid conclusions based on inadequate data. These differences highlight key sources of potential ethical conflicts.

Foote and Shuman (2006) noted that litigants may arrive for mental health evaluation along at least three different routes. First, some are sent by their lawyers seeking an assessment of their mental or emotional state relevant to a potential claim or defense (e.g., an evaluation relative to a potential insanity defense). Second, some litigants may come for evaluation under a court order (e.g., to assess the defendant's competence to stand trial or offer guidance in child custody cases). Third, the parties may agree to have a litigant evaluated in the absence of a court order (e.g., in many civil and criminal cases, the parties understand that the opposing side has a right to an evaluation conducted by their own experts and informally agree to do so). In some cases, the evaluation may have aspects that feel coercive to the person under evaluation. In every case, the litigant's approach to participation in the evaluation has important legal as well as psychological consequences and should follow full information regarding all conditions and options (Allan & Grisso, 2014; Connell, 2006; Foote & Shuman, 2006; Knapp et al., 2013).

Unlike so-called percipient witnesses who testify about what they personally perceived (e.g., saw, heard, touched, smelled, or tasted), expert witnesses may give opinions to the court. Experts help the trier of fact (i.e., judge or jury) reach an opinion by providing specialized information not available to the layperson. Experts may report on specialized examinations they conduct, critique or interpret data provided by others, and respond to hypothetical situations or fact patterns proposed by lawyers. In this context, the word *expert* constitutes a legal term established under rules of evidence, not a psychological or medical term. Expert status is conferred by a judge's ruling after review of information on the training, education, and voir dire examination of the witness. Based on the old French term meaning to "speak the truth," the voir dire involves preliminary questioning of the expert

under oath to establish qualifications. The legal system uses breadth, depth, and duration of experience and education as part of qualifying or credentialing an expert witness. Judges and juries expect expert witnesses to act as unbiased educators who help them understand technical information necessary for their deliberations, despite the fact that one side pays for the service (Ackerman, 1995; APA, 2013). Clinicians must remain aware, however, that clinical experience alone does not ensure the accuracy of diagnostic judgments in the absence of data and the ability to apply it (Faust, 2011d; Garb, 1989, 2005; Garb, Boyle, Lilienfeld, Lynn, & Lohr, 2003; Skeem, Douglas, & Lilienfeld, 2009).

In addition to the differences in perspectives between mental health professionals and lawyers described, the courtroom setting can prove a disarmingly seductive place where an expert witness can too easily forget about professional rigor. Imagine a setting in which you are asked to play a role in assessing truth and justice, both central values of American society. Surrounded by the trappings of power (e.g., official buildings, flags, robed judges, and uniformed court officers), you stand at center stage in the witness box, acknowledged as an expert in the eyes of the court, and carefully questioned about your opinions (a luxury not extended to lay witnesses). All of those present hang on your every word, and a stenographer dutifully records it all for posterity.

You are asked about weighty matters, and the fate of others may well turn on what you have to say. Will the temptation to provide crisp answers and have your advice followed cause you to forget, even for a moment, the scientific underpinnings and caveats that necessarily accompany psychological "facts"? How can therapists or behavioral scientists most fairly and ethically apply their skills in the courtroom and other legal contexts? Should the expert act as a dispassionate educator about behavioral science or a fully partisan collaborator on the advocacy team? The questions are clearly rhetorical, but the ethical dilemmas remain serious. The trappings of expertise cannot be allowed to cloud the judgment or analytical ability of the mental health professional. Rather, they should remain

highly sobering and signal to the would-be expert a need for thoughtful, cautious, nondefensive, and scientifically rigorous testimony.

Specialty Guidelines for Forensic Practitioners

The American Psychology–Law Society, also known as Division 41 of the APA, developed several iterations of practice guidelines that ultimately led to the *Specialty Guidelines for Forensic Psychology* (APA, 2013). The National Organization of Forensic Social Work has also issued a special *Code of Ethics* (2011), the American Academy of Psychiatry and the Law has also published *Ethics Guidelines for the Practice of Forensic Psychiatry* (2005). The American Counseling Association (ACA) addresses such issues in its ethics code in Sections E.1.a and E.13, while the American Association for Marriage and Family Therapy (AAMFT) does so briefly in several parts of Section 7 of its ethics code. In reading these materials, it soon becomes clear that the nature of psycholegal work is exceptionally complicated when it comes to matters such as maintaining confidentiality and the rights of the client, avoidance of multiple-role conflicts, the requirement to remain objective in adversarial settings, appropriate structuring of fee agreements, and the need to be familiar with many aspects of law and the legal system, just to name a few. Elements of the various guidelines crop up throughout this chapter; however, some aspects that bear on the differences between mental health professionals and lawyers deserve special mention here.

Contingent fee agreements provide a useful example of a practice commonly used by lawyers, but very inappropriate for expert witnesses in forensic contexts. Lawyers will frequently take on cases in which the client pays a small percentage of the legal fees and agrees that the lawyer will be entitled to a percentage of any financial award if the case is won. Because the lawyer functions as an advocate for the client, such a contingency appropriately provides an incentive to vigorously pursue an outcome favoring the client. However, when a mental

health professional offers expert testimony on which a judge or jury trying the facts of the case will rely, agreeing to a fee based on the trial outcome is ethically inappropriate.

Case 13–3: Slimy Grubber, Ph.D., was approached by an attorney representing Eben Fired in an employment discrimination case against Large Multinational Corporation (LMC). LMC has alleged that Mr. Fired had serious personality problems that compromised his work and led to his termination. The attorney believes Mr. Fired's assertion that he was inappropriately fired from his job at LMC for discriminatory reasons and tells Dr. Grubber that he anticipates a good chance of winning triple punitive damages to yield a financial award of \$1.5 million or more. Mr. Fired's attorney would like Grubber to evaluate his client with an eye toward rebutting LMC's assertions. Unfortunately, Fired is unemployed and has no money to pay for evaluation service. The attorney offers Grubber 2% of the ultimate financial settlement in exchange for his services.

If Dr. Grubber agrees to these terms, he would be engaging in significant ethical misconduct. To begin, Dr. Grubber would essentially have agreed to support the plaintiff's position before ever evaluating Mr. Fired. In addition, Dr. Grubber would have a significant incentive to cast Mr. Fired in a favorable light regardless of the actual facts of the case or psychological data. Even if Dr. Grubber had the ability to ignore his potential gain and testify objectively, his testimony would have the appearance of conflicting interests and could easily be discredited under cross-examination in court once the contingency arrangement became known.

Role conflicts also constitute a significant issue for forensic mental health professionals. In many situations, invitations to switch roles from therapist to an evaluator (or vice versa) will present themselves. The demands of conducting an ethical, objective, expert evaluation often conflict with those required to function as an effective therapist. It may be possible to shift from one role to another under some circumstances, with the full informed consent of the

client, but such changes should be undertaken only with extreme caution.

Case 13–4: Dahlia Discord, M.S.W., has been treating Melissa Malfunction for anxiety and mild depression in the aftermath of an automobile accident. Ms. Malfunction has been out of work for 3 months and receives disability insurance payments. The insurer has scheduled her for a disability case review, and Ms. Malfunction has asked Ms. Discord to complete a disability evaluation form and possibly testify as an expert in support of her claim before an administrative law judge. Ms. Discord would like to support her psychotherapy client but is not certain that she can objectively support Ms. Malfunction's claim that she is totally unable to work at any job for emotional reasons.

Psychotherapists are often asked to write letters of various sorts in support of their clients but must take care not to compromise their professional integrity. Ms. Discord should not allow herself to be manipulated into making a recommendation or evaluative statement that she cannot, in good conscience, support. At the same time, she does not want to disrupt the rapport with her client. One possible solution would involve advising Ms. Malfunction that, although she cares deeply about her welfare, Ms. Discord cannot take on the role of an independent evaluator to determine disability. Ms. Discord could also agree to write a letter, with the client's consent, documenting her work with Ms. Malfunction, the symptoms reported by the client, her diagnostic impressions, an estimate of the level of symptom severity, and other treatment information. However, the letter should include only accurate information and should avoid commenting specifically on Ms. Malfunction's ability to work or qualification for disability. Those recommendations should be left to other mental health experts who do not have preexisting or ongoing therapeutic relationships with her.

Case 13–5: Ben and Bettina Bombast felt so angry toward each other about their impending divorce that they could not seem to agree about anything. They certainly could not imagine agreeing on

custody plans for their children, Barney and Bella. When Hugh Kidder, Psy.D., a psychotherapist in independent practice with extensive experience in child custody matters, was appointed to provide family mediation services through the court clinic, they reluctantly agreed to try. The Bombasts were amazed by Dr. Kidder's ability to establish rapport with each of them and with the children. He refocused the parents on the children's needs, and they ultimately agreed on a joint custody plan without judicial intervention. Dr. Kidder issued a report to the court in support of their joint decision. A few weeks after the divorce became final, the Bombasts both contacted Dr. Kidder at his private office. Barney was having some school adjustment problems, and both parents agreed that they would like Dr. Kidder to evaluate and counsel him. They expressed considerable mutual confidence in Dr. Kidder because of their previous experience with him.

Assuming that Dr. Kidder's arrangement with the court clinic does not preclude working with former court-referred clients in this way, the Bombasts's request may be a reasonable one. However, Dr. Kidder would first have to carefully consider and discuss with the Bombasts the nature of this role transition. Once he agrees to become the therapist for one member of the divorced family, he could not reasonably resume a mediator or evaluator role should the Bombasts again begin to bicker. His primary obligation would have become refocused on the best interests of their child. Assuming that all agree and that no other roadblocks exist, Dr. Kidder could ethically proceed in his new role.

Training Issues

Standard graduate degree programs in psychology, medicine, social work, or counseling do not adequately prepare graduates for participation in the forensic arena. Most mental health professionals and behavioral scientists lack familiarity with the adversary system and with legal terms and concepts, such as levels of proof, competence to stand trial, criminal responsibility, or legal definitions of insanity.

Well-trained mental health clinicians often confuse psychological concepts (e.g., psychosis) with legal ones (e.g., insanity). Even when the assessment expert or therapist understands the legal concepts and questions asked by the court, usual graduate training in psychodiagnostic assessment or psychotherapy will often prove of little help in answering them (Bartol & Bartol, 2006; Drogin & Barrett, 2007; Knapp & VandeCreek, 2001; Lewis, 2004; Neighbors, Green-Faust, & Beyer, 2002; Poythress, 1979; Schouten, 2001). Few of the standard instruments used in psychological test batteries have, for example, content or construct validity that bear on competence issues or the prediction of dangerousness (Archer, 2006; Faust, 2011d; Weiner & Hess, 2006; Weisner, 2006).

Case 13–6: Hasty O'Pinion, Ph.D., was approached by an attorney to do a pretrial evaluation of his client, who had been charged with assault and battery. O'Pinion administered the WAIS-IV (Wechsler Adult Intelligence Scale-IV), Thematic Apperception Test, Rorschach inkblots, Minnesota Multiphasic Personality Inventory 2 (MMPI-2), and the House-Tree-Person (HTP) drawing. When testifying on the witness stand, Dr. O'Pinion was asked about the defendant's propensity to commit violent acts against others and about his criminal responsibility at the time of the alleged assault. Although O'Pinion had no information regarding the defendant's history (which was devoid of violent acts) and was unfamiliar with the concept of criminal responsibility, he testified that the defendant had a diagnosis of schizophrenia and was therefore clearly both dangerous and not responsible.

Dr. O'Pinion not only misunderstood the legal concepts in question, but also was not in a position to address the questions on the basis of appropriate knowledge. He did not, for example, consider one of the most consistent predictors of dangerous behavior (i.e., prior dangerous behavior) and made the erroneous assumption that being schizophrenic per se absolves one of responsibility for one's acts and indicates dangerousness. In this case, the psychologist made the major mistake of falling back on an old and

successful assessment behavior (i.e., his standard clinical test battery) without recognizing his involvement in a special setting with unique requirements and complexities he was not qualified to address (APA, 2013; Archer, 2006; Archer, Buffington-Vollum, Stredny, & Handel, 2006; Faust, 2011d; Greene & Goldstein, 2007; Knapp & VandeCreek, 2001; Yufik, 2005; Zapf & Roesch, 2006). Dr. O'Pinion also overlooked other instruments specifically designed for use in the psychological assessment of dangerousness (Edens, Buffington-Vollum, Keilen, Roskamp, & Anthony, 2005; Krauss, Lieberman, Costanzo, Krauss, & Pezdek, 2007; Litwack, Zapf, Groscup, & Hart, 2006; Scott & Resnick, 2006; Werth, Welfel, & Benjamin, 2009). In his ignorance, O'Pinion may well have caused serious problems for his client.

The Quality of Expertise: Daubert Revisited

A key example of the importance of understanding the legal context and rules of evidence regarding acceptable testimony flows from the *Daubert* decision of the U.S. Supreme Court (*Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 1993; Youngstrom & Busch, 2000). The court held that experts may testify only within the scope of reasonable and accepted scientific knowledge. The *Daubert* decision identified four factors courts can use to assess validity when admitting scientific conclusions under the Federal Rules of Evidence (Faust, 2011a, 2011b; Petrosinelli, 2011): (a) falsifiability, (b) error rate, (c) peer review and publication, and (d) general acceptance. Using these standards, expert testimony on eyewitness identification would hold up well under scrutiny for scientific validity, whereas expert testimony regarding so-called repressed memories might not (Bruck, Ceci, & Hembroke, 2002; Dalenberg, 2006; Faust, 2011a, 2011b; Loftus & Davis, 2006; London, Bruck, Ceci, & Shuman, 2005). Research results should be used in an impartial manner in the face of adversarial pulls of attorneys. It is not unethical to disagree with other experts about applications of knowledge, but it is unethical to relinquish the role of a neutral expert in favor of highly selective gleaning of knowledge

(Sales & Shuman, 2005). Do not deny existing information that contradicts your conclusions. Instead, freely and without defensiveness acknowledge and discuss any such information, pointing out any shortcomings if appropriate.

The applicable case law clearly indicates a need for mental health professionals to understand basic research methods, even if they never plan to conduct research themselves. One can often easily find a basis to criticize a study on methodological grounds, and when practicing in forensic contexts, being a smart consumer of research is important. For example, understanding the differences between correlation and causation or knowing how to compare one sample population to another will significantly enhance the effectiveness of an expert witness.

A more basic question that is often debated among mental health experts and attorneys involves what kinds of mental health opinions, if any, have sufficient reliability and validity to warrant admissibility in court (Adshead, 2003; Bank & Packer, 2007; Bush, Connell, & Denney, 2006; Faust, 2011b, 2011c; Garb, 2005; Garb et al., 2003; Melton, Petrila, Poythress, & Slobogin, 1997; Sarkar & Adshead, 2003; Taylor & Buchanan, 1998). Beyond the question of whether courts should admit such opinions lies the issue of the limits that ethics must place on the expression of opinions. This becomes especially important when such experts are called to give “informed speculation” (Bonnie & Slobogin, 1980; Faust, 2011c; Golding, 1990; McCloskey, Egeth, & McKenna, 1986) on matters defined in law rather than behavioral science. For example, it is clearly unethical to provide a so-called ultimate issue opinion without also giving the caveat that such opinions constitute legal judgments and have no basis in behavioral science expertise. In a legal case, the term *ultimate issue* refers to the question before the trier of fact (i.e., the judge or the jury charged with weighing the evidence).

Case 13–7: Billy Bezerk was to stand trial for the axe murder of his family of four. His attorney was planning to use an insanity defense and hired Cruddy D. Cider, Psy.D., to conduct an expert psychological evaluation of criminal responsibility.

The evaluation revealed that Mr. Bezerk had a major thought disorder, poor impulse control, and considerable unmodulated anger and frequently expressed paranoid ideation. In particular, Mr. Bezerk’s auditory hallucinations had repeatedly warned him that alien beings had taken over the bodies of his family and were about to embark on the conquest of Earth. Dr. Cider cited all these findings and concluded his report with the statement that Mr. Bezerk was clearly insane at the time of the offense.

The ultimate issue of whether a defendant was “insane” at the time of an offense does not fall within the valid realm of a psychological question because the concept of insanity is defined by law rather than by behavioral science. A bit of history reveals the complexity of the issue. In 1843, Daniel M’Naghten, a Scottish wood turner, attempted to assassinate the prime minister of England while suffering from stark paranoid delusions and killed a different man instead. The court found him not guilty because he clearly did not understand the nature or wrongfulness of his act. Public outrage after his acquittal prompted the creation of a formal legal definition of insanity that became known as the M’Naghten rule. In the 1950s, Monte Durham was convicted of housebreaking in the District of Columbia, and his only defense at trial asserted Durham was that he was of unsound mind at the time of the offense (*Durham v. United States*, 1954). In that case, the U.S. Court of Appeals for the District of Columbia adopted a so-called product test under which legal insanity hinged on whether the person committed the criminal act because of a mental disease or defect. Considerable criticism followed because that standard gave mental health experts too much influence in a decision of insanity and not enough to jurors.

The next development, known as the Model Penal Code (MPC), published by the American Law Institute (ALI), provided a compromise standard for legal insanity, blending elements of the stricter M’Naghten rule and the more lenient Durham ruling. Under the MPC ALI standard, insanity defenses hinged on whether at the time of the

criminal conduct, as a result of mental disease or defect, the defendant lacked substantial capacity to appreciate the wrongfulness of the act or lacked the ability to behave in conformity with the requirements of the law. The MPC ALI standard enjoyed popularity until 1981, when John Hinckley was found not guilty by reason of insanity under those guidelines after attempting to assassinate President Ronald Reagan. Public outrage at Hinckley's acquittal led federal lawmakers to pass legislation reverting to the stricter M'Naghten standard. Some states attempted to abolish the insanity defense altogether by offering juries a verdict of "guilty, but mentally ill," which allowed sentencing of people to terms of years in psychiatric facilities. Today's standards for proving legal insanity vary widely from state to state, requiring those offering expert testimony to focus their opinions on the elements of the particular statutes in question.

Dr. Cider can appropriately describe the defendant's bizarre behavior, confirm his impulsivity and instability using test or interview data, explain how a lack of control might result, link these findings to the facts of the case, and provide other such expert commentary. Based on his knowledge of schizophrenia and his evaluation of Mr. Bezerk, Dr. Cider may also testify about the probability that the symptoms observed most likely affected the defendant's behavior on the day of the crime. However, the judge or jury must weigh the evidence and decide whether the information presented proves beyond a reasonable doubt that Mr. Bezerk met the legal definition of insanity. Too frequently, mental health professionals will neglect such caution in their testimony and may even find themselves encouraged to comment on ultimate issues by some attorneys and judges (Faust, 2011d; Melton et al., 1997; Sales & Shuman, 1993; Sales & Simon, 1993).

Sometimes, even experienced forensic mental health professionals have been caught making inappropriate assertions from the witness stand. Andrea Yates, the Texas woman convicted of drowning her children in a bathtub, was granted a new trial by an appeals court after

an expert witness for the prosecution gave false testimony.

Case 13-8: Andrea Yates confessed to the police in 2001 that she had drowned her five children, ages 6 months to 7 years. A Houston jury subsequently convicted her of murder the next year for three of the deaths, rejecting her insanity defense. The case reignited national debate about mental illness, postpartum depression, and the legal definition of insanity. The court overturned the initial conviction because of false testimony by Park Dietz, M.D., a psychiatrist who testified as the prosecution's only mental health expert. Dr. Dietz, who charged \$500 per hour (\$675 when adjusted for inflation to 2015), testified that Ms. Yates was psychotic at the time of the murders but knew right from wrong, meaning that she did not qualify as insane under the narrow legal definition in Texas. On cross-examination, Dr. Dietz was asked about his work as a consultant on *Law & Order*, a television program Ms. Yates was known to watch. Asked whether any of the episodes he had worked on concerned "postpartum depression or women's mental health," Dietz replied, "As a matter of fact," he answered, "There was a show of a woman with postpartum depression who drowned her children in the bathtub and was found insane, and it was aired shortly before the crime occurred" (Powell, 2005).

That statement by Dietz proved false. No such episode of the television show existed. The falsehood was discovered only after the jury convicted Ms. Yates. Dietz later claimed that he simply made an honest mistake (Powell, 2005). In this particular case, expensive and presumably high-quality expertise (see www.parkdietzassociates.com) proved significantly flawed. Dietz did notify the prosecution of his mistake and submitted a letter to the judge stipulating to his error after the fact. He had apparently confused a similar episode of *L.A. Law* with *Law & Order*.

The Use of Research Data

A number of papers by experimental psychologists triggered a historic debate on the extent

to which behavioral scientists called to testify as expert witnesses can ethically fall back on scientific research data (Loftus & Monahan, 1980; McCloskey et al., 1986; Tanke & Tanke, 1979). Since then, many others have weighed in on the issue (Connolly, Price, & Read, 2006; Faust, 2011d; Fiske, Bersoff, Borgida, Deaux, Heilman, & Stangor, 2000; Kovera & McAuliff, 2000; Krauss et al., 2007; Sales & Shuman, 2005; Shuman & Sales, 1998; Tolman & Mullendore, 2003; Weiss, 1999). Expert behavioral science testimony based on empirical data has been offered in cases that deal with jury size, eyewitness identification, prediction of dangerousness, adequacy of warning labels, and child custody, to name just a few topics. However, judges and juries are not always influenced by these presentations. Some interesting ethical questions have come up regarding the context in which such research is presented.

Are the findings valid and generalizable to the situation in question?

Are there legitimate differences in interpretation of the data, and if so, must the expert testifying present both sides?

How should such testimony deal with the probabilistic nature of some research findings?

What role should the expert's personal values play in the decision to testify or not in certain cases?

Case 13–9: Helena Scruples, Ph.D., has considerable knowledge regarding eyewitness identification. Her own research shows the frequent unreliability of such identifications. When asked to serve as an expert witness by the defense in a rape case, Dr. Scruples feels sympathetic to the female victim and knows that prosecution of alleged perpetrators is difficult. If she agrees to help the defense, she may reduce a guilty defendant's chance of conviction.

Case 13–10: Herman Beastly is accused of raping and murdering an adolescent babysitter. Evidence strongly indicates that he is guilty and may meet criteria for a death sentence based on a state law that permits capital punishment for criminals likely to commit repeated violent crimes of this

sort. John Qualm, M.D., considered an expert on the prediction of dangerousness, has published reports that highlight the difficulty in making such predictions reliably. He is asked to testify by the defense in the hope that his opinions may save Beastly from execution.

Both of these cases illustrate major clashes in personal value systems. Both Scruples and Qualm may feel repulsed by their client's behavior. At the same time, each defendant is entitled to a vigorous legal defense. Although the defendant has a right to present the relevant scientific data, any given mental health professional has no specific ethical duty to testify in such a case simply because he or she is asked to do so. The expert's beliefs, preferences, and personal values certainly enter into any decision about testifying (Cunningham, 2006; Mossman, 2011). In similar situations, Loftus reported reasoning that her testimony could help to prevent the conviction of an innocent person (Loftus & Monahan, 1980). Monahan reported testifying for the defense in a case similar to Dr. Qualm's because, although repulsed by the defendant, he felt morally opposed to the death penalty (Loftus & Monahan, 1980).

The extent to which an expert witness is obligated to present both sides when discussing psychological research or theory is also a complex matter. Several experts (Faust, 2011d; Rachlin, 1988; Rivlin, 1973; Wolfgang, 1974) have argued for the legitimacy of the expert scientist as an adversary. That is, they asserted that a balanced objective presentation of research or theory is not needed in expert testimony. Loftus and Monahan (1980) pointed out, on the other hand, that an oath to "tell the whole truth and nothing but the truth" is violated if the whole truth, as known to the witness, is not told. They noted also that opposing counsel may always ask the witness: "Do you know of any studies which show the opposite result?" (p. 279). We would not argue in favor of universal discussion of all possible interpretations of a data set, but we strongly agree with the assertion that the whole truth remains a necessity for the behavioral science expert acting as an expert witness.

Hypnosis in the Courtroom

Hypnosis has been widely used in forensic settings by psychotherapists and others (Schefflin, 2006) and presents an excellent prototypical example of how a technique widely used by clinicians can lead to special complications in forensic settings. Inappropriate applications of hypnotic techniques have occasionally led to significant compromise in the judicial process (Haber & Haber, 2000; Scoboria, Mazzoni, Kirsch, & Milling, 2002). An article published in *Science* (Kolata, 1980) nearly four decades ago summarized the problem succinctly: "Researchers fear misuse by police and warn that hypnotic state is no guarantor of truth" (p. 1443). While the intense concentration that characterizes hypnosis often enables individuals to recall events or details in striking fashion, many individuals may respond with embellishments to subtle suggestions of the examiners. Following a hypnotic session, some hypnotic subjects may "confabulate" or inject new elements into their reports of events. These confabulations may be based on conscious or unconscious motivations (Kolata, 1980).

Case 13–11: Theodore Trance, L.M.H.C., consulted with the police investigating a double homicide. He hypnotized and interrogated a woman who claimed to be an eyewitness to the murders but recalled little of what happened. During the hypnotic sessions, the woman emotionally recalled being forced by two male companions to shoot the two victims. Her testimony resulted in conviction of the two for murder. Subsequently, it became clear that the two were innocent, and that the woman had substantial motivation to wish them punished for reasons of her own.

It seems that Mr. Trance failed to investigate fully the background and motivation of the woman he was asked to hypnotize. At the time of the trial, there were also allegations that Mr. Trance may have conducted his questioning of the witness in a suggestive manner; however, recordings of his sessions with the woman had somehow been erased. No information was provided to the jury regarding the potential for

confabulation by individuals using hypnotic techniques to "enhance" memory for purposes of testimony.

As a result of cases such as this, many jurisdictions now prohibit information uncovered through hypnosis from being admitted as evidence at a trial. Mental health professionals have long recognized the fact that hypnosis interacts significantly with suggestibility, and Dr. Trance's role in applying it with few caveats and cautions raises serious ethical problems (Faust, 2011d; Knight, Meyer, & Goldstein, 2007; Schefflin, Weiner, & Hess, 2006).

Child Custody

Divorce may affect as many as 40% of children (Krauss & Sales, 2000) and 50% of first marriages (Wallerstein & Lewis, 2004), and parents agree on child custody and visitation 90% of the time (Melton et al., 1997), leaving no dispute for the court to decide. However, in the 10% of disputed cases, mental health professionals have increasingly become involved as *guardians ad litem*, evaluators, mediators, parenting coordinators, and psychotherapists (APA, 2010, 2012; Sparta & Koocher, 2006). Therapists may also find themselves unwittingly involved in such cases when the marriage of one of their clients (or child client's parents) begins to dissolve.

What should we consider the prime standards in child custody evaluation? Most mental health professionals have historically agreed that matters of child custody should focus on the best interests of the child. Occasionally, that seems their only point of agreement. Some writers on the "nature" side of the fence (Boszhormenyi-Nagy & Spark, 1973) have asserted that "family loyalty is . . . [based] . . . on biological hereditary kinship" (p. 42). Others, on the "nurture" side (Goldstein, Freud, & Solnit, 1979), argued that biological ties are far less important than psychological ones based on "a continuing, day-to-day basis . . . [which] . . . fulfills the child's psychological needs for a parent, as well as the child's physical needs" (p. 98). More recently, mental health experts have urged refocusing from the best interests of the child to a least detrimental alternative standard (Goldstein, Solnit, Goldstein,

& Freud, 1996; Krauss & Sales, 2000; Krauss, Sales, & White, 2001).

Common criticisms of mental health professionals' work in child custody cases have focused on competence, confidentiality, and role conflicts. Specifics include deficiencies in professional practice, inadequate familiarity with the legal system and applicable legal standards, inappropriate application of psychological assessment techniques, presentation of opinions based on partial or irrelevant data, overreaching by exceeding the limits of psychological knowledge of expert testimony, offering opinions on matters of law, loss of objectivity through inappropriate engagement in the adversary process, and failure to recognize the boundaries and parameters of confidentiality in the custody context (Anderer, 2011; Sparta & Koocher, 2006; Weithorn, 2006).

Predicting what will happen as a result of custody decisions remains a difficult challenge. Unfortunately, however, one can reliably predict that a contested custody situation will have an adverse effect on the children. Great stresses, both emotional and financial, apply, along with prolonged periods of uncertainty and instability in the lives of such children. Too often, the children become pawns in the legal struggle between sets of angry combatants for custody. Into this void rides (or are tossed) too many unwary would-be psychological Solomons ready to share their wisdom with the courts to resolve these agonizing cases, despite the fact that little research exists on which to support many opinions about custody (Anderer, 2011; Clingempeel & Reppucci, 1982; Clingempeel, Shuwall, & Heiss, 1988; Krauss et al., 2001; Melton et al., 1997; Sales & Shuman, 2005; Weithorn, 2006). Mental health professionals frequently agree to assist in performing child custody evaluations with little understanding of statutes that govern child custody, adversarial proceedings, data useful for making such decisions, or their own values and attitudes that might contribute to biased outcomes (Anderer, 2011; Krauss et al., 2001; Melton et al., 1997; Weithorn, 2006). In some cases, these custodial struggles actually

harm a child rather than attend to his or her best interests.

At times, however, testimony or participation by mental health experts, even short of actual courtroom appearances, can become highly relevant and constructive (Melton et al., 1997; Sales & Shuman, 2005). Ideally, the clinician should function as an advocate for the child or as a neutral expert, preferably appointed by the court to avoid being cast as the advocate of one contesting party or the other (Anderer, 2011; Weithorn, 2006). This will not always work, however, and at times full adversarial proceedings, with experts on both sides, result. We do not seek to provide a "how-to-do-it" manual here (see, e.g., Anderer, 2011; Connell, 2006; Melton et al., 1997; Oberlander, 1995) but rather to highlight some potential ethical problems that can arise and be detrimental to all concerned.

Case 13-12: Helen Tester, Ph.D., agreed to undertake a child custody evaluation. During the course of her assessment, she administered psychological tests, including the MMPI-2 and the Rorschach inkblots, to both parents. The mother, who was born outside the United States, had an elevated L-Scale score on the MMPI-2 and was "evasive" on the Rorschach inquiry. As a result, Dr. Tester concluded that she was a "highly defended pathological liar" and recommended against awarding her custody.

Dr. Tester made several serious errors. To begin, she seems to be basing her evaluation on two instruments never validated for predictive use in child custody work (i.e., the Rorschach and MMPI-2). Indeed, she seems to have misinterpreted the actual meaning of the L-Scale and interpreted one score out of context from the overall profile. Her reading of an MMPI-2 profile obtained from a foreign national, whose culture and language may differ from the standardization group, raises additional validity questions (DeJesus-Zayas, Buigas, & Denny, 2011). Dr. Tester's conclusion, based on two isolated test findings that have many alternative explanations, seems highly suspect. One wonders if Dr. Tester ever bothered to do critically

important interviews with the child or observe parent-child interactions.

Case 13–13: Jack Balance, M.D., undertook a child custody evaluation at the request of the attorney representing the child's father. The attorney advised Dr. Balance that both parents were interested in cooperating with the evaluation. Balance met with the father and the child for assessment purposes, but the mother subsequently declined to participate. At the trial, Dr. Balance testified only with respect to the child–father relationship, but the mother's attorney attempted to discredit him as an expert because he had not interviewed the child's mother.

Dr. Balance would have been better advised to confirm in advance the willingness of all parties to cooperate. He might have accomplished this through personal contact or by court order, if necessary. He certainly behaved ethically in commenting only on his actual contacts (i.e., the adequacy of the child–father relationship), while refraining from any comments about the parent who declined to participate. In addition, Dr. Balance had to pay special attention to note the limitations, based on incomplete data, of any recommendations he might make. The attempt to discredit his testimony is unfortunate, but he did not commit an ethical violation.

Case 13–14: Sam and Sylvia Splitter found themselves in the midst of a bitter divorce and child custody dispute. Each sought and identified a mental health professional willing to advocate on their behalf at the custody hearing. Both professionals testified in support of "their client" based on interviews with the one parent and children. Neither practitioner had sought contact with the other parent or with the other professional prior to the hearing, and each one's testimony dramatically contradicted the other's.

The Splitters have successfully "split" the clinicians they each hired and set up a so-called battle of the shrinks. Nothing does more to discredit the mental health professions in public than adversarial confrontations by experts

with incomplete pieces of the data. While the Splitters may have set up this situation, both mental health professionals were foolish to agree to participate. Under ideal circumstances, the professionals would have insisted on functioning as nonpartisan experts, demanded access to all appropriate data, and sought the right to interview the other spouse as a prerequisite for agreeing to do the evaluation. One cannot help but wonder whether their contradictory testimony grew out of information that their clients kept from them.

Case 13–15: Cynthia Oops, M.S.W., conducted a careful evaluation of both parents and two children involved in a custody dispute. One parent had recruited her, but the other had seemingly agreed to her participation. When Ms. Oops completed her report prior to the hearing, the parent who was not favored asserted her right of confidentiality and demanded that the report be kept out of court. Ms. Oops had not obtained a signed waiver from the parties.

Ms. Oops had the best of intentions, but she should have spelled out the parameters of her role from the outset (Connell, 2006). Her clients (i.e., the two parents and the children) should have been given a clear understanding of her obligations to each one of them, especially because their needs and wishes were mutually exclusive in some areas. In particular, she should have secured written waivers from all concerned to share her findings with the court. Now, the status of one claim of privilege is unclear and will have to be resolved by the judge. It is not possible to predict the outcome based on the information presented, but the problem was easily avoidable. A summary of the key elements one might wish to incorporate in a custody consent process appear in Box 13–1.

While the case of Ms. Oops seems a routine confidentiality problem, a slight variation yields a rather commonly noted problem of a more complex nature. Suppose that Dr. Oops had provided marriage counseling to both parents prior to their decision to divorce and subsequently found herself subpoenaed by one

Box 13–1 Elements of Notification in a Custody Evaluation

Provide a statement of adult parties' legal rights with respect to the anticipated assessment:

- Give a clear statement regarding the purpose of the evaluation.
- Identify the requesting entity. (Who asked for the evaluation?)
- Describe the nature of anticipated services. (What procedures will you follow?)
- Explain the methods to be utilized. (What instruments and techniques will you use?)
- Specify whether the services are court ordered.

Delineate the parameters of confidentiality:

- Will anything be confidential from the court, the parties, or the public?
- Who will have access to the data and report?
- How will access be provided?

Provide information regarding:

- The evaluator's credentials.
- The responsibilities of evaluator and the parties.
- The potential disposition of data.
- The evaluator's fees and related policies.
- What information will be provided to the child, and by whom. (What will the child be told regarding the assessment purpose, nature, and confidentiality limits as developmentally appropriate?)
- Any prior relationships between evaluator and parties.
- Any potential examiner biases (e.g., presumptions regarding joint custody).

Consent documentation:

- Obtain formal consent to disclose material learned during evaluation in litigation.
- Obtain a formal waiver of confidentiality from adult litigants or their legal representatives.
- Provide written documentation of consent.
- Obtain consent for recording, if applicable.

Source: Excerpted and adapted from "Notification of Purpose in Custody Evaluation: Informing Parties and Their Counsel" by M. Connell, 2006. *Professional Psychology*, 37, p. 448. doi:<http://dx.doi.org/10.1037/0735-7028.37.5.446>

to testify in a child custody dispute. In this situation, a legitimate duty of confidentiality to both parties might exist even if Oops believes that she has some basis on which to offer an opinion to the courts. Ideally, Ms. Oops should avoid such a role by discussing the potential problem early (if it appears a couple in treatment may divorce) or by suggesting that they obtain expert testimony from another mental

health professional who does not have a pre-existing relationship with them. All of these examples support the overarching premise that no substitute exists for specialized education and training, including acquiring appropriate sensitivity to special ethical issues inherent in forensic work (Bank & Packer, 2007; Benjamin & Gollan, 2003; Bucky et al., 2005; Ratner, 2002; Woody, 2000).

Conducting a Forensic Evaluation

In undertaking any sort of evaluation that is likely to come before the courts, a mental health expert should pay special attention to helping the person facing an evaluation understand the purpose of the activity and the people or agencies who will have access to the information (APA: 4.02; AAMFT: 2.1-3; ACA: B.2.d, C.6.b, E.13.b; National Association of Social Workers [NASW]: 1.07.j). Even when the evaluation is court ordered or paid for by a governmental agency, the mental health practitioner must recognize that the individual under evaluation also holds client status.

Consent and confidentiality issues must be treated differently from traditional mental health practice when forensic issues are involved. Before undertaking any forensic evaluation, interviewees must have appropriate notification that any of their statements or findings of the evaluation may become a part of public court records. The ethics codes of major mental health professions require that clients be notified of the limits of confidentiality from the outset of the professional relationship as well as whenever new circumstances warrant (APA 02: 4.02a, 4.02b; AAMFT: 2.1; ACA: B.2.d, C.6.b, E.13.b; NASW: 1.07.j). In a forensic evaluation, many layers of clients often exist (e.g., the court, the attorney, and the person under evaluation). Rather than assuring confidentiality, forensic evaluators must fully inform the people they interview when no privilege exists. These individuals should be cautioned to avoid saying anything that they prefer not be revealed. In many jurisdictions and circumstances, the written consent of the interviewee to such disclosures is not technically required because of the statutory wording or judicial orders. We recommend, however, that the practitioner always give notice of the limitations and seek evidence to confirm that the client understands this information. Ideally, this notice should be acknowledged by the client in writing or witnessed by an objective third party. In some criminal cases, expert testimony may be excluded from consideration if such notice was not given.

Case 13-16: Mr. Smith (yes, that was his actual name) was indicted for murder, and the prosecutor for the state of Texas announced that he would seek the death penalty. James P. Grigson, M.D., a psychiatrist who some later nicknamed "Dr. Death," was assigned to evaluate Smith's competence to stand trial. After a single 90-minute interview, Dr. Grigson determined that Smith was competent and so testified. Smith was tried and convicted. A separate penalty-phase proceeding was held for the jury to determine whether to impose the death penalty. One factor the jury had to consider was any propensity for Smith to commit similar acts again. Dr. Grigson was again called by the state to testify about any proclivity of Mr. Smith toward future violence. Based on the same 90-minute interview, Dr. Grigson opined that Smith would be a continuing danger to society. The jury sentenced Smith to death.

The facts summarized here are the essentials of *Estelle v. Smith* (1981), in which the Supreme Court overturned the death sentence. This case was fully discussed by Bersoff (2003), but the key issue can best be understood as one of consent. Mr. Smith was not advised that he had a right to remain mute when interviewed by Dr. Grigson, and Smith was not told that whatever he told Grigson might later be used in the death penalty phase of the case. The same principle applies to all forensic evaluations, both civil and criminal. The client has the right to know at the outset the full purpose of the evaluation and the parties who will have access to it. Even when an evaluation is not court ordered but may ultimately serve some forensic purpose, we recommend clarifying these issues. When conducting a child custody evaluation, for example, it is wise to obtain reciprocating waivers of confidentiality that cover all the contesting parties and their counsel. Many divorcing couples who seek consultation from a mental health professional on custody matters as they plan their custody agreement never intend to litigate the issue, but change their minds later (Coates, Deutsch, Starnes, Sullivan, & Sydlik, 2004; Koocher, 1999; Mahoney, 2006; Sales, Miller, & Hall, 2005; Weithorn, 2006).

Case 13–17: Bob and Harriet Splinter have decided to divorce and want to do what is best for their three young children. They seek therapeutic consultation with Connie Sensus, L.M.F.T., a family counselor in the community, about joint custody and visitation options. During their sessions together, Bob acknowledges that Harriet would be better as the custodial parent because he has a drinking problem and was involved in some unsavory delinquent conduct as a youth. They agree that the children will live with Harriet, and that Bob will have frequent visitation. Just before finalizing the full divorce agreement, Bob and Harriet have a falling out over financial issues, and Bob states his intent to seek sole custody of the children. Harriet wants to call Ms. Sensus as a witness and plans to use her testimony to get Bob's admitted character flaws on the record. Bob demands that Sensus keep confidential all that he told her.

One may not agree with either Bob's or Harriet's conduct, but Ms. Sensus's lack of forethought has created a problem. In some jurisdictions, any rights of confidentiality that Bob or Harriet might assert with respect to their own mental health records could potentially be set aside if deemed by a judge in the interests of the children. If Ms. Sensus had raised this issue at the outset and had obtained consensual waivers from Bob and Harriet, she would be free to testify about any elements of her work with the Splinters that is relevant to the court.

Record keeping and documentation are especially important in forensic cases. Practitioners should keep more precisely detailed records than might be necessary in more routine treatment or assessment work (Drogin & Barrett, 2007; Greenberg et al., 2007; Knapp & VandeCreek, 2006; Otto, Slobogin, & Greenberg, 2007; Reid, 2006). Detailed information of dates, times, durations of appointments, phone calls, sources of information, reviews of records, examination of corroborating information (e.g., police reports), and other points that lead to an opinion should be recorded and cited in any forensic reports. Vagueness may become a source of vulnerability on the witness stand (Barone, 2004; Brodsky, 2004). Some practitioners like to take prolific notes or make tentative observations

and consolidate them into structured notes or reports, but once a formal report or official case note is written, it should not be altered. One can always write and date an addendum or supplementary information to notes, but altering completed reports creates a reasonable aura of suspicion. For similar reasons, we recommend keeping only one set of records.

Case 13–18: Melba Meticulous, Psy.D., undertook a court-ordered child custody investigation for the Fragmento family. She conducted nearly 20 hours of interviews with the parties, the children, and collateral sources. Much of the information she gathered was relevant to the matters before the court, but some was extraneous (e.g., Mr. Fragmento wore a poor-quality hairpiece; Mrs. Fragmento's great aunt Tillie died 6 years ago, and her husband had the temerity to tell jokes at the wake; Mrs. Fragmento is at least 30 pounds overweight; and the maternal grandmother recently underwent a facelift). The extraneous data made their way into Dr. Meticulous's files as she did not know which bits would be relevant as she heard them. She will now complete her report, citing all relevant factors, and either will not cite or will discard all extraneous material.

The procedures employed by Dr. Meticulous are entirely appropriate. If material she gathers proves relevant, it should become a part of the case file and her report. If any of the data collected prove to be irrelevant, they should not become a part of the permanent file.

Preparation for deposition and trial are important obligations of the forensic practitioner. It is important for forensic specialists to ensure that their knowledge remains current in psychological conceptualization, assessment practices, ethical standards, and other relevant professional issues (Barone, 2004; Brodsky, 2004; Brodsky & Galloway, 2003; Faust, 2011d; Otto & Martindale, 2007). For example, if choosing to use psychological tests, one must be sure that the test is validated for the intended purpose (Borum & Grisso, 1995; Grisso & Vincent, 2005; Lipsitt & Goldstein, 2007; Otto et al., 2007). Surprisingly, few normative data for applying

many psychological tests to forensic assessment exist (Heilbrun, Marczyk, DeMatteo, Mack-Allen, & Goldstein, 2007), and some techniques commonly used by naïve evaluators in forensic assessment (e.g., anatomically detailed dolls used to interview alleged child sexual abuse victims) do not even qualify as psychological tests (Koocher et al., 1995).

Depositions (i.e., questioning under oath outside court) are used by both sides for purposes of discovery. Depositions help each side to weigh evidence that may lead to settlement discussions. They also allow witnesses to learn lines of inquiry that may be pursued at trial. Practitioners should expect to have their clinical records reviewed and questioned during depositions. It is entirely appropriate for experts to meet with the attorney who has hired them to review testimony beforehand (Brodsy, 2004). If you do not know the answer to a question, simply say so. Do not speculate beyond your knowledge, competence, or findings (Brodsy & Galloway, 2003).

Mental health and behavioral science experts must take care to stay within the boundaries of personal expertise. For example, special training beyond a generic terminal degree or professional license is often required prior to undertaking forensic assessments that involve children, geriatric patients, or individuals with neuropsychological injuries. Do not feel defensive about your credentials. Readily admit any and all nonaccomplishments in a matter-of-fact manner. Do not fear admitting ignorance or saying "I don't know" in response to questions posed by attorneys.

Case 13–19: Windy Fluffball, J.D., Ph.D., agreed to serve as an expert witness in a civil lawsuit that involved alleged wrongful termination of a clinical psychology graduate student from a doctoral program. Dr. Fluffball expounded on his years of teaching and membership on the National Psychological Society's Education and Training Oversight Committee. On cross-examination, Fluffball was forced to admit that his doctorate was in physiological psychology, that he never had clinical training, that he never worked or taught in a clinical psychology program, that he was not

licensed as a psychologist, and although he had recently won appointment to the Education and Training Oversight Committee of his professional association, he had yet to attend a single meeting.

After the jury returned a verdict favoring the other side, the lawyers were allowed to poll the jurors and discovered that Dr. Fluffball's testimony was given very little weight. One must wonder whether the side for which he testified would have fared better using a witness who did less to inflate his qualifications.

MENTAL HEALTH PROFESSIONALS AS DEFENDANTS

Rather than simply focus on mental health malpractice, it seems more reasonable to think of the broader concept of professional liability as applying to all of one's professional service delivery activities. In a legal sense, there are four elements that must be present before a successful civil liability lawsuit is possible. Think of them as the four Ds: *duty*, *dereliction*, *direct causation*, and *damages*. First, the clinician must have a professional relationship with the party in question. That is, a practitioner-client relationship must have existed with a resulting duty to the client. Second, there must be some negligence or dereliction of that duty on the part of the therapist. Third, some harm must have accrued to the client as a direct result of the negligence or dereliction of the duty. Finally, a causal relationship between the negligence and the resulting damages must be shown (Bennett et al., 2007; Bucky et al., 2005; Caudill, Sparta, & Koocher, 2006; Falender & Shafranske, 2004; Knapp et al., 2013). Needless to say, by this definition a successful prosecution for malpractice would necessarily mean that the clinician had behaved unethically by virtue of negligence. Read the next three cases with these standards in mind and see whether you can hazard a guess about the outcomes.

Case 13–20: G. Ima Hurtin sought the services of Anna Sthesia, Psy.D., in response to her newspaper announcement of a pain clinic Dr. Sthesia

had recently opened. Ms. Hurtin gave a history of low-back pain that began several years earlier, and she expressed interest in the application of biofeedback techniques. Ms. Hurtin told Dr. Sthesia that she had “been to everyone, chiropractors, orthopedists, hypnotists, and even tried acupuncture and a herbalist.” The psychologist initiated biofeedback training. Several weeks later, Ms. Hurtin collapsed at work and was taken to a hospital, where she was discovered to have a malignant tumor of the spine. The disease had metastasized widely and was too advanced for all but palliative care.

Case 13–21: Regina Yahoo met Sonia Specula, M.S.W., at a cocktail party. On learning that Specula was a psychotherapist who specialized in work with children, Ms. Yahoo began telling her about threats that her 15-year-old daughter was making to run away from home. Ms. Specula casually mentioned that “lots of teenagers say things like that to annoy their parents, but they never do it.” Two days later, Ms. Yahoo’s daughter ran away from home and was hit by a truck and killed while attempting to hitchhike out of town.

Case 13–22: Manual Kant felt very angry that, after 9 months in psychotherapy with Seymour Suregood, M.D., he still could not get women to date him a second time. Several of the women had told Mr. Kant: “You need a lot of help!” Dr. Suregood had agreed to work with Kant on this problem, but as far as Kant could tell, things had not changed much.

All three of these clients attempted to sue the therapist in question, but only one proved successful. If you guessed Ms. Hurtin, then you probably understand the basic concepts of malpractice liability. Hurtin clearly held client status with Dr. Sthesia, and the clinician clearly had an obligation to treat Hurtin reasonably. She neglected to check on her physical status or send for reports from the other professionals to whom Hurtin alluded, and she began to treat an important physical symptom (i.e., pain) without first ruling out a medical problem. By this negligent act, she contributed to a delay in forcing Ms. Hurtin to seek other treatment or proper evaluation, giving her cancer time

to spread. While we do not know whether Ms. Hurtin’s life could have been saved with early treatment, the psychologist’s behavior may have cost her the opportunity to find out.

Ms. Specula was not guilty of malpractice. Perhaps she should have exercised more caution in the willing way she gave advice, but it seems clear that Ms. Yahoo never held client status. The contact was casual because it took place at a social gathering rather than in an office, no fees were charged or paid, no clinical records were created, and the relationship between the alleged advice and the injury sustained remains unclear.

In the case of Dr. Suregood and Mr. Kant, a psychotherapist-client relationship did indeed exist. We have no evidence of negligence, however, and no evidence that the client sustained any harm. If Dr. Suregood had promised results within a certain time span and these did not occur, one might accuse him of misrepresentation or misleading the client. But, we have no evidence that any promises of hard results were made. It is also unclear whether the best psychotherapist in the world would have provided any greater help to Mr. Kant.

In some cases, causality becomes an important issue, as in the case of a psychologist named Carmichael, who practiced in Washington, D.C.

Case 13–23: Frederica Saunders sought psychological treatment from Dr. Douglass Carmichael. During the course of counseling, Carmichael and Saunders engaged in sexual relations, and Dr. Carmichael convinced Saunders to divorce her husband. Carmichael and Saunders then married. Saunders later brought a malpractice action against her new husband after he sued for divorce. The trial court found Carmichael liable for malpractice and also granted the divorce. Carmichael appealed, claiming his wife did not prove harm. The appeals court found that Saunders did not present any expert testimony that showed a causal relationship between the malpractice and her injury. Her expert testified about the nature of transference and stated that initiating a sexual relationship during the course of a professional relationship was a fundamental betrayal of a patient’s trust. This testimony could establish that

Carmichael breached the applicable standard of care, and that Saunders's symptoms, which included depression, distress, and suicidal feelings, were consistent with the effects of a doctor betraying a patient's trust. The witness did not testify "to a reasonable degree of medical certainty" that Carmichael's behavior played a substantial part in causing his wife's injuries. Moreover, the expert admitted under cross-examination that all of Saunders's symptoms could have existed when she first sought treatment from Carmichael (*Carmichael v. Carmichael*, 1991).

The ethical offensiveness of Dr. Carmichael's conduct is clear. Unfortunately for Mrs. Carmichael's (the former patient–wife) effort to recover financial damages, it was not possible to legally link his behavior as the cause of the damages she suffered. One message sent to District of Columbia therapists by this case may be as follows: If you plan to have sex with former clients, you may want to marry them.

Standards of Care and the "Good Enough Clinician"

Perfection is not the standard expected in professional practice. No one is perfect, and everyone makes mistakes or errors based on reasonable judgment calls. People cannot avoid mistakes, but a mistake does not necessarily equal negligence.

One step beyond an error in the hierarchy of risk would be termed a deviation or departure from the standard of care provided by other well-trained therapists in the community. The best test of your risk level is to compare yourself to others who are competent to perform the particular service or to treat the specific type of client in question. Perhaps you have the requisite skills but do some things in your practice that, while not unethical, others would not do. In such a case, you should give careful consideration to such practices. The farthest extreme of risk is gross negligence. This amounts to an extreme departure from usual professional conduct and something most practitioners would not do. A plaintiff's lawyer will seek experts in your field in an effort to prove that your unusual

practice amounts to negligence. By consulting nondefensively with colleagues who practice in the same specialty and geographic area, you can effectively assess new ideas or practice plans that others think may stretch the limits of reasonableness.

Common Precipitants of Suits Against Practitioners

Although at least 25 different types of suits (causes of action) against mental health practitioners have been conceptualized (Hogan, 1979), most are unlikely hazards for therapists in the sense that they rarely form the bases of complaints. Examples might include breach of contract, undue influence, alienation of affection, failure to supervise properly, failure to treat, complaints linked to serving on licensing boards or ethics committees, abandonment, false arrest or false imprisonment, abuse of process, assault and battery, and misrepresentation. Interestingly, the greatest number of malpractice or professional liability insurance claims against mental health professionals arise from complaints about boundary violations of both sexual and nonsexual natures, client suicides, clients who commit homicide, finances or billing, or problematic forensic evaluations, including those associated with child custody and child sexual abuse evaluations. Such data underscore the need to develop significant expertise before venturing into such work (Bennett et al., 2007; Costanzo, Krauss, & Pezdek, 2007; Drogin & Barrett, 2007; Faust, 2011d; Sparta & Koocher, 2006; Wettstein, 2002; Woody, 1988).

Retrospective review of claims against psychologists (Bennett et al., 2007) revealed some clear triggers of suits against mental health clinicians: sex with clients, management of clients' dangerous behaviors, and disputes regarding fees for service. Allegations of sexual misconduct are predictable enough as sources of complaint, but it is also worth noting that suits are also frequently filed when a practitioner takes steps to collect a debt (i.e., engages a collection agency or files suit against the client; see Chapter 12). Several commentators offered useful suggestions about what therapists should do

in the event of an actual or threatened lawsuit (Bennett et al., 2007; Koocher, 2005; Woody, 2005). Many of these suggestions are incorporated in recommendations we offer. The good news is that the cumulative risk of a psychologist in the United States being sued is less than 0.5% (Bennett et al., 2007; Knapp et al., 2013). The bad news is that the incidence of licensing board complaints has increased, and defending either type of action is time consuming and costly in both financial and emotional terms.

Avoiding the Tort of Defamation

When false or misleading statements (or true statements that cannot be proven in court) damage a person's reputation, a defamation lawsuit may result. Oral defamation or slander may occur whenever comments about clients are made aloud in public settings. It is wise to remain cautious in public statements regarding current or former clients, even when one has their consent. Exercise particular caution if you are inclined to use disguised clinical case materials in teaching or other oral public presentations. Written defamation or libel may occur when material in reports, letters, or other written media are deemed to have wrongly harmed another's reputation. Use care in record keeping, report writing, and the use of disguised case materials in books or other published materials.

Be especially careful of repeating information provided by angry spouses unless the source is clearly documented.

Case 13–24: I. B. Leavedher, L.M.H.C., had seen Kenya Trustme for only four psychotherapy sessions when Ms. Trustme asked him to write a letter on her behalf. She told Mr. Leavedher that her sessions with him had given her new resolve. She told Leavedher that her spouse had abused her for many years, and that she had finally decided to take action to protect herself and her children. She planned to move to a friend's house and go into court the next day with an ex parte request for a restraining order. She asked whether Mr. Leavedher would write a supportive letter, and he did so, repeating all of the acts of abuse she had recounted to him.

Sadly, Ms. Trustme had lied to her therapist in an effort to extract an improved settlement in a divorce action she planned to file. Sadder still, Mr. Leavedher's letter provided a narrative that seemed to support her claims as fact. Ms. Trustme made several copies of the letter and sent them to her spouse's employer, family, and teachers at their children's school. The spouse, who Mr. Leavedher had neither met nor spoken to, filed both a licensing board complaint and a defamation suit. Mr. Leavedher might have avoided such problems had he qualified his report by incorporating notations that all of the content came solely from Ms. Trustme's self-report (i.e., "Ms. Trustme told, reported, or informed me that . . .") rather than providing a report suggesting he had firsthand or confirmed knowledge of her claims.

Specific Prevention Strategies

Aside from being competent and applying sound professional practices, when devising specific prevention strategies it is important to know and respect both your limitations and those of your employees and supervisees.

- Be aware of your psychological issues and vulnerabilities, including transference and countertransference hazards.
- Avoid behaviors that might lead to sexual intimacies with clients (see Chapters 9 and 18).
- Seek treatment for any substance abuse or personal emotional problems you may have (see Chapter 2).
- Heed cautions from colleagues; if one of them dares to express concerns, there are probably several others who are thinking the same thing but are afraid to speak up. Avoid grandiose claims or outcome promises.
- Provide meaningful supervision to your support staff and to trainees whose work you oversee because you can be held responsible for their actions under the doctrine of *respondeat superior* (see Chapter 10).

The next case illustrates the consequences of failing to heed this advice.

Case 13–25: A woman known as Jane Doe sued the Samaritan Counseling Center as *respondeat superior* for the acts of one of its pastoral counselors; the counselor had sexual intercourse with her when she came to seek “emotional and spiritual therapy.” During two of Doe’s sessions at the agency, the counselor allegedly kissed and fondled her. Sexual intercourse followed outside the center after she had canceled her counseling sessions. A trial court initially dismissed the case, finding that the agency was not responsible for its employee’s acts; however, the state supreme court disagreed. The court ruled that the fact that sexual intercourse occurred after Doe canceled therapy did not bar employer liability because the counselor’s conduct during the sessions constituted the initiation of a sexual relationship and negligence in handling transference issues (*Doe v. Samaritan Counseling Center*, 1990).

In this case, the supervising agency was held financially responsible for the unethical acts of one of its employees, even though much of the offensive behavior was off site. Problems began while the therapist should have been under agency supervision.

Be especially sensitive when treating high-risk clients and in problematic practice areas. High-risk clients include any client you are not competent to treat; litigious clients; those with volatile psychopathology (e.g., borderline personality disorder, especially with histrionic or paranoid features); people with histories of dangerousness, and clients who develop a rapid or intense transference relationship. High-risk practice areas include child custody or other forensic or “high-scrutiny” arenas and work with some trauma victims (e.g., those seeking to recover memories of abuse). We certainly do not suggest that mental health professionals should avoid such clients or provide such services. Rather, we emphasize the importance of training and competence when dealing with these populations or providing services that carry an above-average risk component. (See also Chapter 1.)

Take care to carry adequate professional liability insurance and understand your coverage. Know the differences between a “claims-made” policy and an “occurrence-based” policy (Bennett, 2013). Significant delays often occur between

triggering adverse events and lawsuits. Only about half of the legal claims against therapists surface during the insurance policy year in which the incident occurred. As a result, it is important to maintain continuous coverage. A claims-made policy covers acts that occurred during the policy year only if a renewed policy is in force when the complaint is filed. Therapists who have such policies should buy “tail coverage” to cover any cases filed in subsequent years if they switch insurance companies or retire. The “tail” refers to the trailing off likelihood of claims being filed as years go by and the statute of limitations on filing passes.

An occurrence policy is more expensive because tail coverage is built in to the price. Such policies provide coverage forever for any incidents that occurred during the policy year. Alternatively, if one switches insurance companies, it may be possible to purchase “nose coverage,” technically known as *prior acts coverage*. Such policies will cover potential claims, as yet unknown to the therapist, that may have occurred under another company’s policy. We believe that professional liability insurance is an ethical necessity because it provides a means for clients to recover damages in the event of professional errors, especially when the therapist has few financial resources.

Use consultation. Pay for consultation when needed and treat it as a professional service (Bennett et al., 2007; Knapp et al., 2013). Keep a list of potential consultants handy for use on short notice and have contingency plans for who to call if you must consider admitting a client to a hospital, provide a warning about a dangerous client, deal with a suicidal client, or have another risky clinical situation. Use your consultant as soon as you suspect any risky situation. Do not wait for a disastrous event or a lawsuit. Although not absolutely necessary, in many cases it may be best to go to the head of your agency or outside your immediate circle of colleagues. When you do consult, document it and include the date, details, and actions taken. Mental health professionals who act as consultants will also want to keep careful notes and beware of vicarious liability (i.e., when someone who consults you is sued, and you are also named as a defendant). Develop clear payment

and collection policies and follow them. Inform clients of your billing and payment policies. Do not allow large or unexpected bills to accumulate. Keep “affect” (e.g., emotional outbursts) out of billing and collection letters (see Chapter 12).

When Prevention Fails: What to Do When an “Adverse Incident” Occurs

Professional liability cases and licensing board complaints take a heavy toll on practitioners (Koocher & Keith-Spiegel, 2013; Thomas, 2005;

Woody, 1988, 2000, 2005). Most clinicians who face board complaints or liability litigation experience significant personal and professional distress. They may become vulnerable to cognitive, emotional, and behavioral responses, which in turn may compromise their clinical skills and even their ability to effectively defend themselves. But, remaining aware of the most common sources of distress associated with complaints can allow mental health professionals to take steps to minimize problematic behaviors and self-defeating responses (Koocher & Keith-Spiegel, 2013; Thomas, 2005).

Box 13–2 Steps to Take If an Incident Involving Risk Occurs

- Obtain a formal consultation under privileged communication from a colleague experienced with such clients or issues and take any appropriate actions recommended.
- Consider whether the circumstances suggest that you should initiate termination of the professional relationship.
 - If you decide that it is appropriate to do so, notify the patient both orally and in writing, specifying the effective date for termination and providing a specific and appropriate reason for terminating the relationship.
 - Agree to continue providing interim services for a reasonable period and recommend other care providers or means of locating them.
 - Offer to provide records to new care providers on receipt of a signed authorization.
 - Document all of these steps in your case records.
- We recommend avoiding unilateral termination if the client is in the midst of a mental health crisis or emergency situation or if substitute services will be difficult for the client to obtain (e.g., in a rural area where other practitioners might not be readily available).
- It would also be unethical to seek to terminate a client if the basis for doing so is unreasonably discriminatory (e.g., terminating psychotherapy with a client after learning of his or her HIV status).
- If a high-risk client does not return for a scheduled appointment, follow up by telephone and in writing, documenting these steps in your records. Be especially prompt in doing so if the client seemed depressed or emotionally distressed in the last session.
 - If a high-risk client complains to you about some aspect of your professional relationship, listen carefully and treat the complaint with serious professional concern.
 - Investigate, if necessary, and respond in as sympathetic and tactful a manner as possible.
 - Try not to be defensive.
 - Apologize, if appropriate.
 - Document in your record all steps taken.
- In the event of a client’s death, express sincere compassion and sympathy to surviving relatives but do not discuss any personal feelings of guilt you may be experiencing. Save those feelings for your personal psychotherapist.

Should some significant difficulties or adverse events arise (e.g., a client is not benefiting from treatment, is not adhering to key aspects of a treatment program, has become too difficult to work with, threatens you, or harms a third party), consider the series of steps outlined in Box 13–2, even if no filing or threat of a lawsuit has occurred.

If you become aware of the possibility of a suit against you, do not wait for formal notice of the suit to arrive. Follow the steps described in Box 13–3. (Note that this list is similar but not the same as one presented

in Chapter 18 that offers procedural advice if questioned by a licensing board or ethics committee.)

WHAT TO DO

- Remember that when venturing into the legal arena, whether by choice or chance, specialized training or expert guidance is an *absolute* necessity.
- If you find yourself drawn into a legal case inadvertently, seek consultation from

Box 13–3 Steps to Take If a Lawsuit Is Threatened

- Notify your insurance carrier immediately so that the carrier can open a case file and assign legal counsel, if needed.
 - Never interact orally or in writing, “informally” or otherwise, with a client’s lawyer once a case is threatened.
 - Once a lawyer representing your client contacts you in any dispute that involves you and that client, obtain your own attorney or one hired by your liability insurance carrier involved.
 - Cease all further personal contact with that client until you have consulted your attorney. Never try to settle matters yourself.
- Do not make incriminating statements or discuss the case with anyone other than representatives of the insurance carrier or your lawyer.
- Do not discuss details of the case with colleagues. These other parties may later become subject to subpoena and testimony about what you told them.
- Compile and organize all of your records, case materials, chronicles of events, and so on to assist in your defense.
- Do not throw away or destroy any documents, recordings, or other items linked to the case and do not show any of these to anyone except your attorney.
- When asked to provide information or documents to your legal counsel, send copies and safeguard the originals.
- In any malpractice or professional liability action, you may want to consult a personal attorney (in addition to the one assigned by the insurance carrier), especially if sued for damages in excess of the limits of the policy.
 - Before agreeing to a settlement, consult an attorney whose only interest is you (rather than you *and* your insurer).
- Take steps to manage your own anxiety and stress level. Such cases can take a severe emotional toll and require several years to resolve, even though there may be no legitimate basis for the suit.
- Seeking support from friends and colleagues is a normal reaction; however, discussions of specific details should occur only in privileged contexts.

a colleague with specialized forensic knowledge before responding to the legal proceeding.

- Carefully clarify the professional roles you have agreed to with clients at the outset of the relationship and stay within the agreed-on or court-defined parameters in all forensic cases.
- Hold on to your integrity with respect to role obligations and scientific bases for expert opinions.
- Should an adverse event occur, follow the specific preventive steps outlined in the final section of this chapter and boxes.

WHAT TO WATCH FOR

- Child custody disputes constitute a frequent basis for ethics complaints, particularly when the clinician makes a recommendation based on incomplete data or interviews with only one party. Exercise great caution and follow professional guidelines when undertaking such assignments.
- Mental health practitioners must distinguish carefully between legal issues and mental health issues and, when serving as an expert witness, avoid offering opinions on legal matters.

WHAT NOT TO DO

- Do not allow yourself to “take sides” when serving as an expert. Although one party may be paying for your professional time, your expert opinion should not be for sale.
- Avoid straying from findings grounded in behavioral science when offering an opinion.
- Do not exaggerate your areas of expertise or allow others to misrepresent them.
- Resist any role switching once you have entered a forensic relationship.
- Do not agree to compensation that is in any way contingent to the outcome of the case about which you are asked to work on.

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14

Mental Health Professionals in Academia

To educate a person in mind and not in morals is
to educate a menace to society.

President Theodore Roosevelt

Contents

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The role of educators extends well beyond transmitting a body of information. Whether they realize it or not, those who teach are also influential role models who will, to an extent, determine the quality of tomorrow's practitioners. The next generation of mental health professionals and citizens will also absorb many of their educators' values and behaviors, for better or worse. Ethical professors are those who continuously reflect on their teaching effectiveness and strive to fairly evaluate students (Landrum & McCarthy, 2012).

Today's college and university students are no longer confined exclusively to a youthful cohort of 18- to 22-year-olds born and raised in North America. Often enough, the professor is not the oldest person in the room. "Returning students" (sometimes referred to as "nontraditional students") come back to pick up where they left off years ago, for additional coursework to advance on the job, or just to continue learning.

This chapter focuses on the ethical challenges facing educators and students in "brick-and-mortar" institutions. Although we cannot do justice in a single chapter to the array of dilemmas that can plague higher education, we have chosen topics that cut across a spectrum of ethical issues. (Online training and degree programs are discussed in Chapter 2.) A full discussion of social and other multiple-role relationships between educators and students appear in Chapters 8 and 9, ethical issues in writing letters of recommendation in Chapter 10, and research collaboration with students in Chapter 16.

SOURCES OF DISCONTENT

Colleges and universities traditionally honor and encourage productivity, creativity, and critical thinking. Learning how to learn, given that much of the information students are asked to absorb will become incrementally obsolete, and attaining a kind of maturity that facilitates both individual competence and interprofessional cooperation are other noteworthy goals of today's higher educational agenda.

How well a country's young people are educated largely determines a nation's fitness and status in the world community. Unfortunately, the negative features of our educational system receive far more public attention in than do the considerable positive contributions made by students and their teachers. Yet, incidents involving racism and hate crimes, bullying, sexual harassment and assault, academic dishonesty, and occasional horrific violent acts continue to plague our colleges and universities (U.S. Department of Education Office of Civil Rights, 2014). Schools may not always take appropriate action, or if they do, the penalties seem minor. For example, Miami University (Ohio) found a student guilty of assaulting a woman. He was placed on probation and required to write an essay (Binkley, Wagner, Riepenhoff, & Gregory, 2014).

Campus scandals range from excessive perks for athletes to research misconduct. Huge, impersonal lecture classes and overreliance on part-time contract faculty and teaching assistants who often feel exploited cause the public to wonder what really goes on behind those impressive-looking pillars, particularly as tuition costs far outpace inflation and student loan debt mushrooms. Even the status of the professoriate itself is dwindling according to *Chronicle of Higher Education* writer Robin Wilson (2010). She contended that professors work longer and harder as standards for tenure rise and have become less collegial and more competitive in a sweatshop-style environment occupied by increasing numbers of adjunct faculty. And finally, an apparently prevalent and sour attitude about senior, tenured professors who do not carry the same load is labeled "deadwood resentment syndrome" (Perlmutter, 2010).

Hard economic times have led to funding cutbacks for most academic institutions. Shrinking resources invariably encourage increased competition among faculty for equipment, travel funds, laboratory space, and promotions. Shortages often lead to tension, which may reveal itself in low morale and explosive bickering and dissension. Academics who find it difficult, for whatever reason, to conduct research and publish it in scholarly journals

often put their job status in jeopardy. The ironic result finds energy diverted from teaching and supervising students while churning uninspired work into the knowledge stockpile.

Courts have historically shown reluctance to become involved in academic disputes, viewing colleges and universities as relatively autonomous, self-governing entities. Recent times, however, have seen an increase in legal actions brought by both students and faculty as well as an uptick in courts' willingness to hear them, including complaints about grading (Gajda, 2009). Successful precedents may motivate others to utilize the legal system in an effort to resolve complaints that failed to succeed at the institutional level. The current trend of running institutions of higher education is similar to commercial businesses, thus moving the culture away from the "ivory tower" toward a "corporate structure," may also influence courts to view students as consumers.

Colleges and universities with the best track records have typically given robust support to academic freedom, openness of expression, and institutional autonomy (Gajda, 2009). This includes allowing a wide latitude for framing course content, teaching styles, creative assignments, and free expression of (sometimes controversial) ideas. However, these assumed advantages seem increasingly elusive. Once sacred grounds for freedom of expression, colleges and universities must now wrestle with what can and cannot be uttered in a public forum or even in a private conversation or e-mails. Some schools have issued speech guidelines, hailed by some as promoting civility and decried by others as imposing thought control (Bartlett, 2002). The next case reveals a sobering account of how asserting assumed autonomy and authority can boomerang.

Case 14–1: After checking to make sure Abe Sent did not have a medical or other compelling excuse, Professor Certain assigned him a failing grade. Mr. Sent attended only three class sessions and never completed any of the basic course assignments. The professor was ordered to change the grade to an "incomplete" by the university president, but

Certain refused to do so. When Professor Certain was suspended, he wrote a critical review of the president and was eventually fired.

In the actual case, the professor sued the president and other university officials for dismissing him in retaliation for his refusal to amend a student's grade and for violating his rights to free academic expression and rights under the First and Fourteenth Amendments to the U.S. Constitution. He did not prevail in a U.S. Circuit Court of Appeals (Ewing, 2001).

The concept of tenure, which after a usually lengthy probationary period confers a large measure of job security, gets its fair share of criticism. Some argue that tenure allows professors to become lazy and unproductive. The fundamental purpose of tenure, however, is to help ensure that faculty members are not intruded on by the state or dismissed from their institution solely because of their scholarship, research, or points of view (see Euben, 2002). Intense debate and scholarly disagreements are healthy and fundamental to advancing creativity and discovery. Although the line separating scholarly criticism from unfair slamming is not always bright, every educator must be prepared to answer challenging questions about what they do. Gajda (2009) described a faculty member who brought a suit alleging defamation based on a negative review of his work. In another case, a tenacious professor who was denied tenure ultimately gained access to what the review committee believed to be confidential assessment letters and posted them on the Internet. Such attempts to stifle unfavorable assessments of the work of others put a chill on peer review and a willingness to speak honestly.

Finally, there will always be those wayward educators who attract media attention while embarrassing the rest of us.

Case 14–2: A paper mill admits it hires unemployed professors and advanced graduate students to write term papers for a fee (Schuman, 2014). The audacious headline states, "High quality custom essays crafted by real unemployed professors. We help you play by making your papers

go away." A FAQ question on the site asks, "Isn't it really unethical for you to be writing these essays for cash?" The brash answer is, "Incredibly so, and because the academic system is already so corrupt, we're totally cool with that."

Case 14–3: A professor at Brevard Community College is facing termination of employment for pressuring students to commit to vote to reelect President Obama in the upcoming election. Students were mandated to sign a card pledging to vote for Obama and Democrats. The college report concluded that her actions constituted harassment, incompetence, misconduct, and unprofessional workplace behavior (Jaschik, 2014).

As for the paper mill, further in the chapter we suggest a tactic to counteract any temptation to submit other than one's own written assignments. We also suggest that there may be good reasons why the supposed "professors" are unemployed. As for putting pressure on students to agree to act politically in a specific partisan way, despite the generally held belief that most educators lean to the political left, this act tripped the wire.

STUDENT COMPLAINTS ABOUT PROFESSORS BEHAVING BADLY

When criticism of their educators is solicited, college and university students offer lots of complaints. Among the main student gripes are inferior course planning; weak lecturing skills (e.g., monotonic, too stiff, too long-winded); annoying mannerisms; poor use of class time; unapproachability; and even faculty attire (Perlman & McCann, 1998). The list produced by Braxton, Proper, and Bayer (2011) would add disrespect toward student efforts, harassment of students, neglectful teaching, inadequate mentoring, insufficient course structure, and pedagogical narrowness.

Academic communities have no immunity from the growing tendency to eschew personal responsibility and blame others for real or perceived shortcomings. A few of the more unusual cases brought by students against educators and their institutions are given next.

Case 14–4: Two students sought monetary damages because a course proved too difficult. The judge in small claims court ruled that the professor was guilty of educational malpractice for making an entry-level course too demanding (Shea, 1994).

Case 14–5: While "mooning" those standing in the quad below by pressing his bare backside against a window, an undergraduate student fell through and hurtled 30 feet to the ground. He attempted to sue the university for nearly a million dollars for his minor injuries, which included "deeply bruised buttocks" and "trauma." The student alleged that the university was at fault for failing to specifically warn students about the dangers posed by insufficiently sturdy windows (Gose, 1994).

Case 14–6: A theater student sued five professors, claiming that she was forced to leave her academic program when the faculty refused to allow her to replace profane words in copyrighted play scripts with "nicer" words ("Acting on Faith," 2000).

More commonly students complain about uninspiring or difficult-to-understand teachers, those whose grading criteria are unclear, teachers who are unavailable for advising or assistance, those who are arrogant and demeaning, and those who demand too much or assign seemingly irrelevant work.

Case 14–7: Professor Lazee holds office hours from 6 a.m. to 7 a.m. 3 days a week. Few students take advantage, allowing him to take care of other business. He arrives to class just seconds before the hour, disallows student questions, and shoots out of the room after class without speaking to anyone. Students complain to the department chair that they need clarifications and help but find it difficult to interact with him.

Professor Lazee is not offering students the attention to which they are entitled. Such common complaints are best handled within the institution as opposed to the ethics committees of professional organizations. A faculty member's conduct, however, typically must involve an egregious violation before any formal action is taken. Even when institutional channels function in ways that allow for fair hearings and

due process, only the most assertive aggrieved students appear to use them. Many students may feel relatively powerless, which in turn, discourages them from seeking formal redress when they believe they have been wronged.

PROFESSORS' COMPLAINTS ABOUT STUDENTS BEHAVING BADLY

Professors can produce a litany of complaints about contemporary students. Late-arriving, dozing, whispering, texting, yawning, and “eye-rolling” students can disrupt the learning environment for everyone. Not all students appreciate the demands of the teaching performance and the despair instructors feel when carefully crafted lectures appear to fall on indifferent ears.

Case 14–8: Beanie Blowout made loud “raspberry” sounds when the instructor turned to the data projector, smirked while asking questions that were purposely irrelevant or inane (e.g., “Was the hippocampus named after a school for large animals?”), and constantly dropped his pen and pencil. The instructor felt at her wits end and sought to have Blowout removed from the class.

We assume the instructor attempted unsuccessfully to convince Mr. Blowout, in private, that his behavior made it impossible for her to do her job and for other students to learn, and that the chair or dean proved unable to help. We cannot fault the instructor for instituting Blowout’s permanent dismissal from the classroom. Most campuses have policies and procedures related to troublesome students that allow due process while preserving a climate conducive to learning.

Unfortunately, the rate of student insubordination and intimidation in and out of the classroom appears on the rise, creating trying dilemmas for faculties. Schneider (1998) used the extreme descriptor “classroom terrorists” to describe this no-longer-uncommon phenomenon and offered examples that live up to the term. Educators have experienced verbal abuse

and even challenges to engage in physical fights. The reasons usually involve unwelcome grades, but often enough arise from matters most faculty would consider relatively minor. One student, for example, left a hateful message containing excessively foul language on a professor’s message machine because her textbook was not eligible for resale due to the publication of a newer edition. How to deal with such incidents in a way that allows the faculty to respond with integrity presents a challenge, requiring strong administrative support.

We would suggest two methods to avoid in managing difficult students who disrupt classroom decorum. Overly rigid or uncharitable classroom policies can create ethical concerns. We also believe that shaming tactics in response to boorish behavior undermines the respect that should define relationships between students and their educators.

Case 14–9: Professor Harsh deducts grade points from exam scores when students talk, permit their cell phones to ring in class, or engage in other behaviors he deems disruptive. He defends his practice on the grounds that one can reasonably expect mature behavior from college-level students.

Professor Harsh’s stance illustrates the risky business of subtracting points earned for academic performance in response to undesirable behavior. Whereas Professor Harsh most certainly has the right and the obligation to maintain a classroom environment conducive to learning, legitimately earned academic credit should remain intact.

Humiliating students is another control technique that can swiftly control unwanted classroom behaviors but also raises ethical questions.

Case 14–10: Professor Bringem Down shouts at students who engage in behaviors she finds annoying. She chides them if questions strike her as off target or ill conceived. For example, she told one student who asked what she perceived as an unintelligent question to try again after he located his brain.

Professor Down may have whipped her class into her notion of proper deportment, but we have no idea what else her students have learned. Students are sensitive to humiliation or ridicule. According to the findings of a large survey of undergraduate students, 80% of the respondents rated insulting or ridiculing students or telling a student during a class discussion their input was stupid as "extremely unethical" (Keith-Spiegel, Tabachnick, & Allen, 1993).

Finally, student dishonesty poses what we see as the most serious ethical dilemma for educators. It seems puzzling, as William Lowe Bryan is quoted as saying, "Education is one of the few things a person is willing to pay for and not get." It is widely acknowledged that the cheating in our nation's colleges and universities occurs at unacceptably high rates (Davis & Ludvigson, 1995; Hensley, Kirkpatrick, & Burgoon, 2013; McCabe & Bowers, 1994; McCabe, Trevino, & Butterfield, 2001; Whitley & Keith-Spiegel, 2002). Furthermore, students often rationalize their cheating and deflect blame on to their peers, their professors, or the institution (Beasley, 2014; Olafson, Schraw, Nadelson, Nadelson, & Kehrwald, 2013), which makes dishonest behavior difficult to counteract. We also know that too many instructors ignore cheating and that administrators do too little to address it (Kibler, 1992; Whitley & Keith-Spiegel, 2001). Frequent reasons for ignoring cheating include insufficient evidence, lack of courage, and denial (Staats, Hupp, Wallace, & Gresley, 2009). Intriguingly, however, students themselves overwhelmingly believe that it is unethical for professors to ignore strong evidence of cheating (Keith-Spiegel et al., 1993).

Case 14–11: Professor Hesitant suspected that Peeka Boo was looking at her neighbor's test paper. Boo's term paper also had a "familiar look" and exceeded in both style and content the level expected of an undergraduate. The mere thought of confronting and dealing with the matter made Hesitant nauseous. He figured that he could never prove that Boo cheated and instead resolved not to give her any benefit of a doubt when he assigned the final grade. If, for example, her grade was to

fall between a C and a B, he would assign the lower grade as his way of addressing the dilemma.

Professor Hesitant's "solution" to handling a student suspected of cheating is probably widespread. In a survey of teaching psychologists, 77% agreed that dealing with a cheating student was among the most distasteful aspects of the profession. When asked why they thought that many instructors ignored strong evidence of cheating, the inability to prove the case conclusively was the major reason given. Other frequently selected reasons included anxiety on contemplating a formal hearing, insufficient time to track down the evidence, lack of courage, and a concern about how the conflict would escalate if the student denied the charges (Keith-Spiegel, Tabachnick, Whitley, & Washburn, 1998).

Despite the burden of establishing proof and the noxiousness of confronting dishonest students, cheating must be managed effectively if the mission of higher education is to remain valid. Ignoring cheating positively reinforces dishonest behavior and gives a message to students that actual accomplishment is unimportant. Ms. Boo, if she was innocent, could be disadvantaged without an opportunity to explain herself. If Boo is guilty, then her dishonest method of handling the rigors of a college education has been fortified. As unsettling as it may be, Professor Hesitant should at least call Boo in for a private talk. One preventive tactic is to make it clear in the course syllabus academic dishonesty will not be tolerated and suspected acts of cheating will be investigated.

The cheaters' task of having to retype plagiarized material has all but disappeared, courtesy of the Internet, scanners, and word-processing software. The Internet poses a special challenge as it provides students with an untold wealth of information that can easily be downloaded and woven into papers to hand in as their own work. Surveys reveal that students do directly use material they find online (e.g., Szabo & Underwood, 2004). However, it is also increasingly easier to detect cybercheats. Sometimes entering the right key words or phrase on a search engine site identifies a bogus student

paper almost immediately, and several services, such as Turnitin or SafeAssign, will search even deeper.

With numerous courses and even complete degree programs offered over the Internet, concerns about unproctored online cheating is increasing. It may not be possible to know what tools are being accessed while taking exams or even who actually took them. Whereas it may seem obvious that the ease of online cheating is greater than in a traditional, monitored classroom testing, the evidence is somewhat unclear. After all, cheating rates in traditional test settings are high, and digital devices can (and are) used during monitored tests (Stephens, Young, & Calabrese, 2007). Furthermore, many preventive techniques available to discourage cheating are labor intensive and not feasible for use in large classrooms (e.g., separating desks). Nevertheless, efforts are under way to resolve the problems associated with online cheating that could ultimately result in greater security for online testing than classroom testing overseen by a monitor (Bartram, 2009; Tippins, 2009).

Whereas solving the plagiarism problem by simply dropping writing assignments has a surface appeal, this is a losing tactic in the long run. The next generation of citizens needs to be able to communicate effectively through writing. Instructors would do well to explain early on their policies for written papers, including what plagiarism and unfair use are and how not to use them. Another deterrent to plagiarism is to let students know in advance that they may be asked to answer questions about their written assignments (e.g., "You say, 'Direct observation of children remains the best way to assess behavior problems despite the many limitations.' What limitations are you referring to?"). Those who did not actually work with the material will be unlikely to offer answers.

COMPETENCY ISSUES IN TEACHING

Effectively imparting knowledge to others while modeling ethical leadership and good

citizenship requires distinct competencies. These include mastery of and enthusiasm for the subject matter, contributing to one's profession in ways that enhance teaching and learning, maintaining proficiency in teaching methods, evaluating students appropriately and impartially, and interacting professionally with students in and outside of the classroom (National Research Council, 2003). Continual self-assessment is also a primary marker of the competent educator (Wise & Cellucci, 2014). Navigating complex relationships with students in ways that acknowledge but do not exploit the power differential requires interpersonal competencies tempered with fairness and respect (Landrum & McCarthy, 2012).

Ethical educators present accurate information and remain within the boundaries of their competence, based on such indicators as educational background, continuing education, and supervised experiences (American Psychological Association [APA] 10: 2.01, 7.03.b; American Association for Marriage and Family Therapy [AAMFT]: 3.1; American Counseling Association [ACA]: F.7.a, F.7.b; National Association of Social Workers [NASW]: 3.02, 4.01.b). However, proficiency requirements extend beyond mastery of the subject matter. Examples of teaching-related issues related to incompetency include poor communication channels with students, inadequate syllabi and course design, and advisement negligence (Braxton et al., 2011). (Other matters requiring competent and adept management, evaluation, and relationship skills with students and supervisees are discussed in Chapter 10.)

Teaching Skills and Course Preparation

Keeping current in one's field is an ethical mandate because of the implications for effectively educating students. Given the continual exponential growth of the knowledge stockpile, including within specialties, maintaining currency can be daunting and time consuming. Options to update skills and knowledge include taking courses, self-directed reading, collegial discussions, mentoring, and attendance at professional meetings and teaching conferences.

Case 14–12: Professor Ann Tiquaited's child psychology course consists primarily of what she learned during her doctoral training in the 1980s. More recent, significant research on evidence-based practices was absent in her lectures. The assigned readings were 30 or more years old. Several students expressed concern, given that they planned to continue their studies in child clinical psychology. Professor Tiquaited's response was, "Just do more reading on your own. There is too little class time and too many books and articles for me to cover it all."

Certainly, there is nothing inherently wrong with citing or requiring students to have familiarity with classic research and theory given that considerable scholarly work remains viable and sometimes even superior. However, Professor Tiquainted seems stuck in the past, failing to fulfill the obligation to ensure that her students are exposed to the most recent scholarly material.

Case 14–13: Students complained to the department chair about Professor Daze Fluster regarding the quality of Fluster's classes. The students claimed that he often arrived late, spent time flipping through a tangled mass of papers in his briefcase, had no readily apparent agenda for each class session, and spoke in an unconnected fashion. The students asserted that their time and tuition were not being well spent.

Assuming the validity of the students' accounts, we cannot tell for sure if Professor Fluster has competence in his field but lacks skill as a lecturer, is disorganized, or has a more serious underlying problem. Regardless of the reason, if Fluster appears ill-prepared for class on a regular basis, he fulfills neither his professional nor his ethical responsibilities.

Infusing Diversity Content

Courses attracting future mental health professionals require educators to possess, teach, and practice cultural competency and a command of and sensitivity to diversity issues (Rodriguez & Bates, 2012). The criteria for meeting adequate

multicultural coverage have changed since the days of warning students about the dangers of stereotyping and haphazardly tacking on a few facts about different peoples. The term *infusion* is used more often, signifying that multicultural material should be blended with every topic whenever appropriate and relevant. This is not always easy, but the body of helpful resources is growing. The collection edited by Bronstein and Quina (2003) includes ways to include Native American, Latino, African American, disability, Jewish, and gender issues, to name but a few, into course curricula. Whittlesey (2001) offered 75 classroom activities related to diversity.

Ethics codes invariably contain references to respect for all persons, although they differ on the amount of detail related to education and diversity. The NASW is direct and proactive in its mandate that social workers "obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability" (1.05c) and that they promote respect for cultural and social diversity and expand cultural knowledge and resources (6.04.c). The ACA is similarly proactive by mandating that educators actively infuse multicultural/diversity competency into their courses and pass such knowledge and skills on to their students (ACA: F.7.c., F.11.c).

The APA's *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (2002) states, "As educators, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education." The aspirational (unenforceable) section of the APA ethics code asks psychologists to be "aware of cultural, individual, and role differences, including those due to age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, and socioeconomic status" (APA: D).

Despite increased attention, progress in multicultural education within mental health

professions appears to be slow, revealing reluctance and discomfort on the part of teachers to incorporate diversity material (Phelps, 2012). For example, discussions of lesbian, gay, bisexual, transgender, and intersex (LGBTI) issues, despite the heightened awareness of relevant issues to psychotherapy and counseling, are often inadequately encompassed into the curriculum (Weinstock, 2003). The possibilities of difficult dialog and negative or biased student reactions are ever present when multicultural issues are under discussion. This is likely to occur when students are racially or multiculturally diverse or when the professor's identity differs from most of his or her students (G. Young, 2003). Teachers may also feel awkward teaching nondiverse students about diversity without making the diverse students in the room feel singled out as tokens (Good, 2013).

Other ethical dilemmas can arise from cultural difference. For example, students from other cultures may not view plagiarism as cheating, exactly. A study of Iranian students generated a list of reasons that may sound odd to Eurocentric educators. Examples of their justifications for claiming others' work as their own include a response to absurd assignments; a need to mask the shame of not understanding the assignment; the belief that quantity outweighs quality; the belief that graduation is more important than achievement; and even retaliation for professors cheating by taking PowerPoint lessons off the Internet (Sohrabi, Gholipour, & Mohammadesmaeli, 2011). Whereas these excuses seem unjustifiable to most of us, such perspectives need to be understood if a response is to be effective.

Not all diversity issues are about race, gender, sexual orientation, age, disability, religion, or ethnicity. Students with considerable life experiences, for example, may have a difficult time learning alongside 21-year-old students fresh out of college with no job experience.

Case 14–14: Addie Vanced, age 38, is in her first year of a Ph.D. counseling psychology program. Ms. Vanced has an R.N. degree and served on a busy emergency ward for 15 years before deciding to change her career focus. She is bored and

unhappy with her classes and asks her advisors if there is some way she can "test out" of most of her course work because she has "already actually done all of this" and "the books and lectures are a waste of my time."

We do not know if Ms. Vance has an inflated sense of her own expertise or a strongly redundant knowledge base. However, her attitude is somewhat disturbing and warrants a thoughtful discussion with her advisor. Although people with some professional background who seek advanced degrees in related fields may believe that they have previously mastered certain content, the rapid evolution of knowledge often outpaces job skills or classroom content more than 4 to 5 years old. By exploring these issues with Ms. Vance, the faculty can help her to critically assess her actual competence and simultaneously consider whether their course content is up to date.

Teaching Courses Without Formal Training

Sometimes, by choice, instructors seek proficiency to teach in areas for which they have received no or little formal training. Often enough, and especially at smaller colleges, instructors may find themselves assigned several unrelated courses, including those for which they possess only the rudiments.

Case 14–15: Professor Mutate took no graduate-level courses in industrial psychology but wanted to teach the undergraduate seminar titled, "Psychology in the Workplace." He spent a summer reading relevant textbooks and a number of primary sources. He interviewed several industrial psychologists.

It is often possible for instructors to arrange a course of study that will enable them to teach competently classes for which they received no previous training or experience. An adequate plan can vary from self-directed reading to undertaking additional course work or obtaining supervised experiences. The time and effort required are based on such factors as the course level (e.g., lower-division survey vs. specialized

upper division or graduate levels) and type (e.g., text knowledge vs. technique application). It is far less likely that preparing to teach an advanced therapy techniques course can be accomplished informally.

Whether Professor Mutate has put together a sufficient undergraduate course is not entirely clear, but there are ways he can reassure himself. Consultation with colleagues who are fully capable of teaching the course should be sought to review the syllabus, exams, and assignments. Locating a colleague who will supervise course progress during the time the course is first taught is desirable.

Impaired Instructors

Mental health professionals who teach can themselves be impaired, ranging from mild to debilitating. First, we consider the more common types of personal difficulties that plague almost everybody, including instructors. A national survey revealed that 92% of a large sample of psychology professors admitted to being unprepared for class on occasion, and 66% had taught classes at times when they felt too distressed to teach effectively (Tabachnick, Keith-Spiegel, & Pope, 1991).

Case 14–16: The electricity went out for 3 hours, a friend needed to spill out the problems she was having with her boss, and the dog vomited on the new carpet. So much for the evening that Professor Addie Lib was planning to prepare tomorrow morning's lecture.

Case 14–17: Professor Wo Izmee had a volatile breakup fight with his girlfriend of 4 years, and he just learned that his son from a previous marriage was arrested for vehicular manslaughter. When the alarm went off the next morning, he felt so agitated that he called in sick.

Professors Adlib and Izmee (adapted from Keith-Spiegel, Whitley, Balogh, Perkins, & Wittig, 2002) will most likely rebound fully. In the meantime, can they deal with their misfortune in ways that protect students while still fulfilling their professional responsibilities? Professor Lib could have “pulled an

all-nighter,” just as students force themselves to do sometimes, and put together an adequate presentation. Or, she could have facilitated a useful discussion among the students. Because unanticipated events occur so commonly, such anecdotes serve as reminders that early preparation is always preferable.

Professor Izmee's stressors seem most acute, and he may not have the ability to perform adequately that day. Arranging to show films instead, or even canceling classes if no other options existed, would be ethically acceptable because his mental anguish is probably as debilitating as a physical illness that would qualify for taking a “sick day.”

Case 14–18: Once a vibrant and active member of the department, Professor Downe Hill has steadily retreated from contributions to the college. He requires minimal performance from students and often tells colleagues that “nothing much matters anymore.” He goes home as soon as he can get away to watch TV or nap.

Professor Hill seems burned out (and, most likely, clinically depressed) and appears disinterested in or unable to seek assistance. Although Hill may have other problems, his students and commitment to the institution and its mission have certainly eroded significantly. An intervention is required.

Case 14–19: Professor Iva Lostit smashed her car into a tree and did not have funds to cover the insurance deductible to have it repaired. She became enraged when her father refused to loan her the money. On entering the departmental office in a huff after having to take a taxi to work, she threw a book at the receptionist, who, noting her intensity, asked in jest, “Did you just eat a firecracker?” She then went to her class and angrily announced to the students that not one of them had what it takes to make it into graduate school.

Professor Lostit would have spared everyone, most of all herself, had she taken sufficient time out to calm down. Should a distressed state prove other than transient, instructors are responsible for seeking professional help and

to refrain from teaching altogether when they cannot function competently (APA: 2.06b; AAMFT: 3.3; ACA: C.2.g., F.5.b; NASW: 4.05).

More rarely, instructors can experience even more severe disturbance.

Case 14–20: When Professor Spurn discovered that he and a graduate student working in his lab were both dating the same woman, he terminated the student's access to lab equipment. Spurn became increasingly paranoid and subsequently accused the student of turning poisonous spiders loose in his office, although no such spiders were ever found.

Psychotherapy clients can be hurt by vengeful or troubled therapists, but clients have greater freedom to "fire" the therapist at any time and seek help elsewhere. Students, however, cannot extricate themselves so easily from a relationship that is inseparable from their academic program, thus running the risk of a poor grade assignment or worse. In some situations, the faculty member might even cause students longer-range career problems. For example, if Professor Spurn was the only instructor teaching in the student's specialty area, the student's professional future could be endangered. In the actual episode on which our vignette is based, Spurn's student fortunately found academic shelter in the laboratory of a sympathetic colleague.

Case 14–21: Professor Gloom spoke in great detail in his abnormal psychology class about his hospitalized wife's condition. She was diagnosed as schizophrenic and believed herself to be an Amazon warrior queen. Whenever Gloom went to see her, she ordered him executed. The class heard a rundown on her condition after each of his visits. Finally, a class representative approached Gloom and expressed considerable sympathy but firmly communicated that Gloom's disclosures provided far more detail about his wife's illness and their marital relationship than the students felt comfortable in knowing.

Gloom is an example of a more piteous figure and surely requires considerable support.

But, his students are not the appropriate source of it. (See also Chapter 2 for a discussion of impaired professionals.)

Some difficult instructors fall short of having clear signs of mental illness but sport rather nasty temperaments much of the time and may even take pleasure in exerting power over students. Instructors with combative interpersonal styles rarely have insight into the harm they cause students and the institution. Unfortunately, institutions of higher education have not proven effective in managing perpetually grumpy, mean-spirited, or irksome faculty members once they achieve tenure. (See Chapter 10 for a discussion of incivility in the workplace.)

Student Ratings of Their Teachers' Competence

Once upon a time, student evaluations were confined to in-class surveys with results shared only with the teachers, department chairs, personnel committees, and perhaps deans or other higher level administrators. In recent times, students have taken advantage of opportunities to rate their teachers anonymously online, the most popular site being RateMyProfessors.com. Despite guidelines prohibiting certain types of content, comments can be devastatingly negative, leaving many to believe that these sites are revenge havens for disaffected students. Even a single criticism has more influence over students' assessment of a professor than the presumably more valid base rate data (Scheer, Muller, & Fast, 2013). Blogs devoted entirely to disparaging incompetent and unethical educators dot the Internet. Even positive comments may raise students' expectations unrealistically (Clay, 2014).

It is certainly possible that students may profit from reviewing peer ratings to decide whose classes to sign up for and whose to avoid, and professors may benefit from constructive feedback. On the other hand, studies revealed that such publicly available evaluations have an impact on professors' self-concepts and perception of competence (Kowai-Bell, Guadagno, Little, & Ballew, 2012), raising the concern that

those fearing public criticism and embarrassment may offer easier courses or inflate grades to deflect attacks. Sadly, a cycle of poorly educating students accelerates.

PERSONAL STYLES AND CLASSROOM ACTIVITY

Lecturing on Sensitive or Controversial Topics

It is impossible for teachers to be totally objective and value free. With today's widely diverse student population and the inherently delicate and controversial nature of many mental health and psychological topics, remaining both sensitive and evenhanded becomes somewhat of a challenge. Here, we use the terms *controversial* and *sensitive* to refer to topics or theories about which strong enough differences in opinion exist or the potential for distressing reactions is high.

Case 14–22: Chip Straight complained to the department chair that Professor Open offended him by discussing homosexuality in class and showing a film that depicted people of the same sex kissing in a bed. He believed such matters should “not be discussed in an institution of higher learning.”

This case illustrates how an instructor might offend a particularly sensitive student. During an informal inquiry by the department chair, Professor Open produced materials indicating that the topic of homosexuality had relevance to the course content and was based on scholarly writings. The movie was an educational film, owned by the university library.

It is possible to lower the incidence of offensiveness for some students without compromising the rights of instructors to express themselves. Students might be informed from the course onset if sensitive or controversial material will be covered. Such up-front disclosures allow students to make a voluntary, informed decision about whether to remain in the class. If exceptionally sensitive material is

scheduled for a particular day, the instructor might consider informing the students during the prior meeting and at the very beginning of the class session.

It is best to stick as closely as possible to a scientific database (if one exists) when discussing sensitive or controversial topics. If the information base originates only in opinion or studies with questionable methodology or conflicting results, the full range should be presented rather than only one side. Offering other points of view, in as objective a fashion as possible, is always encouraged. An instructor can always state why he or she personally disagrees with other opinions. Students should be allowed an opportunity to express their own views respectfully without penalty, censure, or ridicule and be given opportunities to discuss in private any feelings about material presented in class.

As long as class presentations can be justified on pedagogical grounds and related directly to the course, disapproval is less likely to occur and attempts to censure less likely to succeed. Sometimes, criticism arises because the material was added for “effect” or “shock value.” The American Association of University Professors (1940) warned against persistently interjecting into the classroom controversial matter that has no relation to the subject at hand.

Arguable Classroom Demonstrations

Issues associated with classroom demonstrations (including films) that align closely with lectures on controversial topics may require consideration before proceeding. No bright line demarcates creative and innovative teaching techniques from those that would qualify as inappropriate or ethically questionable. Sometimes, instructors find themselves taken off guard, and at other times they are insensitive to contemporary students’ values.

Case 14–23: Professor Ablation showed a video in his undergraduate neuropsychology class demonstrating vivid depictions of brain surgery techniques on a puppy and a cat. Two students fled the room in tears, and many others became visibly distressed. When one student asked Professor

Ablation why he had not given them some warning, he replied, "You're supposed to attend every class. This is a course about the brain, after all."

Images evoke powerful emotions. Having sat through multiple previous showings, instructors may lose touch with the reactions some students will have to seeing visual depictions for the first time. Students seem to be more squeamish or more open than students from much earlier decades in expressing distress when shown videos or demonstrations that involve animal experimentation (Herzog, 1990). We recommend remaining alert to what kinds of film experiences may prove too intense for some students and excuse them or provide alternative assignments if at all possible. In areas that predictably upset many or most undergraduate students, such as invasive research procedures using primates or companion animals, the instructor might consider available alternatives.

Unusual classroom demonstrations can range from exciting and memorable to the questionable or inappropriate. The next case is illustrative.

Case 14-24: Professor Wiley Sly came to class a little early, left his briefcase on the desk, and walked out of the room. While students were still filing in, a young man snatched the briefcase and ran from the room. When Sly returned, he looked confused, then worried, and then boomed out, "Has anyone seen my briefcase? I left it here just a minute ago."

Professor Sly is attempting to bring to life his about-to-be-delivered lecture on eyewitness testimony. As long as the students do not feel embarrassed or distressed by such demonstrations in which they become unwitting participants, no ethical issues pertain. However, although sensitivities may have changed in 25 years, a number of students indicated that they would be upset by demonstrations published by APA as suggested classroom activities (Harcum & Friedman, 1991). Potentially controversial demonstrations might be checked out with a focus group given that regional and cultural differences may lead to varying

degrees of tolerance. This procedure would help to ensure that the intended lesson is received without untoward side effects, such as the student who informed on the "thief" who stole Professor Sly's briefcase later being scorned as a "snitch." In any event, students should never be deceived for long, and any staged demonstration should be easily defensible as educationally sound.

Case 14-25: Professor Peter Selfie stunned his students when he showed photographs of male and female genitalia in his human sexuality class and then announced that the last slide of the series was of his own penis.

Professor Selfie used terrible judgment and skidded way past the bounds of propriety. In the actual case, his indiscretion eventually cost him his job. We do not imply, however, that all forms of personal disclosure fall out of bounds. Instructors in psychology, counseling, social work, and related fields, especially, find that what has occurred in their personal or professional lives often closely parallels what they are teaching. Students enjoy stories with a personal touch, especially if the stories are also amusing. But, it is wise to think again before getting into intimately personal areas.

Unconventional Teaching Styles and Assignments

Nontraditional teaching styles and assignments may raise questions of an ethical nature. Many instructors are deeply involved with innovations geared to motivate students' involvement in the learning process. It is, indeed, a daunting task to try to second-guess all possible sensibilities in an increasingly pluralistic culture. While we neither desire nor intend to regiment teaching style or stunt originality, it is worthwhile to note how ethical controversy can arise. In each of the next two cases, the instructors argued that their methods were used to "focus attention" or to "bring a sense of reality to the learning process." However, questions about pedagogical justification arose in each instance.

Case 14–26: John Nicetalk complained about Professor Flam Boyant's language in class. Nicetalk felt offended by Boyant's frequent use of four-letter words during his lectures to describe nearly everything. He found such language not only unprofessional, but also as providing a poor role model for other students as well as trivializing the knowledge imparted.

Just as some comedians have become known for their ability to be funny *without* resorting to a barrage of "F-bombs," so should instructors strive to teach effectively without using language offensive to others. Instructors may use off-color language because they think all students will enjoy it. The available data suggest that this assumption is untrue. A national survey of psychology students revealed that 27% rated the use of profanity as unethical under "most" or "virtually all" circumstances, indicating that over one in four may have strong negative reactions. Students presented far more concern with off-color stories or jokes, as opposed to words, with more than half of the students regarding the sharing of such material during class as unethical under "many" or "virtually all" circumstances. Only 12% viewed off-color stories as ethically acceptable in the classroom (Keith-Spiegel et al., 1993). At least one professor has experienced a suspension for "creating a hostile learning environment" due to his colorful expressions uttered in the classroom (Southwick, 2001).

What about unusual out-of-class assignments? Instructors must discriminate between the acceptably nontraditional and the problematical.

Case 14–27: Professor Brazen faced university sanctions when students complained about required assignments for a course on contemporary lifestyles. These included visiting swinging singles clubs, gay bars, group living compounds such as nudist camps and religious cults, massage parlors and bathhouses, militant political group meetings, and sexual paraphernalia shops.

It would appear that Professor Brazen's assignments did mirror the course topic. However,

a number of the students and their parents objected to having to do "such strange things" off campus. Brazen might have escaped some of the criticism had he included other options that did not demand such intense experiences. But, he did not seem to realize that requiring his students to engage in off-campus experiences could put them at possible risk of emotional and possibly even physical jeopardy; he could also expose the university to legal liability.

EVALUATING STUDENT PERFORMANCE

Most professional ethics codes contain a message for individuals to do no harm to those with whom they work. Educators are in an unenviable position in that, at times, they have a *duty* to inflict what will be perceived as harmful. Students feel distress when issued a failing (or unwanted) grade, a highly critical supervisory evaluation is entered into the record, or they are terminated from a program. Of course, the instructor or program director must be able to substantiate that such actions were taken fairly and according to school policy should negative evaluations be challenged.

Case 14–28: Brittany Brilliant was upset because she received a C in her counseling class, and it was the only C on her record. She wrote to the ethics committee, claiming that Professor Washout's exams were unfair, and that his term assignments were not carefully explained.

Case 14–29: Felicia Flunkey complained to an academic dean about a low grade, noting that, "I paid tuition and studied really hard!"

Such cases received by ethics committees are invariably returned to students with the suggestion to utilize the grievance procedures within their institutions. Ms. Flunkey seems to have confused alleged effort with competent performance. Only on rare occasions, when a student has documented negligent or prejudicial evaluations, have ethics committees intervened. In those instances, the student typically

has support from other faculty members and institutional officials who corroborate the student's position. It is common also to find that departments with seriously aggrieved students are embroiled in bitter factional disputes or controversies. The grievance mechanisms have broken down, and the students appear to have received insufficient due process during squabbles not of their making.

The fact that professional association ethics committees do not address, except under unusual and extreme circumstances, grading and evaluation disputes does not mean that profound ethical issues are not inherent in the evaluation of students. Indeed, academic performance ratings are assumed to differentiate among bright, average, and poor students. Given the significance of such labels in our culture, these blessings and stigmas have major implications for admission to advanced educational programs and future employment as well as status in one's family and one's own concept of self. In this context, academics must hold themselves accountable for their judgments. To assess students using hastily developed test questions or biased evaluation criteria constitutes infliction of harm and is therefore unethical.

Case 14–30: Barney Bummed complained to the dean of students that Professor Bubblein based a semester's grade on only a single final exam, consisting of 50 multiple-choice questions that seemed vague and poorly written.

Diagnostic tests and assessments emerge as more relevant for ethics committee scrutiny than do students' performances on course examinations. This is not because clinical assessments are more important, but because the "rules" of their construction, administration, and interpretation have been formalized, making it possible to assess their validity and competence to administer them (see Chapter 7). Academic course assessments are based on information and assignments unique to the educational experience each instructor offers. These factors, however, do not excuse instructors from personal and ethical obligations to

invest considerable effort in educating and evaluating students fairly, according to their actual performance and in a timely manner (APA: 7.06; ACA: F9.a, F9.b; NASW: 3.02.b, 3.03). Mr. Bummed has a right to expect that his learning in the course will be fairly and adequately assessed.

Ironically, grade inflation is an insidious issue that we cannot avoid mentioning. Skewing grades toward the upper end of the scale has plagued the academy for many years and shows no signs of abating, even at the nation's top colleges and universities (Crumbley, Flinn, & Reichelt, 2012; Gose, 1997; Mansfield, 2001; Pederson, 1997; J. R. Young, 2003). *The Economist* ("Grade Expectations," 2014) reported that the average grade at Harvard rose from a C+ in the 1950s to an A-by 2012. The most commonly assigned grade at Harvard is an A. Instead of complaining about Ds and Fs, today's students complain about (and have even sued over) a grade of C. It is not uncommon to find students dissatisfied with a B. Grade inflation may cause students to feel happier and less stressed. Professors may receive higher course evaluation ratings. However, the best students are seriously disadvantaged because they cannot be differentiated from those whose transcripts are bloated despite less stellar performances. Employers are also deprived of nuanced information to assist with hiring decisions. This is unfortunate because faculty may no longer be assigning grades to reward outstanding achievement (Kfir, Fresko, & Benjamin-Paul, 2002). And, perhaps most problematic of all, grade inflation may reduce significantly the effort students put into their education (Babcock, 2010).

Regardless of the many issues associated with grading procedures, instructors are expected to remain objective when evaluating students. Students see the maintenance of a "level playing field" as a primary ethic of the professoriate. The vast majority of students in a national survey rated "grading students based on how much the instructor liked them" as unethical under "most" or "virtually all" circumstances (Keith-Spiegel et al., 1993). Almost two thirds of instructors, however, admitted to allowing

how they felt about students (either liked or disliked) to influence their assigned grades, at least on occasion. However, most of these same respondents also agreed that such biased practices were ethically questionable (Tabachnick et al., 1991).

Case 14–31: From a restroom stall, Professor Uptite overheard her best student, Lettit Slipout, refer to her as “an arrogant dweeb.” Later, Uptite made a point of being particularly critical of Slipout’s paper, assigning it a B minus. When Slip subsequently asked for a letter of reference, Uptite refused.

Professor Uptite has no obligation to provide any student a reference, and Ms. Slipout’s remark cost her dearly. It was unethical, however, for Uptite to bias her grading criteria in retaliation for Slipout’s bathroom blunder. Professor Uptite might have better used the incident as a valuable teaching moment, confronting Slipout directly about the consequences of how (and where) we characterize others.

Case 14–32: At the urging of his vocational rehabilitation counselor, Joe Fleet, a disabled Iraq war veteran, returned to school. Fleet had been volunteering as a counselor for a year at the local junior high school and had received outstanding evaluations. The school principal offered Fleet a full-time position once he earned a master’s degree and counseling credential. One of Fleet’s instructors, Professor Wannahelp, also appreciates Fleet but has concerns because Fleet’s grades are below average. Professor Wannahelp feels sure that Fleet has the capability to do better but has trouble motivating himself. Professor Wannahelp assigns Fleet a B in the course even though, based on his performance in class, he earned a low C.

Professor Wannahelp is trying to assist a student who needs a credential to enter a profession for which he already has demonstrated a degree of skill and suitability. However, Wannahelp acted unfairly to the other students who received no special consideration. In addition, Wannahelp may have failed Fleet by moving him toward a licensing exam failure

based on inadequate knowledge. Other options for advocacy—such as providing a detailed letter of recommendation that focuses on Fleet’s strengths, arranging for tutoring sessions, or attempting to alter Fleet’s attitude about the requirements of schoolwork—were appropriate and available options that Wannahelp could have considered.

Other possible sources of bias include believing or accepting some students’ excuses for missed exams or noncompliance with course requirements but not others when concrete evidence of veracity is unavailable (Saville, 2012). A “no excuses” policy is one solution, but likely disadvantages students worthy of another chance.

RESPECT FOR STUDENT PRIVACY

The rules and requirements regarding confidentiality in academic settings are not the same as the duty owed to psychotherapy clients. Whereas student academic records are protected by law (e.g., FERPA, Family Educational Rights and Privacy Act, 1974), what is revealed in the classroom and informally among faculty and students is not uniformly codified. Nevertheless, ethical considerations apply, and imprudent disclosures that violate a reasonable right to privacy can cause students harm.

Experiences Requiring Student Disclosure

Concern has been expressed about the ethical risks of blending elements of therapeutic treatment with academic course work. When complaints do arise, they typically involve intense feelings, and the inherent dual role (i.e., student/quasi client and instructor/quasi therapist) is usually at the root of the dissatisfaction.

Case 14–33: Alli Hangout often spoke up during group practicum supervision. She tearfully revealed many areas of personal discontent, assuming that by doing so she was being “the good student.” Soon, she began noticing that the instructor was reacting to her differently. The other students began to withdraw from her. Her

supervisor made vague suggestions that she select another program. Hangout eventually instituted grievance procedures against the instructor for explicitly encouraging supervisees to reveal innermost feelings, resulting in considerable gossip and endangerment of her academic reputation as well as alienation from her peers.

This example involves a graduate-level course, but similar examples from undergraduate courses, such as “abnormal psychology,” abound. Research suggests that students may react negatively to certain types of disclosures (Harter, Harter, Atkinson, & Reynolds, 2009). It is not that uncommon for students to blurt out their own highly personal issues in class, especially when the topic is relevant. Instructors would do well to develop strategies in advance for effectively managing such disclosures and protecting the student’s welfare (Branch, Hayes-Smith, & Richards, 2011). The supervisor or instructor should have pulled Ms. Hangout aside the moment it became clear that her vision of achieving success in the course was counterproductive. Even if Ms. Hangout had significant psychopathology and seemed potentially unfit to deliver mental health services, this particular forum was not the appropriate one to expose her lack of suitability.

A variation on the self-disclosure theme involves written assignments, sometimes in the form of a journal, requiring students to record their personal feelings and share private recollections. This type of assignment has also come under ethical scrutiny, with claims that it often requires inappropriate self-revelation (e.g., Berman, 2001; Hanley, 2004). A required assignment to reveal a childhood trauma, for example, may exacerbate feelings of powerlessness and deference to authority figures (Swartzlander, Pace, & Stamler, 1993).

The APA has taken a detailed stand on the issue of requiring self-disclosure by listing specific topics in the ethics code (APA: 7.04) that psychologist educators may *not* require students to recount. These include sexual and abuse history, psychological treatment, and relationships with parents, peers, spouses, or

significant others. There are two exceptions. The first is clear-cut; if the admissions criteria or program at a training facility require this kind of information and clearly identify such expectations in their program and application materials, then requesting such disclosures does not violate the code. This follows from the expectation that the student has enrolled with full understanding of the requirements. The second exception is somewhat tricky. Requiring such information is *not* unethical if it seems necessary to evaluate and obtain assistance for students who are not competently performing their training or professionally related activities due to personal problems or because they may pose a risk to others. Fisher (2003) offered the example of a student who the supervisor suspected may be seeing clients socially. When confronted, the student replied in the affirmative. At this point, the supervisor asked if the relationship is romantic. Thus, during the advanced stage of training, more intrusive measures may be necessary to ensure that the individual is fit to practice independently as a mental health provider. Seeking the information in an effort to assess ethical and professional appropriateness or when a student’s mental health becomes an issue constitutes a reasonable exception.

Some programs allow (or require) students to enter individual psychotherapy for academic credit or as part of an advanced training program. We do not recommend using faculty members who regularly teach courses in the program to provide such clinical services. This separation helps insulate the evaluation of academic accomplishment from a therapeutic component.

Case 14–34: At the Farnsworth Academy of Revisionist Therapy, students are required to enroll in individual psychotherapy to assist them to better understand the roles of patient and therapist. A part-time instructor, Hylie Gassy, Ph.D., also offers therapy to students at a reduced fee and teaches two core courses required of all students. Dr. Gassy has been known to make comments on student’s assigned course papers based on things he learned about them in therapy.

Dr. Gassy seems blind to the contamination between his low-fee therapy service and teaching role. He can continue to offer the therapy but should limit access to students who have completed his required courses or to people who are not students at the Farnsworth Academy. Creating a separation from the ongoing training pipeline greatly softens any dual-role conflicts that might be experienced by both students and regular, ongoing faculty (APA: 7.05b; AAMFT: 4.2; ACA: F.9.c; NASW: 3.02.d). One exception may be psychoanalytic training, in which faculty members may serve as both instructors and training analysts for candidates. In this instance, the training model is usually well described by the analytic institute and well understood by the candidates prior to entering the program.

Using Material Originally Shared in Confidence for Teaching Purposes

Few would dispute the value of using detailed material derived from clinical work for educating future mental health professionals. Ethical concerns have been raised about the permission-seeking process when one will discuss therapy clients in the classroom. Some clients may feel they have no choice but to agree, and their reluctance may erode a willingness to be truthful during therapy. (Levine & Stagno, 2001). When consent for use of confidential material is part of a comprehensive informed consent package, important dynamics related to the current treatment process may be overlooked (Barnett, 2012). Therapist-educators must remain self-aware to ensure that their own interests relevant to the use of client-based materials are not overriding the client's best interests (Sieck, 2012). It is important for therapist-educators to be mindful of the fact that they are asking their clients for a favor, thus creating an inherent conflict of interest that must be honestly assessed. (See also AAMFT: 2.2; Chapter 6.)

Formal consent may not always be necessary if disguising the material makes identification impossible. This can be accomplished by changing demographic descriptions, altering

circumstances, compositing similar cases in a way that obliterates the identity of any individual, and using (although still disguising) older case materials while retaining the core issues of importance (see Box 6–2 in Chapter 6 for specifics). We disagree with Blechner (2012), who equated disguising case materials to faking scientific data. Educators know the desirable outcomes in advance and what lessons are to be taught and proceed to teach them in a way that protects their sources.

Telling Other Students' Stories in Class

Mental health-related educators probably have more opportunities to learn intimate details of students' lives than instructors in other disciplines, given that the subject matter is often conducive to discussion of personal issues. Such instructors are also likely viewed as having more expertise in dealing with personal problems. The almost naïve openness of many students during private office hours suggests that they believe their personal disclosures will be kept confidential. That assumption is not well founded. A large national survey revealed that, at least on occasion, 38% of the psychology faculty sample passed along material shared during personal conversations with students, even though most of those who admitted doing so felt it probably was wrong (Tabachnick et al., 1991).

Student-teacher interactions are very different from client-therapist relationships. Teachers and students are with each other in various contexts (e.g., as advisees, denizens of the hallways and snack bars, and so on), making the lines of communication complex and sometimes gnarly. Nevertheless, the same concerns can be applied to what students divulge to their educators regarding what educators divulge to students.

Case 14–35: A case of a sordid, abusive childhood was relayed to the class by Professor Lucy Lips. Although no identities were shared, a current student recognized the story as one a sorority sister recently told her in the strictest confidence. The student mentioned sharing her past traumatic

history with Professor Lips as well. The victim felt devastated on learning that her story had been openly told in Lips's class.

Students enjoy lectures heavily peppered with interesting case stories. Nevertheless, instructors must thoroughly disguise material before using someone's private life as a teaching tool (APA: 4.07; AAMFT: 2.3; ACA: F.8.c; NASW: 1.07.p). We advise that personal stories, even if disguised, based on current and recent students not be told at all. It is also imperative that teaching assistants are fully sensitized in the students' rights to privacy (Landrum & McCarthy, 2012).

Revealing Information About Students Outside the Classroom

Another dilemma arises when colleagues relax with each other and talk shop. Instructors behave just like everyone else with a job. Flushing out frustrations in the presence of sympathetic peers can release work-related stress. However, if the sessions have a ritualistic quality (e.g., a weekly contest to see who can tell the most outrageous student story), the appropriateness and constructiveness of this social tourney must be questioned.

Case 14–36: Six instructors in the psychology department enjoy meeting at the faculty club on Friday afternoons. A frequent topic involves incidents of stupid, weird, or suspicious student behavior. Several students have become especially fair game because most of the instructors know them. "Guess what Nancy Nits put as the answer to a quiz question this week?" typifies how such interactions may start.

Students' behavior can be amusing (even when not intended as such). Purposely disgracing students, however, is not an ethical way to release tension, and actual harm is more likely than may be evident in the lightness of the moment. However, just as gossiping about clients is deemed unethical (Behnke, 2007), we believe the same standard is as important—and perhaps even more so—for students. Unflattering stories

used as entertainment fodder that identify the students by name or other means will likely influence the way other instructors will see them. In this case, Ms. Nits has little chance of gaining serious support by this faculty group because, by now, her reputation precedes her. To the extent that discussion includes information about a student's academic records (e.g., grades), such casual discussion may also violate federal law (i.e., the FERPA Act) (see AAMFT: 4.7).

We would note that naming students cannot always be avoided in conversations with colleagues and can even have a beneficial intent and outcome. An instructor experiencing trouble dealing with a particular student may seek counsel from a colleague known to be wise in such matters or who had previously taught that student. When such consultations take place, they should occur in private and in a professional setting (e.g., campus office rather than the local pub). Addressing issues that will advance the student's welfare should be the *sole* intent of any such communications with others.

Occasionally, an emergency creates an unavoidable confidentiality dilemma for instructors.

Case 14–37: Bonnie Bruised told her instructor, Professor Disclose, that she feared for her life. Her boyfriend had threatened and beaten her badly, breaking her wrist, and is currently stalking her. Professor Disclose advised the student to contact campus security and the counseling center immediately. The student adamantly refused to interact with either resource. Professor Disclose contacted them herself to warn of the potential danger to her student.

Professor Disclose has been put in a difficult position because there is no mandated duty to impose herself into her student's life. However, she feels morally obligated to take protective action despite possibly alienating her student by divulging information presumably shared in confidence. Depending on the circumstances (e.g., if the alleged offender is another student), Professor Disclose might have a reporting obligation under Title IX. It may be difficult

to rebuild the student–instructor relationship with Ms. Bruised after she learns of the intervention. Under emergency conditions, ethical guidelines are not always helpful. Instructors (and therapists) can minimize greatly the risk of future censure, however, as long as their actions will be viewed as attempts to protect others rather than to exploit or harm them. (See Chapter 17 for more on decision making in emergency circumstances.)

Futzing With FERPA

The Family Educational Rights and Privacy Act, a federal law (i.e., 20 U.S.C. § 1232g; 34 CFR Part 99, 1974), applies to all schools that receive federal funds from programs administered by the U.S. Department of Education. FERPA imposes firm limits on disclosing students' educational records. Specific rights are assigned to parents by FERPA, but it transfers these to the designation of "eligible students" on attaining the age of 18 or when attending a school beyond the high school level. These rights include the ability to inspect and review any of the student's education records maintained by the school. Redress procedures exist when parents or eligible students believe the records contain errors.

Generally, schools must have written permission from the parent or eligible student to release any information from a student's education record. Schools may disclose, without consent, directory information such as a student's name, address, telephone number, date and place of birth, honors and awards, and dates of attendance. FERPA does allow schools to disclose records, without consent, under certain circumstances (see 34 CFR § 99.31). Examples of such releases might include those to school officials with legitimate educational interests; other schools to which a student seeks to transfer; appropriate parties in connection with accreditation, audits, or financial aid; responses to a judicial order or lawful subpoena; appropriate officials in cases of health and safety emergencies; and state and local authorities, pursuant to specific state law.

Case 14–38: Hector Pushy contacted the dean of students at Cookie University seeking a progress report on his daughter, Flail, a 19-year-old sophomore. He explained that Flail had not done well during her freshman year due to homesickness. He wanted to "quietly check on how she's doing," without revealing the fact her parents had concerns.

Case 14–39: Professor Sam Slippage has taught college students for nearly three decades. He routinely posts exam grading curves on his office door with individual student grades listed by the student's actual initials. At the end of each semester, he piles graded written assignments in a box outside his office so students can pick them up at their convenience.

The dean will doubtless explain to Mr. Pushy that she cannot reveal information about his adult daughter's academic progress without his daughter's permission. Professor Slippage's once-common practice now violates FERPA rules and could subject his university to regulatory enforcement actions. He must find other ways to post grades and to return hard copies of graded materials to students, such as inviting them to pick them up in his office during certain hours, leaving postage-paid envelopes for mailing, or arranging with a support staff member to return the papers to each student during business hours.

In another actual case, a professor left scored exams for students to pick up as they entered the classroom. A disappointed student requested that his exam be rescored, but only after he changed several answers. The professor countered with a duplicate of the student's original score sheet and turned the student in for cheating. After unsuccessful appeals on various grounds within the university, including asserting that he was framed by another student, the student filed a case in federal court alleging, among other things, that the professor's method of returning exams was negligent. Surprisingly, those attempts ultimately prevailed when the student's legal counsel persuaded an appeals court that the numerous procedural errors would likely convince a jury that the matter was

badly managed by the university. Considerable resources went into working this case (*Atria v. Vanderbilt University*, as described in Gajda, 2009), leaving the takeaway message to limit opportunities to cheat in the first place and scrupulously follow procedures when cheating is reported.

A Note About Confidentiality Related to Research and Training Involving Student Volunteers

Considerable social science data are collected on students, due primarily to the convenience with which samples can be mobilized. Issues of confidentiality arise for both the faculty conducting and supervising research and their student research assistants.

Case 14–40: Rod Undergrad collected essays on “What I do on first dates” from freshman students for his professor’s study on college dating behavior. The topic seemed harmless enough on the surface, but many of the statements contained explicit sexual, sometimes humorous, and occasionally bizarre material. Mr. Undergrad retained a list of students’ names with the associated numbers on the paper provided to students. He shared some of the “more juicy ones” along with the essay writers’ identities with his fraternity brothers.

Whether Mr. Undergrad was poorly supervised or disobeyed the planned procedure is not clear, but he did betray the students who were led to believe their identities would not be retained, even for those who may have not have taken the task seriously. It is imperative for undergraduate students with advanced training aspirations to learn and understand research ethics concepts. Because they are not yet sufficiently socialized into the values associated with responsible research conduct, we suggest that they not be assigned projects involving solicitation of potentially sensitive material or making use of any deceptive technique. (See Chapter 16 for a discussion of the sensitive issues involving deception in research.)

Providing opportunities to administer diagnostic and other assessment techniques is vital

in some programs. Obtaining fully informed consent from test takers is essential, including any conditions under which confidentiality could be broken (Pawlow, Pomerantz, & Sullivan, 2007).

Case 14–41: Doctoral student Herman Inker solicited volunteers to take the Rorschach test as part of his assessments training. One of his volunteers responded to a card, “It reminds me of how I want to kill myself almost every day.”

Mr. Inker needs to disclose his concerns to his supervisor and attempt follow-up. This is also a reason why gaining identities, at least for tests that assess depression or other potentially dangerous behaviors to self or others, may be useful. We know of a case where the student scored 56 on the Beck Depression Inventory (BDI II, with scores above 29 are considered “severe”), causing both the student and his supervisor considerable concern. Because the tests were administered to a large group as part of a research project with no requested identifying information beyond simple demographics (age and sex), there was no practical way to even consider an intervention (see also Chapter 6).

DESIGN AND DESCRIPTIONS OF EDUCATIONAL AND TRAINING PROGRAMS

Educational programs and course descriptions included in catalogs or other promotional materials constitute a type of service advertisement, although we usually do not think of them as such. However, students (including professionals seeking continuing education and nonprofessionals interested in nondegree educational experiences) often rely on promotional materials when searching for programs and making course decisions. Accuracy, then, becomes an ethical issue.

Complaints about program and catalog entries rarely come to the attention of ethics committees for two reasons. First, ethics committees typically address the behavior of individuals, and only rarely are names disclosed as

responsible for catalog or other promotional content. Second, other entities, such as institutional authorities or accrediting bodies will typically provide better means of redress for dissatisfied students. Nevertheless, and perhaps because of the potential for misrepresentation, the most detailed coverage of teaching-related ethics in the APA's ethics code deals with program and course advertisements (APA: 7.01, 7.02; ACA: F.8.a).

Those responsible for training programs should ensure inclusion of a suitable overview of knowledge and required experiences to qualify for whatever claims the program makes, such as fulfilling requirements to obtain licensure or certification. They should also ensure that published materials accurately describe the program content, what stipends or benefits are available, and the requirements for successful completion of the program, including any mandated counseling or therapy, projects, or service to the community (APA: 7.02; ACA: F.8.b). Those responsible for promoting workshops and nondegree programs should also include accurate descriptions of the content and objectives, the presenters, the audience for whom the program is intended, and any fees (APA: 5.03).

Case 14–42: After Pam Sincere completed a semester of her master's-level counseling program at Minus College, she learned that the degree would not qualify her to sit for a licensing exam. When she confronted her advisor, he pointed out that the program did offer a legitimate academic degree with the title "counseling," but made no promises about qualifications to enter into a licensed profession. He advised her to complete the program and later try to transfer into a doctoral-level program. Sincere had not planned on committing to advanced study.

Had Ms. Sincere actively sought information on licensing requirements she might have saved herself time, grief, and money. Students may readily assume, as did Ms. Sincere, that an advanced degree in counseling would lead to the opportunity to practice as a counselor without having to take additional course work. Minus College is, however, ultimately to blame.

The degree description should have conspicuously issued an appropriate caveat. Program representatives have the responsibility to take whatever extra steps are necessary to ensure that applicants are informed of changes or circumstances that may affect their legitimate educational needs. Helping professionals who become involved with continuing education programs and workshops must realize that today's busy consumers on a budget (and that includes other helping professionals) expect to get value for their time and treasure. Promotional materials should offer current and complete information, including realistic descriptions of what to expect. We have heard complaints from workshop attendees that the participants added nothing new beyond presenting material from their previously published books, which the attendees had already read.

Many students base their course selections on catalog descriptions, especially when signing up for an unfamiliar course or one outside their major field of study. When a significant course component is added, shifted, or eliminated, a correction should be made in the next catalog printing. In the meantime, any discrepancies should be communicated in other forums (e.g., e-mail and websites, bulletin boards, department newsletters) and, most certainly, specifically addressed on the first day of class.

Case 14–43: Doogie Stretch was eager to obtain more hands-on research experience to enhance his application to graduate programs. He enrolled in Psychology 414 because the catalog description stated that the completion of an original research project was required. However, the syllabus handed out on the first day of class included only required textbook readings, three exams, and two brief review papers. When Doogie inquired about the research project, Professor Switcheroo replied, "Oh, we used to do that, but it became too difficult to implement."

It appears that Switcheroo's department had known of the discrepancy for some time. That nothing was corrected was unfair to students, especially those as sincere as Mr. Stretch.

Educators would be wise to think of their syllabi as representing far more than “first-day handouts.” Syllabi provide the basis of a student’s informed consent to commit to a course (Handelsman, Rosen, & Arguello, 1987). When a student recognizes a catalog description inconsistency, the student usually has the option of dropping the class. However, if the syllabus fails to reflect how the course will actually play itself out, students can be unfairly disadvantaged.

Syllabi are increasingly viewed as contracts with students and have even served as legal exhibits when disputes arise.

Case 14–44: Les Miserables instigated a grievance procedure against Professor Crisplist. Miserables was given a 25% point deduction for a late paper. Miserables supplied the single-page syllabus for the course that made no mention of these penalties. Professor Crisplist retorted that he had made announcements about these matters several times in class, but Miserables was either not paying attention or not present to hear them.

Professor Crisplist fell vulnerable to criticism because the rules that governed student evaluation did not exist in a written syllabus. To qualify as an effective guide for students, as well as the best possible defense should complaints arise, syllabi should detail what will be covered in the class, learning objectives, required reading, details about assignments, any grading rules and deadlines, test formats and bases for performance evaluation, any penalties for non-attendance or late papers, and whatever else will help connect the student to the course (Rubin, 1985; APA: 7.03.a). Gajda (2009) also suggested including a statement outlining the conditions under which changes in the class might occur and avoiding any content that might promise more than what the course actually offers (e.g., proficiency in some skill). We strongly suggest including a stern statement about expectations for honesty and what consequences might result for cheating (Whitley & Keith-Spiegel, 2002).

Today, all class-related materials can be placed online at most institutions. Faculty web pages provide a source of information that

students find useful. Included might be how to contact the instructor (e-mail address and office phone number), office hours, syllabi of courses offered, advising information, and descriptions of research interests and background, as appropriate (Palmiter & Renjilian, 2003).

ACADEMIC ADVISEMENT

Ethical problems can result from advising relationships with students. (Chapter 8 discusses purely social relationships with students.) The first case deals with a dilemma all educators have faced more than once when students request assistance with career goals. Alas, students’ aspirations do not always match with an assessment, based on available evidence, of their abilities. Nevertheless, harshness is neither necessary nor recommended.

Case 14–45: Nellie Naïve told Professor Tactless that she wanted to become a neuropsychologist and could he recommend an easy graduate program because she did not want to have to study too much. Ms. Naïve was performing at a C level in Professor Tactless’s physiological psychology course and barely maintaining a B average in her major. Dr. Tactless looked her straight in the eye and replied, “You don’t have the intellect or the aptitude. I suggest you pursue a career selling shoes.”

Whereas no educator would enthusiastically encourage Ms. Naïve on her stated goals and caveats, Professor Tactless’s response was bad form and unnecessarily devastating to a young person’s feelings. He would have done better to lay out realities more gently, avoiding the nasty jab. He might try to explore both her academic performance as well as her concept of advanced degree programs and what level of commitment is required. Ensuring that the student has a full understanding of potentially interesting careers to which she is suited also seems warranted, perhaps referring her to available resources, including vocational interest testing.

Case 14–46: Professors Angela Sturm and Portia Drang are intense rivals at Trenchant University.

Drang filed an ethics complaint against Sturm, charging that she took on a graduate student who she then convinced to develop a dissertation aimed at discrediting Drang's research.

Students have the freedom to request their own advisors and dissertation sponsors. Once having paired up, advisors usually exert a heavy influence on their students. Whereas the freedom to pursue any area of valid scientific inquiry must always remain open, special care to avoid pulling students into personal disputes should be exercised. In this instance, it is not clear that Sturm behaved unethically in attempting to interest a student in a dissertation topic, but she may well have jeopardized that student's welfare by injecting him into her dispute with Drang. Initiating projects primarily designed to embarrass or expose individuals lacks integrity.

Sometimes, the student, perhaps unwittingly, may start a troubling ball rolling.

Case 14–47: After taking a seminar from Professor Trance, an impressed graduate student decided to change his masters thesis topic to medical hypnosis. The student had already been working on a masters project with Professor Drop, who had recruited the student the previous year. The student told Trance that he wanted to terminate his work with Professor Drop and start a new project with Professor Trance.

Assuming Professor Trance is interested in taking this student on, he might reasonably send the student to Professor Drop to discuss the matter or prefer to approach Professor Drop himself, depending on what feels most comfortable and reasonable given the nature of their relationship. The two professors should communicate about the situation at some point to ensure an equitable understanding. Responses by major professors to students who express a desire to jump ship vary from acceptance (sometimes even relief) to feelings of resentment toward both the student and the new advisor. Sometimes, the original advisor already has a contentious relationship with the potential new advisor, and the student's departure might feel like a humiliating mutiny.

How far the student's project had already progressed, the interdependence that had been created, and the level of the advisor's commitment to the student or the student's project constitute important factors that will have an impact on an original advisor's response to a student's request to leave. In most instances, a wise potential advisor will remain cautious until the student and the original advisor have reached an understanding. Sometimes, simply refusing to take on a student already working for someone else will yield the most equitable outcome. Switching advisors from the master's thesis to the doctoral dissertation occurs frequently, and Trance could suggest that the student discuss the possibility of working together later. Professor Trance may also want to remind the student that he had, after all, committed to work with Professor Drop. Just because the student's interests have changed does not automatically absolve a responsibility or erase an obligation.

Finally, when does student advisement go beyond acceptable boundaries? Instructors in a mental health field may find themselves sought after for free personal advice on matters that go well beyond a discussion of the literature, school- or class-related topics and projects, and the student's future education or career.

Case 14–48: Virgil Vestal fidgeted in the chair, looking very disturbed. "What is it?" Professor Blunt asked. "I have a girlfriend," Virgil responds, "who wants to have sex." "So, what's the problem?" asked Blunt. "I'm 22 and have never done it. I am really afraid, and I wanted to ask you what I should do," replied Virgil. "Go for it," replied Professor Blunt with a big grin.

Matters relating to sex, family and relationship conflicts, personal fears, and complaints about almost anything constitute typical conversational staples for approachable instructors. However, Professor Blunt treated what may have been a very complex issue as one he concluded required only a little encouragement. His impulsive blessing could well be contraindicated. Blunt would have served the student better by offering to help set up an appointment

with the counseling center as a caring and ethically acceptable alternative.

We advise setting one's professional training and expertise aside when students seek highly personal advice deserving of more than a quick comment during office hours. Instead, instructors should ask themselves, "Does this matter seem one that an instructor should refer to the counseling center or some other type of mental health professional?" If the answer is even "probably," we suggest that such a referral be made. Even if the instructor has the proper credentials to offer counseling, crossing the boundary from classroom teaching to professional counseling carries hazards (see AAMFT: 4.2).

EXPLOITATION OF STUDENTS

When educators place their own needs for achievement above the welfare of their students, abuse is the likely result. Because students often want to please their instructors, they may allow themselves to be mistreated. Or, because students can sometimes benefit from participating in activities that also fulfill their instructors' needs, they may not recognize the point at which a collaborative relationship morphs into being used. This section provides examples of instructors taking from students with little or nothing given in return. Ethics codes admonish educators to refrain from any form of student exploitation (APA: Principle B. 3.08; AAMFT: 3.8, 4.1, 5.7; ACA: F.2, F.3; NASW: 1.06.b, 2.07, 2.08, 3.01.c, 6.04.d).

Case 14–49: Clinton Clever's term paper contained a literature background and a detailed design for an ingenious experiment. Professor Purloin fleshed it out a little more, collected data, and published it without any reference to Clever. Mr. Clever complained to his advisor, who in turn confronted Purloin. Purloin's response was, "Clever expressed no intention of ever running the study. He is just an undergraduate student. If he had asked to be involved, I would have let him help with it. He could never have executed it on his own. Besides, I gave him a perfect score on this paper."

Professor Purloin's attitude reflects a lack of respect. That Clever is "just an undergraduate" is not relevant in and of itself. Further, it was not Clever's responsibility to initiate an intention to execute the study to maintain proprietary rights of the design. It may well be true that Clever did not intend to run the study on his own and would have faced difficulties had he tried; however, Professor Purloin should have consulted with the student. At that point, Clever could have declined the invitation to collaborate and given Purloin permission to go ahead independently. Even then, it would have been very appropriate for Purloin to credit Clever's contribution to the design in a footnote (APA: 8.12a, 8.12b; AAMFT: 5.6; ACA: G.5).

What if Clever's work had been less detailed, maybe in the form of a few sentences that suggested an idea for a study? We acknowledge that there comes a point at which a student paper or a casual discussion provides a glimmer of an idea that stimulates the development of an executable project. In such instances, involving the others who may have jump-started an independent creation is not morally mandated, although we maintain that acknowledging the contributions of others never hurts anyone and can even enhance a positive reputation for mentoring.

Research collaboration with students (including undergraduate students) is popular because of the benefits that can accrue to everyone involved. Scholarly output remains a primary consideration in faculty promotion and retention decisions. Research experience is one of the primary determinants of graduate school admission for many academic programs (Keith-Spiegel, 1991; Keith-Spiegel, Tabachnick, & Spiegel, 1994). Instructors must be careful, however, to prepare their students with a realistic picture of expectations.

Case 14–50: Professor Gallop's research fascinated Sid Sweat. Gallop warned Sweat that coming on board as a volunteer research assistant would be time consuming. Nevertheless, Sweat assumed that he would be actively collecting data on human participants as part of a team. But, what started out as a boon for Sweat became a drab and tedious drain

on his already busy schedule. Sweat's task was to enter data while sitting alone in a small cubicle for up to 15 hours a week. Sweat felt both disappointed and used and did not always pay careful attention to what he was doing. He fought urges to stick in bogus numbers just to get away early.

Although a plan cannot always be cast in stone, this case illustrates how feelings of exploitation might have been diminished had the student been better informed and voluntarily agreed to all aspects of the commitment in advance. That Professor Gallop has unknowingly put her own work in jeopardy by insufficiently preparing her now-resentful helper reveals how clear lines of communication are also in everyone's best interests. Inexperienced research assistants, in particular, should be monitored carefully, not only for the quality and accuracy of their work, but also for their satisfaction with the arrangement. (Additional issues involving student exploitation that arise from multiple-role relationships are discussed in Chapters 8, 9, and 16.)

SELF-SERVING INTERESTS

Textbook Adoptions

Instructors have the obligation to select required educational materials, be they hard copy or electronic textbooks or computer-assisted instruction. These materials should be based strictly on the merits of the content. However, educational publishing is a multibillion-dollar-a-year industry. When money is involved, ethical issues are not far behind (Weiten, Halpern, & Bernstein, 2012). For example, what is judged to be an outstanding textbook may be far out of line with students' ability to pay, posing a challenge for educators to attempt to balance issues of student welfare.

Case 14–51: Professor Miniracket told a book sales representative that she would adopt the company's text for her classes if the company agreed to a \$1 kickback on each copy purchased by her students.

Unfortunately, as the textbook publishing industry becomes more competitive, questionable adoption practices may accelerate (Bartlett, 2003). Nevertheless, Miniracket exploited students for personal gain.

Case 14–52: Professor Buddy adopted his best friend's book for use in his large introductory class, not because he thought it was the best and most appropriate one, but because he did not want to disappoint a close friend.

Professor Buddy sacrificed his students just to make a friend feel grateful. Buddy would have done better to bite the bullet and explain to his friend how a different choice better served his students' needs.

Case 14–53: Professor Duplicator receives a complimentary copy of a 600-page textbook priced at \$175. He finds an outfit that will print 200 copies for \$30 each. He then sells them to students for \$35, keeping the extra to pay for his time.

We cannot disagree that books, especially textbooks, are very pricy and a strain on most anyone's budget. It may seem implausible that 300 pieces of paper should cost so much. Professor Duplicator may even be justifying his actions as benevolent. However, he is not only engaging in a copyright violation, but also cheating the publisher and its authors. Writing and revising textbooks takes years of authors' unpaid time, and producing and marketing them requires a staff of professionals, all of whom were defrauded.

Moonlighting

Does working off campus during the active school year in addition to holding a full-time teaching position constitute an ethical issue? Many mental health professionals also maintain off-campus practices, and many universities allow such practice or consulting to a limited degree that does not compromise obligations to the institution. One can argue that it is unfair to students if an instructor is available minimally

or only at odd hours or is too tired or distracted to attend to students' legitimate needs.

Case 14–54: Tillie Rushbutt holds a full-time university teaching position and sees 20 private practice clients per week. She also consults regularly to mental health clinics, causing her to miss classes several times a semester. Professor Rushbutt reasons that her outside employment provides excellent teaching material and keeps her current position in her field.

The ethics of moonlighting are difficult to resolve at a macro level. From an ethical perspective, a meaningful hard-and-fast hour limit for off-campus employment is impossible to calculate. People have higher- or lower-energy levels, require more or less sleep, have no or many family obligations, require considerable or little effort to do their outside job, and so on. These factors affect the impact of outside employment on students as well as the quality of teaching, advising, and committee service to the institution. Regardless of an instructor's stamina and life circumstance, however, a tipping point is reached at which both the students and the institution are being shortchanged. Professor Rushbutt, for example, sees more clients than do most full-time private practitioners.

Some types of moonlighting are more self-serving than others. This is the most extreme case that has come to our attention.

Case 14–55: Buzi Agent, Ph.D., is a tenured professor with a real estate broker's license. He holds office hours from 8 to 9 p.m. and teaches his classes from 7 a.m. until noon three mornings a week. Students rarely come to his evening office hours, and Agent uses this time to pull out his lecture notes and to create and process multiple-choice exam scores. He leaves promptly at noon to go to his real estate office. He never comes to campus on Tuesdays or Thursdays.

Professor Agent contributes nothing to his campus community besides meeting the barest job requirements. It would be difficult to argue convincingly that his ongoing real estate career

contributes anything of substance to teaching his neuropsychology courses. Many colleges and universities do have disclosure policies that limit the extent of off-campus employment and restrict how many classes can be taught end to end. Regardless, it remains every instructor's personal responsibility to know when extracurricular activities—whether outside employment, an absorbing hobby, or even research or book writing—impair the quality of services undertaken on behalf of the academic institution and its students.

WHAT TO DO

- Prepare course syllabi and program descriptions that inform potential students of all that they would reasonably want to know (e.g., content, workload, accreditation status, grading system, etc.).
- Make sure all assignments are clear and pedagogically sound.
- Grade students fairly using criteria that apply equally to all students.
- Treat students and colleagues (even those with whom you disagree) with respect.
- Become competent in multicultural and diversity issues and incorporate them appropriately into the curricula.
- Deal with any academic dishonesty promptly, directly, and fairly.
- When students reveal personal information in a private setting, respect their privacy by not sharing such information unless there is a compelling reason to do so.

WHAT TO WATCH FOR

- Be aware of legal liability issues that apply in academic institutions.
- Make sure that you have the current knowledge and competence to teach assigned courses and workshops.
- Resist temptation to dummy-down course content and expectations of students for the purpose of earning higher course evaluation ratings.

- Clarify the difference between known facts, areas of controversy, and private opinions.
- Understand and clarify any confidentiality obligations due to students, as distinct from clients in a therapy setting.

WHAT NOT TO DO

- Do not sanction undesirable student deportment or conduct by subtracting points earned for earned academic credit.
- Avoid letting personal problems degrade your responsibility to your students and the institution.
- Avoid interactions that compromise appropriate professional boundaries between student and teacher.
- Do not provide therapeutic services to individual students in your classes or under your supervision or over whom you have evaluative authority.
- Refrain from gossiping about students.

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15

Challenging Work Settings *Juggling Porcupines*

Do the right thing.

Spike Lee

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A short-lived British comedy series, *No Heroics*, aired for a mere six episodes in 2008. One memorable moment in the show involved a brief interaction between She-Force and her imprisoned ex-flame Light Killer.

She-Force: You should use your powers for good.

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Lightkiller: Yeah, yeah, right. So being able to plunge the world into complete darkness is an ideal power for a good guy, right?

Most mental health professionals want to follow Spike Lee's call to "Do the right thing." But, several sections of this book have indicated that the right or best outcome for one person

may be the worst outcome for another. How should we parse the good work done for some clients, even if doing so causes a relative loss or potential harm to others to whom we may or may not owe a professional duty? Consider the following examples:

A psychologist evaluates children's reactions to prototypes of video games for a large computer media company that hopes to sell many copies to young males by using graphic violence, scantily clad females, and addictive game play strategies designed to encourage impulsive in-app purchases.

A marriage and family therapist assists an online dating service with strategies for matching its members and designing appealing advertising for lonely people. The company plans to promote its products as designed by relationship experts.

A social scientist creates push polling messaging that will try to influence potential voters by presenting negative information about a candidate in the guise of an opinion poll.

A psychiatrist hired by a group of bounty hunters assists in better understanding personality and cultural factors that will assist them in tracking and catching fugitives.

A wide range of work settings that have traditionally employed mental health professionals usually adheres to common ethical values that cut across the professions. Increasingly, however, mental health practitioners and behavioral scientists have found interesting employment opportunities in nontraditional work settings. Ethical pressures or challenges within such workplaces may trigger reactions, leading from subtle erosion of professional values to overwhelming emotional distress. Some settings seem especially likely to evoke ethical quandaries. For example, the mental health professionals described briefly in the examples will invariably run into specific ethical and moral dilemmas not well addressed by ethics codes. As games and apps become increasingly pervasive on all manner of console and handheld devices, will the psychologist become concerned about fostering violent content or addictive game play that enhances impulse purchases while playing? Will the

marriage and family therapist balk on learning that the matching scheme is actually far more superficial than the "sophisticated scientific selection program" advertised to its members? Will the social scientist have moral stirrings when she realizes that the one-sided push messaging is aimed at discrediting a decent candidate for office? How will the psychiatrist feel when he learns more about the actual tactics bounty hunters use to "catch their man"?

This chapter discusses the more common examples of work settings that present unusual ethical challenges, such as business consulting, the military, schools, medical centers, prisons, and even independent practice. In each of these work settings, therapists and behavioral scientists may find themselves expected to serve clients with specialized needs under unique constraints. At times, individual needs may actually become incongruent with other demands of the agency or institution, automatically placing the mental health professional in an ethical predicament. Independent practice also represents a unique type of work setting with its own special pressures, as do academic and social and behavioral research laboratories. (The last two categories are also addressed in Chapters 14 and 16.)

In categorizing the sorts of difficulties linked to specialized work settings, consider three distinct areas of focus:

- the nature and demands of the agency, organization, or special context within which the professional renders services;
- how the ethical issues relate to the particular nature of the clients and their problems; and
- the special skills or competencies (including ethical sensitivities) professionals should have to work in such settings

BASIC CONSIDERATIONS

Who Is the Client?

The classic monograph, "*Who Is the Client?*" (Monahan, 1980), grew out of the work of the American Psychological Association's (APA's)

Task Force on the Role of Psychology in the Criminal Justice System. Despite the “criminal justice” focus, the edited collection of papers has important and generic value for helping mental health professionals recognize the complex nature of different types of client relationships. Many of the issues that arise in the mental health treatment of incarcerated persons are either unique to or significantly different from the services offered to nonincarcerated persons (Walsh, 2003). In particular, we must always remain mindful of who we owe professional duties to and remain prepared to define carefully client relationships with respect to matters of confidentiality, responsibility, and other critical ethical issues.

Many employment situations involve serving varying categories of clients and distinct client need hierarchies. It is critical that therapists and behavioral scientists carefully think through and conceptualize these situations because the needs of the different components may often compete or be mutually exclusive. For example, mental health professionals employed by a government agency (e.g., the U.S. Justice Department, Bureau of Prisons) could provide services to an individual person (e.g., an inmate at a federal correctional center). In such circumstances, the practitioner owes certain professional duties to that individual (i.e., inmate), the employing agency (i.e., the Bureau of Prisons), and society as a whole (i.e., the citizens, who may be taxpayers or the victims of crime), although the specific details and clarity of the lines of obligation will obviously have great potential variability. In such situations, the ethical professional has an obligation to clarify the nature of the duties owed to each party, to inform all concerned about the ethical constraints, if any, and to take any steps necessary to ensure appropriate respect for the rights of the person at the bottom of the client hierarchy.

Employee or Consultant?

One of the first challenges facing colleagues who serve people directly or indirectly via

organizations involves one’s status as an employee or as a consultant. The employee essentially becomes a part of the organization working for wages or salary. Some employees serve in managerial or executive roles that involve setting policy and may offer incentive or bonus compensation for achieving specific results. Consultants have been described as people who borrow your watch, tell you the time, and keep the watch. Unlike salaried employees, consultants generally consider themselves self-employed and have a contract that proposes payment at an hourly rate for a particular service or project. Unlike employees, the business hiring the consultant does not pay fringe benefits (e.g., Social Security taxes, health insurance, or retirement benefits). A variant on this theme is the consulting firm at which the individuals or team doing the actual work are the paid employees of the company that contracts them out. These nuances become important when one attempts to grasp layers of responsibility for actions or inactions that may have ethical consequences.

The APA ethics code states in its Preamble: “This Ethics Code applies only to psychologists’ activities that are part of their scientific, educational, or professional roles as psychologists.” The code goes on to describe the importance of recognizing and resolving conflicts between ethics and organizational demands (APA: 1.03). Similar language is cited by the American Association for Marriage and Family Therapy (AAMFT) in the Preamble to its code. The American Counseling Association (ACA) also addresses these issues (ACA: 1.1d), as does the National Association of Social Workers (NASW; 3.07.d, 3.09.d).

The key point made in all of these nuances is that the consultant remains responsible for his or her actions, just as an employee would. One cannot argue that a duty was not owed to a person: “I did not do that work as a psychologist [or counselor, or psychiatrist, or social worker]. I did that work as a consultant.” One cannot shed ethical responsibility by hiding under the consultant label. Adhering to these tenets requires a high degree of personal integrity, as well as asking the right questions when

agreeing to the assignment and monitoring the situation as matters progress.

What Skills Are Needed for the Job?

The issue of competence assessment and recognition of limitations by mental health professionals is addressed in Chapter 2, along with the difficulties inherent in evaluating competence, especially with respect to new or emerging areas of practice. In this chapter, we stress the importance of recognizing a more subtle issue in assessing one's skills: the ability to perform with appropriate sensitivity and expertise in unique contexts. For example, one may be highly competent at performing psychodiagnostic assessment and psychotherapy in general practice, but these talents will not necessarily transfer directly to providing psychotherapeutic treatment in a prison setting or conducting psychodiagnostic assessments to aid in the selection of a corporate executive.

In some circumstances, enthusiasm, necessity, or poor judgment may propel a mental health professional into a new professional arena. The transfer or generalizability of training across situations or populations varies considerably, and those who fail to recognize and compensate for this fact may encounter serious ethical problems. Without a clear and thoughtful assessment of the situational demands, the risk of an ethical violation is substantially increased. A cautious approach affords the primary means of avoiding these sorts of problems, but the discussion that follows highlights some of the more subtle aspects of specialized skills needed at certain work sites.

Organizational Demands

As detailed in Chapter 18, most individual mental health professionals pledge accountability to a set of ethical standards or code of conduct when they seek professional licensure or join a professional association. Enforcement of such codes may take place through such associations or through investigations by statutory licensing

bodies. However, people who do not join professional associations, people who do not hold a specialized license, and organizations cannot be held accountable in the same manner. There are times when clinicians—employees may find themselves asked or ordered to behave in an ethically inappropriate manner as a function of the employing organization's needs. Monahan (1980) and his colleagues provided a cogent example by citing the case of a client of a psychologist in independent practice who reveals racist attitudes or behavior in the course of treatment. Such attitudes may or may not have relevance for the treatment program, but the content clearly constitutes a confidential matter between client and therapist. However, what if part of a therapist's work involves providing consultation to a law enforcement agency, and in the course of interviewing various employees, the clinician discovers a pattern of racist organizational policies or discrimination? The therapist might feel both repulsed and outraged but simultaneously under an ethical obligation to keep that finding confidential from the general public. However, cooperating in establishing, maintaining, or implementing such policies would constitute unethical conduct. Going public with insider information may violate organizational policy or legal standards in some situations. The mental health professional must balance an obligation to protect the individual and organizational client's confidentiality with the rights of the public or other parties not privy to the inner workings of the agency.

What if the mental health professional in the situation described chose to inform the agency's governing body (e.g., the legislative body or board of directors supervising the government agency or employer) about the racist policies? What if the mental health professional took the story to the press? As discussed in Chapter 6, limited breaches of confidentiality may be permissible to the extent needed to protect intended victims from clear and imminent danger or if otherwise mandated by law. However, racist behavior does not usually meet such an imminent danger test or legal mandate tests.

Certainly, in some circumstances "whistleblowing" behavior does become appropriate

ethical behavior, although the matter is not a simple one to sort out. As Monahan (1980) noted:

We are not suggesting that psychologists should avoid serving in imperfect organizations, only that the perennial debate concerning whether it is better to work from inside to achieve gradual change or to leave the organization and apply pressure from the outside for reform . . . is common to all organizational structures. (p. 3)

The point to remember is that what is ethically appropriate for a practitioner's work with an individual client may not ideally suit the best interests of client organizations or employing agencies and vice versa. The differentiation of obligations and the linkage of these obligations to broader issues of human welfare constitute important ethical questions that require thoughtful analysis. Yet, clear answers are often lacking. (See Chapter 17 for a more detailed discussion of whistle-blowing.)

When Interventions Cause Harm

Public trust in behavioral science and mental health professionals has led to wide acceptance of our work in many areas of commerce and government service, as well as in both medical and mental health care. With such successes come new workplace-related ethical challenges, not the least of which involves identification of our ethical responsibilities both to individuals and to society at large. We must begin to conceptualize our professional obligations much like the leaves of an artichoke, all connected at the base by our ethical responsibilities and closely packed, but still distinct and separable.

Beneficence and nonmaleficence lie at the core of most health professions' ethics codes, followed closely by concepts of fidelity and responsibility. We strive to benefit those with whom we work, while attempting to do no harm. We attempt to safeguard the welfare and rights of those with whom we interact professionally and with other affected persons. When we confront conflicts among our obligations or concerns, we try to resolve them responsibly while seeking to

avoid causing harm. Unfortunately, avoiding *all* harm becomes impossible at times, and we must instead seek to minimize harm resulting from our work. At the same time, we strive to establish relationships of trust with our clients, and we must remain mindful of our professional and scientific responsibilities to society and our communities. (The APA, AAMFT, ACA, and NASW codes all address this issue in their preambles.)

At times, the medical tradition has recognized the necessity to favor the needs of one person over others (e.g., making a triage decision to provide immediate treatment for the patient who has suffered a respiratory arrest, even though doing so may delay treating another person who arrived earlier and must wait in acute pain with a compound fracture) or to coercively limit the freedom of individuals to advance the interests of society at large (e.g., quarantine of highly infectious patients or the use of restraints with a violent mentally ill patient). In the past half century, many mental health professionals have taken on the mantle of applying behavioral science for societal benefit apart from direct individual-focused contracts. These include services to multiple individuals delivered as a unit, services provided at the behest of a known third party, and professional activities undertaken on behalf of a third party unknown by or invisible to the individuals under treatment or study (Koocher, 2007).

The individual client offers the simplest case for observing principles of beneficence, nonmaleficence, fidelity, and responsibility. After all, with only one client, the therapist's professional obligations seem well focused. However, history and law have long recognized the role of healers to assist in acting on behalf of the greater good of society. The doctrine of *parens patriae* provides an example of how government may mandate some types of medical or mental health intervention or usurp the rights of parents or legal guardians to act as the protector of a vulnerable person (e.g., a child whose parents are unable or unwilling to provide care or an incapacitated and dependent individual of any age).

Under this doctrine, legislative bodies have routinely enacted statutes mandating breaches of confidentiality and reporting by designated professionals to government authorities when a vulnerable person or society becomes threatened in defined ways (as detailed in Chapter 6). The most common examples affecting mental health practitioners in the United States include laws that command us to breach a patient's confidentiality to report suspicions that a child or an elderly or dependent person has suffered abuse. We may also face obligations to seek the hospitalization of people who pose a danger to themselves or to others, including an obligation to warn potential intended victims or to notify firearm registration agencies. Similarly, physicians and nurses may face requirements to report patients seeking treatment for gunshot wounds or highly infectious diseases to police or public health authorities, respectively. Obviously, some of the clients who come to us and disclose such behaviors or hazards would prefer that we keep silent and may experience the consequences of our reporting and subsequent intervention by the state as nonbeneficent or harmful.

The couple, family, or group of clients seen together poses a more complex situation of conflicting interests (as detailed in the section on multiple-client therapies in Chapter 4). Suppose a couple seeks the services of a therapist to help improve their relationship. Now, suppose that, over time, it becomes clear to the therapist that the best outcome for one member of the dyad would involve exiting the relationship, while the best outcome for the other would require maintaining the relationship. In such situations, one party may well suffer harm, while the other benefits. Does the fault lie with the therapist whose intervention triggered a decision-making insight by one partner, or does the decision rest on free will of one client?

Similarly, whenever groups of people enter treatment together, the best outcomes for all parties will seldom prove congruent. We constantly strive to do good, retain clients' trust, and minimize harm, even when we recognize that some parties may ultimately feel unhappy

or harmed as a result of their participation. Our ethical obligation involves foreseeing potential difficulties, affording thoughtful informed consent or permission, and retaining our professional integrity as we strive to advance the common interests. Nonetheless, sometimes we must recognize that some parties to our interventions may well experience feelings of harm resulting from participation in multiple-client interventions.

Conflicting interests also occur frequently when the authority or request for a practitioner's services originates with a known third party. In the most benign context, a third party such as an insurer or managed care company provides its customers with a panel of selected providers who have agreed to afford selected services for specified fees. Subtle conflicts may sometimes occur in such situations if a mental health professional feels dependent on or subject to pressure from the third party in a way that precludes acting in the client's best interest. In most circumstances, however, little reason exists to question the practitioner's goal of helping and not harming the client. In a number of other situations, however, therapists may ethically undertake intervention or evaluation at the behest of a third party that may lead a client to feel harmed. Examples include child custody, competency, or criminal responsibility evaluations and independent examinations to determine disability, fitness for duty, or suitability for employment. In such contexts, a third party (e.g., the courts, an employer, an insurance company, or a government agency) may have requested or ordered the evaluations.

Both the contracting party and the party undergoing evaluation hold a kind of client status in such cases. The process involves not only an appearance of mutual consent but also conflicting interests and hence a degree of subtle coercion. The individual facing evaluation may decline to participate or to share the results of such an evaluation with the requesting party. However, such refusals will have predictable adverse consequences, such as loss of custody, loss of employment, or loss of disability coverage. It is hoped that a

competent professional with a high degree of integrity will perform an excellent evaluation and provide accurate, useful data that benefit both the institutional client and the individual client. Society as a whole clearly gains by having significant decisions of this sort aided by valid behavioral science data. Still, one party may experience a degree of harm or fail to benefit from the otherwise entirely ethical and competent work of the behavioral science practitioner.

Case 15–1: Theodore John Kaczynski, Ph.D., also known as the Unabomber, sent mail bombs that killed 3 and wounded 23 people at several universities and airlines between the late 1970s and early 1990s. Federal agents arrested him on April 3, 1996, at a remote cabin outside Lincoln, Montana. On January 7, 1998, Kaczynski attempted to hang himself in jail. Two weeks later, he pleaded guilty to all the government's charges and received a sentence of life in prison without possibility of parole. The careful evaluation of Kaczynski in 1998 by Sally C. Johnson, M.D. (1998), chief psychiatrist and associate warden of health services for the Federal Correctional Institution in Butner, North Carolina, helped make the negotiated plea agreement possible.

Dr. Kaczynski has a very high IQ and a troubled psychological history, with paranoid and other psychopathological symptoms. He resisted allowing discussion of his mental state in court and refused to permit use of an insanity defense by his attorneys. The thorough and careful court-ordered evaluation conducted by Dr. Johnson enabled both defense and prosecuting attorneys to reach a plea agreement with Kaczynski that spared him from the death penalty and avoided a potentially costly and challenging criminal trial. This case illustrates a situation in which the clinician had ethical obligations to many parties. She owed professional duties to the court, counsel for both sides, and the defendant. By conducting a thorough and fair evaluation that delineated how Kaczynski's mental state interacted with the legal issues (e.g., intelligent, competent to stand trial, but highly paranoid and prone to decompensate

or act out in court), she produced a report that facilitated a negotiated settlement in a highly contentious case.

The Invisible Practitioner

A more complex set of ethical issues arises when the authority or request for a mental health professional's services originates with a concealed or invisible third party. In such situations, therapists remain unseen and unknown to the objects of their professional attention. For example, attorneys with cases that involve psychological issues or testimony by mental health experts will often hire their own experts to review and critique the work of the other side's experts, who will soon face cross-examination. Still other experts might help advise a lawyer on jury selection, run a jury simulation, use crime details to devise profiles of perpetrators to assist police investigators, help the Secret Service assess the seriousness of threats made against the president, help an employer strategize about interviewing applicants for a specific job, or develop a training program to assist investigators (pick the venue of your choice). In such instances, the client owed the ethical duty may well not be the person on whom the mental health professional focuses attention but rather a third party seeking advice. The person under scrutiny may never know that he or she has been studied, profiled, critiqued, or subjected to behavioral observation as the expert's activities effectively take place invisibly behind the scenes. In addition, the people studied without their knowledge may experience harm as the result of the practitioner's work. Serial killers may find themselves identified and convicted based on psychological analysis of crime scene evidence. Candidates for executive positions may lose a job opportunity because of emotional or personality factors uncovered during a probing interview. Careless or incompetent alleged experts may find themselves embarrassed on the witness stand.

Consumers also become frequent objects of study by anonymous social science researchers in the employ of advertising agencies.

Case 15–2: In the late 1980s, the R. J. Reynolds Tobacco Company planned to test market two new brands of cigarettes. One brand, called Uptown, contained menthol, and its marketing was aimed heavily toward Black American smokers (Ramirez, 1990). Marketing for the other brand, called Dakota, was aimed at young, poorly educated, white females, termed virile females (Cotton, 1990). In both cases, the marketing strategies were framed with the help of psychologists, who ran focus groups to assess what images and music might prove most effective with the target audiences.

The APA urged its members not to participate in helping to market “lethal and addictive” products, although some members objected, noting that the profession should not bar colleagues from working for purveyors of legal commercial entities. Still others argued that professional ethics should preclude assisting in the marketing of alcohol and firearms as well.

Hostage situations afford another example. Suppose that an angry and troubled teenager has brought a gun to school and taken a class captive. A special weapons and tactics (SWAT) team arrives and prepares to storm the classroom as snipers focus their laser sights on the armed teen. Now, suppose that a behavioral science expert working with the police interviews one of the hostage taker’s parents, who has since arrived on the scene. Based on information gleaned from the parent, the expert contacts the hostage taker via cell phone, attempts to establish rapport, asks questions, and engages him emotionally. Based on the intentional work of the behavioral science expert, the teen ultimately becomes tearful or distracted and momentarily lowers his weapon, allowing the SWAT team the seconds needed to rush in and disarm him. By using psychological skills and personal data in such situations, clinicians have saved lives while never incurring a therapeutic obligation or even disclosing professional identities to the people whose behavior they attempt to influence.

Some mental health professionals occasionally argue against any concealed roles involving

application of behavioral science to serve the needs of some third parties, usually by asserting a personal moral values position. Ethics codes have generally not attempted to prohibit such activities as long as the professionals in such roles perform their duties lawfully and follow other ethical rules (e.g., related to competent practice and avoiding conflicts of interest). As behavioral science advances, we must expect that private parties, governments, and corporations will continue to seek such consultation out of public view. Our ethics codes should compel attention to human welfare, integrity, appropriate role clarity, and obedience to law but not become a tool for advancing political or narrow social agendas.

Protection of the public and vulnerable members of society should remain a prime directive for mental health professionals. In many situations, we will face requests for services that involve multiple layers of clients, each with different positions in a hierarchy of control and vulnerability. We must remain mindful of these nuances and focus on retaining our professional integrity while providing high-quality service in the context of relative strengths and weaknesses of the parties involved.

WORK SETTINGS POSING SPECIAL ETHICAL CHALLENGES

Government Employment

The government employs mental health professionals on many levels and in all branches. These individuals serve at the municipal, state, and federal levels and have roles in the legislative, judicial, and executive branches. We specifically discuss some subsets of governmental agencies (i.e., the military, schools, community agencies, and the criminal justice system) in detail. First, however, it is worth considering government service as a whole. Working for the government involves upholding an important degree of public trust while potentially falling under high levels of political pressure. Functioning as a public servant–behavioral scientist/clinician can provide both rewards and

frustrations, especially at the level of integrating professional judgment with policy making (DeLeon, 2002, 2006; Sullivan, Grovesman, Heldring, DeLeon, & Beauchamp, 1998).

The next three case vignettes illustrate the range and complexity of issues that may occur in government service.

Case 15–3: Sam Uncle, Ph.D., a psychologist working as a clinician at a federally operated hospital, was instructed to provide access to case records in a manner that seemed contrary to the APA ethics code. He expressed his reservations to his nonpsychologist supervisor, who replied, “Those ethical principles do not apply to federal employees at this facility.”

Dr. Uncle’s supervisor’s claim that the agency employees’ professional ethics codes do not apply to professionals working within that (or other) government agencies is simply untrue. The APA and other professional associations’ ethics codes address such matters in the very first section of its code of conduct. Under the heading “Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority,” the code specifies that when “ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to the Ethics Code and take steps to resolve the conflict. If the conflict cannot be resolved, psychologists may adhere to the requirements of the law, regulations, or other governing legal authority” (APA: 1.02). The following section, “Conflicts Between Ethics and Organizational Demands,” notes, “If the demands of an organization with which psychologists are affiliated or for whom they are working conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and to the extent feasible, resolve the conflict in a way that permits adherence to the Ethics Code” (APA: 1.03; AAMFT: Preamble; ACA: I.1.d; NASW: 3.07.d).

Members of mental health professional societies pledge to uphold their group’s ethical standards on joining and are bound by the code in all contexts of their work. The supervisor

in this particular case actually misinterpreted federal policy; however, situations may arise in which employers will demand that their employees behave contrary to the dictates of ethical standards. Each person must consider how best to handle individual situations as they occur, but the basic principles are not waived for any employer, government or otherwise. The codes cited enjoin members to adhere as closely as possible to their professional code, while recognizing that some laws, regulatory procedures, or institutional rules may differ. By the use of this language, the professional groups intended to say, in essence, that when law prescribes a different course of action, psychologists must seek to resolve the conflict. Generally, obeying the law does not constitute ethical misconduct. However, the introduction to the code clearly states “If this Ethics Code establishes a higher standard of conduct than is required by law, psychologists must meet the higher ethical standard” (p. 3). The language also allows a member who may have a conscientious objection to a law or policy the option to decline to follow it. The context for psychology and other professions clearly asks members to work within the system by calling attention to the problem and attempting to resolve it within parameters allowed by the respective ethics code (AAMFT: Preamble; ACA: 1.1.c; NASW: Preamble).

Case 15–4: A municipal government hired Maxima Datum, Psy.D., to explore the question of whether racist attitudes among certain officials influenced hiring practices. Datum’s study and analysis of the personnel system confirmed the presence of active racial discrimination. The officials ordered Dr. Datum to keep these findings confidential, and after several months had done nothing to alter the illegal personnel practices.

The case of the municipal personnel research adds a new wrinkle to the role of the mental health professional. Presumably, the city in question was the client, and the same government officials who hired Dr. Datum have a right to control the data collected on their behalf, much as an individual would have

a right of confidentiality. One could argue that the public interest would best be served by making the data public, but would that produce the socially desirable change? Suppose the municipal officials say to Datum that they will use the information to “bring about appropriate change in our own way.” Does Datum have a right or a duty to challenge this assertion? Can one draw an analogy to the racist client in therapy (see Ralph Redneck in Case 3–20), who listens to the therapist interpret the racist behavior but has no desire to change current attitudes? These questions are not easily answered, but they lead to an important issue in understanding appropriate ethical behavior. The consultant must assume the burden of articulating the nature and expectations of his or her professional role (APA: 3.11; AAMFT: 3.1, 4.1, 4.6, 7.9; ACA: I.1.d; NASW: 3.07.d). When a mental health professional works for a government agency, it is no less important to explore these issues to assess the degrees of freedom and ethical comfort one may expect to enjoy in the job.

Next, we explore specific ethical issues related to particular components of government: the military, schools (including both public and private schools), criminal justice settings, and community agencies. We then discuss special considerations that arise in psychologists’ work in business and industry, medical institutions, independent practice, and pastoral counseling contexts.

The Armed Services

Given that mental health professionals and behavioral scientists dedicate themselves to advancing the cause of human welfare, should they work for the military, the Central Intelligence Agency, or similar governmental units? The question is not as simplistic as it might seem. Military and intelligence services are certainly necessary for national security, and the behavioral sciences have much to contribute to any other complex human organization (Johnson, 1995; Kennedy & Williams, 2011; Lazarus & Zur, 2002; Moore & Barnett, 2013; Russell, 2006; Staal & King, 2000). At the same time, many mental health professionals

might feel concern about the contribution of their expertise to military activities.

An article on military psychology published during the Viet Nam era (Crawford, 1970) evoked a stinging response (Saks, 1970), which claimed that, “The chief goal of military psychology is the transformation of human beings into more efficient murder machines” (p. 876). This in turn brought forth a series of rebuttals (Kelley, 1971; Leuba, 1971) and considerable acrimony. While that debate may have been more a function of the political ethos of the times than of ethics issues, some would express similar concerns today on both sides of the issue.

For purposes of this chapter, we delineate two distinct aspects of military psychology. One is the work of the civilian employee or military personnel in research and consultation, and the other is the role of civilian employee or military personnel in the delivery of mental health services in military settings. Much of the ethical decision making is precisely analogous to that which goes into the work of the research or industrial–organizational psychologist or the clinician in general. But, special subtleties do exist, and there are matters of relative emphases that necessitate critical ethical review.

Allen, Chatelier, Clark, and Sorenson (1982) described a variety of roles behavioral scientists or professionals trained in mental health perform for the military in the nonclinical realm. These may include personnel functions (e.g., selection, assessment, classification, and retention of military personnel); training (e.g., leadership development, skill acquisition, teaching, and effectiveness enhancement); human performance research (e.g., human factors engineering, job design, information process, and decision-making studies); development of specialized training (e.g., simulators and assessment centers); and health-related research (e.g., sleep deprivation, fatigue, and physical fitness studies). While the goal of such research may involve enhancing the ability to destroy an enemy before being destroyed, any moral decision about whether to participate in such programs is chiefly a matter of personal

conscience. The constraints on such research or training programs are essentially the same as those in nonmilitary settings (i.e., informed consent of participants, appropriate respect for the rights of the individual, etc.). It is evident that much of the research conducted on behalf of the military will have beneficial civilian applications, such as flight simulators designed for the military that can also be adapted to train civilian pilots. Physical fitness research and treatment protocols for posttraumatic recovery done for the military may be generalized for the public at large.

When a military mental health professional functions as a provider of clinical or counseling services, some special ethical dilemmas do arise from time to time, as illustrated in the following situations:

Case 15–5: Captain Henry B. Trayed filed a complaint with an ethics committee against a military social worker at his base hospital. The therapist had informed Captain Trayed's superiors of his extreme depression and other psychopathological symptoms; this resulted in considerable career sanctions. Captain Trayed believed that the counselor had indicated that information received in the context of treatment would be held in confidence. The counselor responded to the committee's inquiry by noting that Captain Trayed knew the base hospital treatment setting operated differently from those "on the outside."

It is not unethical to disclose confidential information without an individual's consent when the law demands it. However, practitioners must inform their clients of the limits of confidentiality at the outset of the professional relationship. The obligation to provide such information applies in both military and civilian settings. Federal law does allow officials of the U.S. Department of Defense (DoD) access to service members' health care records on a need-to-know basis; however, these circumstances are vaguely defined. Active duty military practitioners occupy multiple roles as therapist-clinicians and commissioned military officers. Frequently, simultaneous allegiance to professional ethics and military regulations

becomes impossible. Ongoing collaboration between the APA, its Division of Military Psychology, and the DoD has focused on establishing appropriate criteria to manage the resulting difficulties (Johnson, 1995; Johnson, Ralph, & Johnson, 2005; Moore & Barnett, 2013; Staal & King, 2000) similar issues arise for military social workers as well (Rubin, Weiss, & Coll, 2012).

Case 15–6: Major Freddy Shaky, a skilled fighter pilot, appeared tense and interpersonally erratic in ways that his squadron commander could not precisely grasp. Shaky refused attempts to discuss these issues, so the commanding officer ordered him to the base hospital for an outpatient evaluation. After Major Shaky had met with a psychiatrist for several sessions, the commander went to the hospital and confiscated the patient's file for review without consulting the attending clinician.

Confidentiality issues are a key source of concern in mental health service delivery to military personnel by military personnel. On the one hand, individuals in sensitive defense-related positions could become especially dangerous when attempting to perform their duties in emotionally troubled states. At the same time, such individuals ought to have an expectation of privacy and confidentiality so important to effective general psychotherapeutic care. One way to deal with the issue, as noted, is to make certain that clients are informed from the outset of the professional relationship of all limitations placed on their confidentiality.

The military client will typically be informed in the first session that certain types of problems (e.g., those related to fitness for duty) must be reported. An individual with concerns about privacy might then have the option to seek treatment off base or from civilian personnel, if appropriate. Obviously, such referral is not possible on a ship or in a battle zone (Barnett, 2013; Johnson, 2013; Johnson et al., 2005; Schobitz, 2013; Staal & King, 2000). In addition, military personnel can be ordered to submit to evaluation or treatment against their personal wishes. Although it is

easy to understand the concerns of Major Shaky's commander, confiscation of the records was inappropriate. The content of the records may not specifically address issues of concern (e.g., fitness for duty), which could be more specifically and comprehensively addressed by consulting the clinician who assessed and treated Major Shaky. Having given proper warning to Major Shaky, the clinician can reasonably release information in accord with military regulations.

Increasingly, mental health practitioners find themselves embedded with units at or near the front lines. How can a clinician deployed as an embedded member of a small team or military unit ethically manage pervasive and uncomfortable multiple-role relationships? Embedded practice often enhances the clinician's understanding of service members' needs and increases the likelihood of members to seek services. Yet, such proximity also ensures multiple roles with every member of the community and diminishes the clinician's ability to employ usual ethical strategies for minimizing multiple-relationship hazards.

The last two decades have seen increased attention to the ethical problems of mental health clinicians in the military. The DoD requires that practitioners in professions that qualify for licensing must maintain an active state license. Johnson and colleagues (Johnson, 1995; Johnson et al., 2005) noted that military psychologists strive to maintain a delicate balance between APA and DoD requirements. However, this can become particularly challenging in some unavoidable situations. Johnson and her colleagues also presented some fascinating examples related to confidentiality and multiple-role relationships while serving as warfare-qualified officers and psychologists on an aircraft carrier. The following three cases were adapted from that article (Johnson et al., 2005):

Case 15–7: Having treated an emotionally fragile dental technician for several months, the psychologist arrived at the onboard dental clinic for a teeth-cleaning appointment only to find the client assigned to the task. The psychologist became a captive audience, as the technician scraped,

sprayed, and suctioned, along the way unloading a stream of personal material more appropriate for the psychotherapy office. The psychologist attempted to respond authentically despite having a mouth full of fingers and equipment. When the dental appointment ended, the psychologist wondered about the need to make a clinical note of this "session."

Case 15–8: As a warfare-qualified officer, the psychologist must stand regular watch on the bridge of the ship. While doing so during flight operations one evening, the helmsman failed to listen to a command issued by the psychologist, became flustered, and turned the ship in the wrong direction. Although quickly corrected, the error could have led to disaster had an aircraft been on final approach at that moment. The psychologist quietly had a few words with the helmsman, after which the captain called the psychologist over and half-jokingly remarked on the soft approach in responding to the helmsman's egregious error. He expected the psychologist to address the helmsman more forcefully. The psychologist quietly reminded the captain that he ordered this sailor to psychotherapy by the psychologist a few weeks earlier. The psychologist noted that a dual relationship with this particular helmsman existed, and that any screaming delivered now will become fodder for the next therapy session. The captain shook his head and rolled his eyes, as if to say, "Now I've heard everything."

Case 15–9: During a morning briefing, a female psychologist learned that her social security number had been randomly selected for the day's "operation golden flow," the term given to the random urine collection and drug-testing program. The rather-demeaning process involves the master-at-arms personnel accompanying the person being tested into a bathroom and closely observing while the examinee urinates into a cup. Both then march back to the security office carrying the sample in plain view. When the psychologist reported for testing, only male observers were present, requiring a call for a qualified female observer. One of the psychologist's long-term patients walked through the door and gasped, visibly embarrassed to be in this position. Both did their best to make small talk and maintain some professional demeanor as the

psychologist disrobed and urinated in front of her. Fortunately, they were able to look back and laugh at the incident during later sessions.

Sometimes, serving as an embedded clinician in a combat zone can pose dangerous clinical challenges. Consider the following case:

Case 15–10: U.S. Marine Private First Class Johnson arrived to see Lieutenant Commander Heidi Kraft in her tiny office on a military base in western Iraq on the referral of his superior, who thought he was “acting strangely.” The outside temperature was 130 degrees, and Johnson arrived armed with his M-16 rifle and K-Bar, a knife issued by the Marine Corps. Kraft, an embedded military psychologist, wore a 9-mm sidearm in a shoulder holster. As she interviewed Johnson, it soon became clear that she was seated with a dangerous and increasingly agitated heavily armed man who was experiencing psychotic hallucinations and had no interest in obtaining treatment. She managed to calm the situation enough to let Johnson exit and then initiated the process of having him disarmed safely and medically evacuated over the objections of his executive officer, who saw Johnson as a highly productive Marine, overlooking his apparent eccentricities (Kraft, 2011).

In an earlier article, Johnson and Wilson (1993) presented examples of problems unique to psychology internships at military sites. Others have written of the difficulty of being “in service of two masters” (Jeffrey, Rankin, & Jeffrey, 1992) and presented two illustrative case studies on point. In one instance, a military psychologist was reportedly disciplined by the APA for failure to maintain the confidentiality of a service member’s care records long after the psychologist had been transferred to another post. In the second case, a psychologist was disciplined by his commanding officer for failure to reveal an alleged violation of the Uniform Code of Military Justice by a third party. Psychologists are not alone in confronting such dilemmas. Camp (1993) wrote of the “double-agent” status of psychiatrists serving the military in the Viet Nam era.

The role of psychologists in prescribing medication on military bases has drawn considerable

attention because of the DoD’s demonstration project, in which a specially selected cadre of psychologists received special training to qualify for that role. However, at least one ethics inquiry about psychologists prescribing medication pre-dated the DoD project, occurring in the mid-1980s.

Case 15–11: During the mid-1980s a psychologist in the community became concerned when he learned that a female client, whose husband was a military officer, was taking psychoactive medication prescribed by another psychologist working at the base hospital. The community-based psychologist feared that the prescription had been fraudulently written and called this to the attention of a state licensing board.

The psychologist accused of prescribing medication without a medical degree had indeed done so, but not unethically. In addition to his psychology degree, this individual had trained as a physician’s assistant and secured authorization under military regulations to prescribe medication, under specific circumstances, for military personnel and their dependents receiving treatment at military facilities. In this instance, the psychologist practiced within his sphere of competence in full compliance with military regulations appropriate to the care of the client in question. While this particular type of service was unusual for psychologists in the 1980s, the subsequent demonstration project undertaken by the DoD in the 1990s proved extremely successful in providing sufficient psychopharmacology training to enable psychologists to function successfully in such roles under military authorization. The DoD demonstration project also helped pave the way for state legislation allowing psychologists with specialized training and credentials to include psychopharmacology in their practices (Sammons, Paige, & Levant, 2003).

School Systems

Schools come in all shapes and sizes: public and private, secular or religious, day or residential. Most American children are required by law to

attend school and hence become subject to the powerful influence of the school as a socialization agent. Many psychologists, counselors, and other mental health professionals who practice in school settings hold master's degrees rather than doctorates. Some controversy in the practice of school psychology or counseling involves issues of competence, credentials, and professional control. We address questions of competence and qualifications in Chapter 2. We shall not rehash regulatory or professional disputes in school psychology here but instead focus on more specific types of ethical dilemmas in the schools that apply to all the mental health professionals working in school settings (Jacob & Hartshorne, 2003; McNamara, 2008).

Many important issues of special ethical concern have come to light in school settings (Hansen, Green, & Kutner, 1989; Jacob & Hartshorne, 2003; McNamara, 2008; Woody, 1989), including informed consent for assessment and intervention privacy and confidentiality (Kopels & Lindsey, 2006; Lewis & Porter, 2004; McGivern & Marquart, 2000; McNamara, 2008; Nagy, 2005; Raines, 2004; Reamer, 2005); rights of children with disabilities (Jacob & Hartshorne, 2003; Lewis & Porter, 2004; McNamara, 2008; Perrin, 1998); determination of classroom goals and legitimacy of rewards and aversive controls in the classroom (Koocher, 1976); and the use of the "time-out" as a potential type of abuse (Prilleltensky, 1991).

A survey of school psychology training directors suggested that the most common ethical violations among their students involved confidentiality, competence, and professional and academic honesty (Tryon, 2000). We also discuss the role of the school psychologist as "whistle-blower" (Bersoff, 2003).

Special problems for school-based mental health professionals also occur at the interface of ethics and the law. At times, laws bearing on mental health and educational issues may conflict (Jacob & Hartshorne, 2003; Shribberg, Song, Miranda, & Radliff, 2013). For example, FERPA (Family Educational Rights and Privacy Act, 1974), IDEA (Individuals With Disabilities Education Improvement Act, 2004), and related state laws give parents access

to the relevant records as well as control over whether their child receives evaluations or special services. Suppose that the state also gives minors the right to independent access to drug counseling, sexually transmitted disease information, abortion advice, or psychotherapy? Which set of laws does the school psychologist obey? The next four cases raise, in a fashion somewhat exaggerated for emphasis, a sampling of the issues confronted regularly by school psychologists.

Case 15-12: International Psychometric Services was in the process of developing specialized norms for its high-school-level achievement tests for use in job classification assignments of new recruits by the military. They offered school systems the opportunity to have their senior classes evaluated on the instrument free of charge to establish an improved normative base. They also added some additional questions regarding "attitudes toward the military" to the instrument. These included some potentially sensitive questions, such as asking male students, "Have you registered with the Selective Service System?" Schools were offered the free service only if they would require all of their high school seniors to take the test. The director of psychological services at the Lakeville Unified School District accepted the offer.

This case illustrates the issues of informed consent and privacy with respect to testing. In particular, one wonders whether the answers to questions irrelevant to school functioning (i.e., draft registration information) would reach government authorities along with the student's name. If the school requires a student to take a test, compelling answers to such questions would constitute an invasion of privacy. It appears that the director of psychological services should carefully examine the intended uses of the test information before signing up for the program. In addition, the students should not be required to take the examination or otherwise provide personal data without appropriate informed consent relative to the nature of data to be collected, purpose of the program, and information regarding who will have access to it. We would assert that the school has no

justification to waive these important personal rights of the students.

There is not much by way of actual case law on this type of situation, but at least one federal district court decision seems relevant. In the case of *Merriken v. Cressman* (1973), the American Civil Liberties Union represented the mother of a student who objected to an ill-conceived program intended to predict which junior high school students in Norristown, Pennsylvania, might become drug or alcohol abusers. A “consent” form asking whether parents objected to the program was sent home. School authorities assumed that parental consent was granted if no objections were raised (Bersoff, 1983). Although the case raised many constitutional issues, the court specifically addressed the invasion of family privacy rights, finding in favor of Mrs. Merrikin, acting on behalf of her son. The court noted the children were “never given the opportunity to consent to the invasion of their privacy; only the opportunity to refuse consent by returning a blank questionnaire” (p. 919). The court also criticized the lack of “candor and honesty” on the part of the school system, comparing the so-called consent letter to a Book-of-the-Month Club solicitation (Bersoff, 1983). The question of the child’s privacy rights above and beyond those asserted by his parent on his behalf were not clarified in this case; however, we would encourage colleagues to extend respect for privacy to child as well as adult clients.

Case 15–13: Jonathan Swift, Psy.D., gave a lecture on the use of time-out interventions to teachers and administrators at the Centerville Public Schools, where he was employed as a school psychologist. Several weeks later, he discovered that a school principal had interpreted his talk as a license to lock misbehaving children in a darkened closet for up to an hour at a time.

When Mr. Swift gave his lecture on time-out practices, he never dreamed that it would result in misinterpretation and abuse. While the school principal was most directly responsible for the inappropriate intervention, Mr. Swift should have used warnings and cautions in an

effort to avoid any misunderstanding. Ideally, Mr. Swift could have helped to formulate a school or systemwide policy on the use of time-out techniques and arranged for appropriate training or supervision of those authorized to use isolation strategies. As the expert presenting the information, Swift had the additional responsibility of presenting appropriate limitations or otherwise alerting the participants at the lecture on appropriate constraints.

Case 15–14: At the Farnsworth Elementary School, teachers have full access to a child’s cumulative school record. Material of a personal nature entered in these records occasionally became a topic of conversation in the teacher’s lounge. When school social worker Sylvia Caution, M.S.W., learned of this, she decided that she would no longer document any of her clinical observations in the record.

The case of the school record system highlights a variety of issues covered in Chapter 6 and well described specifically in the school confidentiality context by others (Bor, Ebner-Landy, Gill, & Brace, 2002; Glosoff & Pate, 2002; Jacob & Hartshorne, 2003; McNamara, 2013; Moriya, 2006; Reamer, 2005). Sadly, Ms. Caution’s response seems a bit overreactive. As discussed in Chapter 6, record entries must be considered with a balance of utility and the need to know. The teachers may not need to know that Johnny Smith was born prior to his parents’ marriage, but it would clearly help Johnny if his teachers understood his tendency to withdraw socially when stressed. The circumstances of Johnny’s birth add nothing to assist in the promotion of his educational progress, but information regarding a tendency toward social withdrawal might help a teacher reach out to him more effectively in the classroom. In any case, his parents have a right to know who within the school will have access to what information and have the option to give or withhold their consent. Ms. Caution should take some professional initiative in educating her colleagues about more appropriate treatment of confidential information, or she could take steps to limit access to records if necessary.

Case 15–15: Andrew Rigor, Psy.D., was frequently asked to assess “special needs children” in his role as a psychologist for the South Suburbia school system. When the special education budget began to show signs of strain, the superintendent instructed Dr. Rigor to administer shorter evaluations, produce briefer reports, and refrain from recommending additional services or evaluations for the children he assessed. The superintendent explained that these steps were needed to keep costs in line.

The case of Dr. Rigor applies increasingly to public school systems under pressure to control costs while also obligated under federal law (IDEA, 2004) to meet the needs of special students. It also applies to other nonschool institutions in which administrators without credentials in assessment may attempt to limit or modify professional standards as a way to meet institutional needs. In a case similar in some ways to Dr. Rigor’s, although considerably more complex, the APA filed an amicus brief in support of a school psychologist attempting to cope with such pressures (APA, 1980).

Ideally, Dr. Rigor should vigorously resist any attempt to do less than a fully professional job on his assigned cases. He should stand willing to consider any reasonable administrative requests consistent with professional standards but should not compromise his integrity by providing less-than-adequate services (or violate legal obligations to report genuine student needs) to comply with administrative fiat. The difficulty, of course, falls to sorting out the appropriateness of each position and balancing one’s integrity with threats of job loss or other retaliation (Glosoff & Pate, 2002; D. Lewis, 2006; Lovett & Lewandowski, 2015). In some circumstances, one may have to choose between a job and his or her conscience, but often a reasoned attempt at accommodation and a careful explanation of professional standards will bring less drastic formulas to bear on a solution.

College Counseling Centers

University and college counseling centers encounter many ethical challenges related to

training practicum, internship, and postdoctoral students (Brown, Murdock, & Abels, 2014). The ethical dilemmas flow from the nature of the small community and the competing missions of patient care and training. How can one best balance the potential difficulty of offering counseling to students who are also in training and possibly eligible for practicum or internship placement? How can one best respond to trainees who refuse to counsel certain clients due to religious beliefs (see Cases 5–18 and 5–19)? How does one balance supervision time focused on ensuring competent services to the supervisee’s clients versus addressing training needs of the supervisee?

Case 15–16: The Goodenough University (GU) Counseling Service offers psychotherapy to GU students for a highly affordable \$20 per session. Services are provided by graduate students in practicum classes or internships associated with the GU School of Social Work M.S.W. program and clinical psychology Ph.D. program, working under the supervision of licensed faculty members.

Milton Mediocre is a doctoral student working as a psychology intern at the center. He has treated freshman student Mindy Morose for the last 6 weeks. They have a good working relationship, but Mindy still reports feeling very homesick, at GU and feels increasingly anxious about midterm exams, even though she is doing well academically.

Felicia Fretful is enrolled in the M.S.W. program at GU. She recently broke up from a yearlong relationship and would like to obtain some help at the Counseling Service but feels concerned about privacy because several of her classmates are placed there as student-therapists. As a GU student, Felicia is entitled to use the reduced-fee services and cannot afford to seek private treatment in the community.

These examples illustrate just a few of the potential challenges. Mr. Mediocre’s treatment of Ms. Morose may not qualify as expert treatment, but is it adequate for her needs? How can Mr. Mediocre’s supervisor balance the trainee’s

need for skill development with Ms. Morose's need for effective treatment? It is hoped that this will occur with attentive supervision and with an eye toward escalating or adjusting treatment as Ms. Morose's needs dictate. As the more vulnerable party, the patient's needs warrant priority over the training needs of Mr. Mediocre. However, the facility is a training clinic, and it is hoped that it informed Ms. Morose that her therapist is a trainee working under supervision.

Ms. Fretful has legitimate concerns about her privacy. At the same time, her student status at GU does entitle her to services just like any other student. It is hoped that the counseling center has some policies in place to deal with trainees who may also hold student status. This could include reserving some senior staff time to treat students in training programs and segregation of waiting areas and clinical records so that her patient status is invisible to peers.

While these few examples certainly do not exhaust the range of issues one expects to encounter in such settings, boundary and multiple-role problems must be anticipated. The key takeaway message is the mandate for educational institutions with joint clinical and training components to frame policies that ensure competent treatment, adequate supervision, appropriate privacy, and a careful balancing of trainee and client needs.

The Criminal Justice System

We began this chapter with reference to the APA task force report on the ethics of psychological intervention in the criminal justice system (Monahan, 1980), and Chapter 13 discusses the role of mental health professionals in the courtroom. It seems appropriate, however, to dwell at least briefly on the broader role of mental health practitioners within the criminal justice system, including their work with criminal defendants, prison populations, and police agencies (Brodsky & Galloway, 2003; Dvoskin, Spiers, & Brodsky, 2007; Haag, 2006; Hartwig, Granhag, & Vrij, 2005; Kinscherff & Koocher, 2015; Porter, 2005; Walsh, 2003).

In each of these contexts, the critical route to successfully negotiating the complex ethical

relationships involves carefully sorting out obligations to clients. This requires that the mental health professional give substantial forethought to the matter of duties owed different parties and spend sufficient time and energy clarifying the accompanying obligations, roles, expectations, and work conditions. When one can explicate ethical duties clearly in advance, a violation becomes much less likely, in part because the practitioner has anticipated potential problems and in part because the client has received appropriate cautions.

According to the U. S. Bureau of Justice Statistics, 1.6 million Americans were incarcerated in state and federal prisons at the end of 2013 (Bureau of Justice Statistics, 2014), and except for the occasional exposé, their treatment remains hidden from most of society. Some have described the prevailing ideology of correctional administration as one that deemphasizes treatment or "corrections" and focuses attention on punishment, security, and custodial matters (Weinberger & Sreenivasan, 1994). Others noted that the choice of the word *corrections* implies the ability to change human behavior for the better in the punitive and sometimes rehabilitative institutions we call jails and prisons (Dvoskin et al., 2007). Others asked whether we can truly instill a professional ethic for prison personnel given formal regulatory constraints and the nature of such institutions (Kipnis, 2001). The American Correctional Health Services Association (ACHSA) and the American Association for Correctional and Forensic Psychology (AACFP) have developed codes of ethics to provide mental health care professionals a clinician-derived guide for ethical clinical practice within correctional settings. These specialized codes complement existing general ethical principles in decision making for correctional mental health providers. The major foci of these codes include client welfare, informed consent, competence, dual relationships, confidentiality, and social responsibility (Bonner & VandeCreek, 2006).

Mental health practitioners in correctional settings find themselves using their expertise to perform a wide range of duties. These might include evaluating and classifying inmates,

conducting psychotherapy or crisis intervention, providing employee assistance, participating in the personnel selection process, and serving as consultants for institutional decisions and policies related to the correctional climate (Brandt & Morgan, 2005; Lowman & Lowman, 2006). Professional association ethics codes do not call out correctional issues for special attention; however, most would agree with the issues cited as specific concerns of correctional psychologists in Canada (Haag, 2006). Haag (2006) focused particular concerns from the Canadian Code of Ethics for Psychologists (Canadian Psychological Association, 2000) on the issues of who is the client, confidentiality, protection of psychological records, informed consent, assessment, corroboration, refusal of services, nondiscrimination, competence, knowledge of legal structure, accuracy and honesty, misuses of psychological information, and multiple relationships. The ACA and NASW address these fundamentals as well as social justice issues.

At the same time, research tells us that psychotherapy alone will not lower recidivism rates significantly (Ochipinti & Boston, 1987), leading some to assert that psychotherapists who work in correctional settings often serve only as “window dressing” (Weinberger & Sreenivasan, 1994) and frequently do not provide meaningful clinical services. In support of their contention, Weinberger and Sreenivasan (1994) cited a Federal Bureau of Prisons’ orientation program for new employees that focuses on correctional concepts, self-defense, and searching for contraband (among other topics). They cited case examples in which mental health professionals find themselves ordered to perform the duties of correctional officers during personnel shortages (i.e., contraband or pat-down searches in inmate cells), asked to undertake psychological testing with a specific goal of finding a reason to prolong incarceration, or asked to participate in disciplinary hearings. In addition, they described circumstances in which institutional staff with differing priorities and views may ignore or trivialize a clinician’s legitimate therapeutic recommendations. They raised important and valid issues, but also appeared to paint all corrections systems with an overly

broad brush. The common thread in the situations they described remains the difficulty faced by mental health specialists who work for departments of correction as opposed to those who work for administratively distinct mental health units.

The key ethical issues involve the degree to which a mental health professional’s ethical standards and professional role become compromised by any given correctional setting. When working in such settings, practitioners do not become exempt from their ethical responsibilities. Prior to undertaking such employment, the wise mental health professional will carefully examine the expectations placed on them in the new job and raise any apparent conflicts with their superiors from the outset. To the extent that role expectations seem inconsistent with appropriate ethical standards, practitioners should make every effort to bring the role into conformity with their ethics code (APA: 1.02–1.03; AAMFT: Preamble; ACA: 1.1.c; NASW: Preamble, 1.01). If that is impossible, they should not agree to remain in the inappropriate role.

The next three cases represent classic ethical problems for the mental health professional in the criminal justice system. They were modified from material presented by Monahan (1980) and Vetter and Rieber (1980).

Case 15–17: Roberta Reason, Ph.D., often participates in the evaluation of criminal defendants as part of court-ordered determinations of their competence to stand trial. Defendants must usually meet with her unaccompanied by their lawyers. When she begins to interview a woman charged with the beating death of an infant, the defendant complains, “If I don’t talk to you, they’ll say I’m not cooperating, and I’ll be in trouble. If I do talk to you, I’ll be losing my Fifth Amendment rights.”

The defendant who confronted Dr. Reason quite accurately recognized the risks of her cooperation or noncooperation. We hope Dr. Reason has thought through her role sufficiently to guide the defendant. Dr. Reason might note, “My job is to help determine whether you have the ability to understand the

charges against you and their potential consequences, and that you can cooperate in your own defense. You may choose not to answer some of my questions if you wish, but I shall try to focus them on matters relative to your ability to assist your lawyer at the trial. I do not want to discuss your guilt or innocence." Dr. Reason must clearly delineate for herself and the defendant her role and responsibilities and must do her best to avoid an undue invasion of privacy or placing her client at inappropriate legal risk.

Dr. Reason should also consult carefully with the defense attorney and judge to ensure issuance of proper protective orders that limit access to her reports. Most courts that have considered the problem have held that the Fifth and Sixth Amendments prohibit admitting as evidence information obtained during a competency evaluation. Some prosecutors might seek to use such information as investigative leads for delving further into or planning the conduct of the case. Such use of Dr. Reason's report would be ethically troubling.

Case 15-18: Andrew Penal, L.M.H.C., works at the Stateville Prison Colony as a correctional counselor. During an individual treatment session, a new inmate reports that an escape attempt involving taking hostages will soon take place. Following this revelation, the client begs, "Please don't tell anyone about this. If the other cons find out I snitched, they'll kill me."

Mr. Penal now has a difficult predicament. As noted in Chapter 6, a mental health professional facing such a decision might have an obligation to warn certain potential victims, but Mr. Penal must also protect the rights and welfare of his client. Several commentators reported a full range of conflicting views on what Mr. Penal should do (Brodsy, 1980; Brunswig & Parham, 2004; Dvoskin et al., 2007), varying from upholding absolute confidentiality to the opinion that no such thing as confidentiality exists in prison settings. In such confinement, inmates/clients will often test the therapist, particularly to determine whether they can possibly trust the clinician. The reasons why inmates seek treatment or consultation will vary

widely; these range from the traditional (e.g., "I need psychological help") to the pragmatically self-serving (e.g., "It will look good when I come up for a parole hearing to have therapy on my record here"). While we do not know enough about the context to determine exactly which options Mr. Penal has available, we can outline the steps he should have considered prior to this situation.

Mr. Penal should have clarified his legal and professional obligations with prison authorities relative to their expectations. If they expect him to report all infractions of the rules, for example, he would need to evaluate his willingness to work in that context. When beginning work with inmates, Mr. Penal should also have clarified with each authority and inmate the limits of his role and the nature of their relationship. For example, will he honor every confidence? Which confidences can he not respect? Do inmates have the right to ask that he not speak to the parole board or that he clear with them in advance what he would say? What if the results of a psychological assessment might lead to the death penalty (DeMier, 2011)? These few examples illustrate the questions that mental health professionals should routinely raise. A mental health practitioner should never surrender professional integrity and standards to competing pressures of the work site. Each client has the right to know the special constraints on, or parameters of, the professional relationships prior to entering it.

Case 15-19: George Cops, Psy.D., is a special consultant to the Center City Police Department. He is available on retainer to provide therapeutic intervention to police officers under pressure from job-related stress and especially to assist officers with their feelings following involvement in shootings resulting in a suspect's death. A newly appointed police chief has asked Dr. Cops to provide comments for the personnel files of the officers he has counseled.

It is hoped that Dr. Cops will advise the new chief of police that he must respect the confidentiality of the officers he is asked to treat as therapy clients, citing both professional

standards and court rulings (*Jaffe v. Redmond*, 1996). If the chief wishes personnel selection advice, fitness-for-duty evaluations, or other consultation, that information should not come from the same person expected to provide an uncritical therapeutic role. In addition, the officers have the right to know in advance who will have access to and what use will be made of any data they provide (APA: 4.02; AAMFT: 7.4; ACA: A.2; NASW: 1.07). We have not raised the more complex situation regarding what Dr. Cops should do if an officer he counsels appears to be at some nonspecific but real risk for future behavior problems. The point at which Dr. Cops becomes responsible to report a “clear and immediate danger” becomes an important ethical problem he will have to address for himself. Ideally, we hope that Dr. Cops will have thought through and resolved these issues with the police department prior to accepting the job (Bartol & Bartol, 2006).

Community Agencies

A community agency, for purposes of this discussion, might include a government-funded community mental health center, a nonprofit community-run clinic, a municipal hospital, or some similar service delivery system. These facilities provide critically important community service resources but function in a politically reactive mode by their very nature (Backlar & Cutler, 2002; Caldwell, Domahidy, Gilsinan, & Penick, 2000; Helbok, 2003; Melton, Levine, Koocher, Rosenthal, & Thompson, 1988; O'Neill, 2005; Riger, 1989; Robertson & Walter, 2014; Serrano Garcia, 1994). They often depend on funding or regulatory support from local governments. Such agencies often have competing demands placed on them by various interests, and mental health professionals working in these agencies are likewise subject to multiple demands that occasionally conflict (O'Neill, 1989, 2005). At times, these conflicts become significant ethical issues.

Joseph and Peele (1975) illustrated the particular problems presented by the fact that professionals in such settings serve both the community and their individual clients. The

following two cases are adapted from their presentation:

Case 15–20: Casey Tuff, a 14-year-old boy, found himself referred to a community agency by his mother and his school because of his unmanageable, hostile, and aggressive behavior. The assessment indicated that collateral treatment for both Tuff and his mother would provide the best chance for success. Although she initially agreed to the plan, Tuff’s mother refused to keep appointments. She did not respond to information that the program would cease serving Tuff if she refused to participate. Ultimately, the program discharged Tuff because his mother would not cooperate in the treatment plan.

Case 15–21: The inpatient service of a community mental health center admitted Mrs. Morass for treatment of severe depression. Because she had abused her children, a protective services agency also became involved in her case. After a few weeks, her depression had improved sufficiently to warrant her discharge to outpatient treatment. Afraid that she would again harm her children, the protective service agency urged the mental health center to delay her discharge.

Joseph and Peele (1975) noted that the mental health professionals in both cases felt caught between two conflicting sets of duties. In Tuff’s case, they had begun serving the young client but soon realized that their treatment plan could not work effectively without the support and involvement of his mother. Without maternal involvement, allowing Tuff to occupy a treatment slot might result in deprivation of services to some other client who might make more effective use of treatment. When Tuff’s mother broke her initial participation contract, the clinic’s obligation to Tuff was likewise ended.

In Mrs. Morass’s case, a similar situation existed in terms of the allocation of scarce resources and effective cost control in community agencies. The mental health center had the obligation to provide the most effective and least-restrictive treatment to their client, Mrs. Morass. Because she no longer required inpatient care, hospitalizing Mrs. Morass simply

to serve the needs or convenience of another social agency, however laudable the goal, clearly violates professional ethics. The children's protective service agency had the obligation to provide necessary care for the children regardless of their mother's hospital status.

While other creative solutions might have existed in the cases of Tuff and Mrs. Morass, our attention focuses on how professionals may often find themselves caught between their appropriate concern for individual clients and concern for the community. Bureaucratic demands in such social welfare agencies can become overwhelming at times, and legislation intended to improve services may result in unrealistic expectations and frustrations. Sharfstein and Wolfe (1978) cited the example of a community mental health regulation that required centers to have a wide range of services operational within a limited amount of time if they hoped to obtain continued funding. The relatively inflexible rules did not take into consideration startup costs, redundant services in the community, components of desirable services, or adequacy of service levels.

Sometimes, mental health professionals at community agencies run into unusual issues as they attempt outreach work. One anecdote reported on an attempt to deliver home-based care services while a disabled client's dog barked and snarled, making the therapist quite anxious during the visit, while the client laughed (Knapp & Slattery, 2004). Other examples included requests for the therapist to babysit or assist with family chores.

Not surprisingly, some self-report studies of agency workers and administrators have suggested that the supremacy of agency needs over individual client needs may constitute the norm (Billingsley, 1984). As governmental budgets face cuts and as managed care constraints on private insurance and other revenue sources increase, clinics and mental health centers have come under continuing pressure to take direction from the bureaucracy regarding how to contain costs and serve clients. This will place substantial pressure on the value systems of practitioners working in community settings. Individual long-term psychotherapy will likely

suffer as a service option in place of modes of treatment judged more cost-efficient. The only question is the degree to which clients' needs will be subordinated to their detriment (Backlar & Cutler, 2002; Riger, 1989; Robertson & Walter, 2014; Serrano Garcia, 1994). When the survival of the agency (or one's job) stands at stake, considerable intellectualization and rationalization becomes possible (O'Neill, 1989, 2005). Community mental health work and service in public social welfare agencies clearly forces mental health professionals in those settings to examine their values and motivations closely.

Business and Industry

Behavioral scientists and mental health professionals are often involved as participants in, or consultants to, businesses or industries. Their roles might include management consulting, personnel selection, organizational research, human factors applications, program evaluation, training, consumer psychology and advertising applications, public relations services, marketing studies, or even applying clinical skills to enhance the functioning of an organization and its executives. The ethical difficulties such professionals face in business settings derive both from the special demands of their particular role and from the fact that the ethics of mental health professionals and the ethics of business often seem incongruent.

We refocus on the basic question: Who is the client? This point forms a repeating theme in widely read books and articles on the ethics of the industrial or organizational practitioner (Brady & Hart, 2006; Fuqua & Newman, 2006; Ilgen & Bell, 2001; Jones, Felps, & Bigley, 2007; Lefkowitz, 2003, 2012; Lowman, 2006; Newman & Fuqua, 2006). The notion of the consultant's seduction by the pressures of the industry or the marketplace, with resulting severe role conflicts, is hardly a new issue (APA Task Force on the Practice of Psychology in Industry, 1971). Most ethical complaints against mental health and behavioral science experts arising in business settings deal with a practitioner's responsibility to his or her client

or assessment, advertising, or marketing issues. Often, one senses that the psychologist or other behavioral or mental health consultant in the business world who becomes the object of a complaint may have become a servant of economic power or may have lost some focus on human values compared to those of productivity and the company.

Case 15–22: Hardy Driver has been a member of the management team at Western Bolt and Wrench Corporation for the past 6 years. He has become lead candidate for promotion to the chief operating officer position in the company, and the human resources office has referred him to the company psychologist for an evaluation as part of the final selection process. Driver knows that he can refuse to participate in the evaluation but probably would lose the promotion in that case. He worries about what sort of personal information revealed in the evaluation might fall into the hands of others in the company.

The situation involving Mr. Driver is not new and occurs frequently. London and Bray (1980) discussed the issue of predicated a promotion on a psychological assessment in detail. Psychologists conducting such assessments (see Chapter 7) understand the problem well (Lefkowitz, 2003, 2012; Lowman, 2006). It is hoped the evaluator involved will recognize the vulnerability of Mr. Driver as well as the legitimate needs and rights of Western Bolt and Wrench. The company has a right to screen its applicants using reliable and valid assessment tools. Driver knows that he has the right to refuse participation, just as the company has the right to pass him over should he do so. One assumes that the evaluator will carefully discuss these issues with Driver, including the nature of the assessment, type of report planned, and the likely uses of the report, including access issues. Driver, for example, may fear that some personality inadequacy will come to light and become widely circulated in the company, when in fact the planned assessment does not include personality assessment tools. Driver also has a right to know in advance whether he will have access to the report, test data, debriefing, and so on.

In summary, Mr. Driver has the right to fully informed consent regarding the nature of the planned evaluation before he decides to participate. The evaluator should recognize this and provide Driver with ample information to assist him in making his decision.

Case 15–23: Because of declining sales linked to an economic recession, the Paragon Electronics Corporation plans to lay off several hundred workers. The company wants to attempt a modification of its union contract and base the layoffs on employee productivity rather than seniority, as the union's contract specifies. They ask their corporate psychologist to prepare a detailed memorandum that cites research data to support their position. They have no interest in contrary data and in fact would prefer that the psychologist not mention any that might exist. Headquarters also wants a detailed plan for assessing the productivity of its workers to fit these needs.

The Paragon Electronics case raises the use of research as an influence strategy (Ilgen & Bell, 2001; Lefkowitz, 2003, 2012; Lowman, 2006; Purcell et al., 1974) but does so in a manner that implies a one-sided bias. Many business executives eschew current trends in corporate social responsibility (Lindgreen & Swaen, 2010) and firmly believe that corporate self-interest is inexorably involved in the well-being of the society or, as Charles Wilson put it long ago, “What’s good for GM is good for the country” (Purcell et al., 1974, p. 441). Many businesses find nothing wrong in asserting their best interests using all legal means available; they rationalize that they ultimately help society and the economy. Economic success does not require intellectual or scientific honesty in many cases, and total scientific honesty might not help (or even harm) the business in some instances. Assuming that data exist to support the company’s position, that valid assessment of productivity can occur, and that laying off employees who do not perform well is desirable, has the psychologist who found the data and conducted the assessment behaved ethically in applying it? The answer is probably yes, as long as in doing so the psychologist did not ignore or conceal meaningful contrary data.

Case 15–24: Bozo Pharmaceutical Industries sells over-the-counter “natural food” diet aids. It has developed a new diet, known as SkinnyGreen, based on roasted kale and clover extract. The company approached a consumer psychologist to work as a consultant in devising a marketing survey and advertising plan. Bozo Industries offered a substantial fee plus a bonus based on the ultimate effectiveness of the program in boosting sales. When the consultant asks about data on the product to incorporate in the project, she discovers that no evidence exists to support claims that the product actually helps dieting. While not harmful, the SkinnyGreen formula has shown no documented benefits.

How about the ethics of overlooking misleading public statements as long as the lies are benign? That question forms the heart of the Bozo Pharmaceutical case. Any marketing plan would, at the very least, focus on making the public believe that SkinnyGreen could help them lose weight. The consultant might reason that the product will not actually hurt anyone or that placebo effects might actually help some people. Does that constitute a sufficient ethical basis for assisting in the promotion of an ineffective product? We would argue that providing support for this product’s marketing constitutes unethical behavior, although this would prove difficult to establish as an ethics case. As described previously in this chapter, the psychologist in this consulting role would have little public visibility (Koocher, 2007), and an ethics complaint most likely would not occur as an idea to the parties who had first-hand knowledge of the otherwise-invisible professional activity.

Case 15–25: Manny Jobs, Psy.D., works as an industrial psychologist assigned to a job-enrichment program aimed at improving the quality of life, and hence quality of work, among assembly-line workers at Amalgamated Motors. After a careful job analysis, many hours of interviews, and considerable effort, Dr. Jobs produced a report with many potentially useful suggestions. Management thanked him and shelved the report, which they regarded as “ahead of its

time.” Dr. Jobs felt frustrated that his efforts and the potential benefits he had conceptualized were ignored and toyed with the idea of leaking the report to union negotiators prior to the next round of contract talks.

The Amalgamated Motors case presents another set of complex and conflicting needs. Amalgamated Motors wanted information and ideas but was not necessarily prepared to act on them. Dr. Jobs feels angry that his hard work has seemingly been wasted, although Amalgamated Motors paid him, and his client, the company, seems satisfied. Does he have the right to violate his duty of confidentiality to the client corporation by revealing information to the unions? Dr. Jobs might argue “society’s interests are at stake,” but he has an obligation to respect the proprietary rights of his employer as long as it is possible to do so and still maintain standards of ethical practice (Ilgen & Bell, 2001; Lefkowitz, 2003, 2012; Lindgreen & Swaen, 2010; London & Bray, 1980; Lowman, 2006).

Medical Settings

It will come as no surprise to the thousands of mental health professionals at work in medical settings that behavioral and medical care providers do not always speak the same language. A degree of mutual education and, implicitly, a willingness to learn are required for any mental health professional planning to work in such settings. One must, for example, acquire a new lexicon of terminology that may seem paradoxical (e.g., a “progressive disease” is one that gets worse and “positive findings” are a bad sign when discovered during a physical examination). Knowledge of physical illnesses, their symptoms, and treatments as well as an understanding of how medical hospitals (as distinct from mental hospitals, community mental health centers, or college counseling services) will prove important.

Mental health practitioners in medical settings also must remain keenly aware of their expertise and its limitations. These include interdisciplinary collaboration in outpatient

settings, maintaining competencies (Tovian, 2006), and attending to issues in hospital practice related to confidentiality (Robinson & Baker, 2006) and the Health Insurance Portability and Accountability Act (HIPAA) (Benefield, Ashkanazi, & Rozensky, 2006). Many medical conditions can present in ways that suggest psychopathology, and having a medical degree does not ensure against diagnostic errors. Some physicians seem at times too willing to see physical complaints as psychological, and some mental health practitioners seem all too eager to go along with them. Although the following case is unusual, it provides an important illustration.

Case 15–26: Teri Slim found herself referred to a major pediatric teaching hospital for the treatment of anorexia nervosa. She had always been petite and slender, but seemed unusually thin to her father just prior to her 14th birthday. She underwent medical evaluation at a large hospital near her home, and the staff referred her to the specialized pediatric hospital for treatment. The admission evaluation at the second hospital confirmed the diagnosis of anorexia and admitted Teri to their Psychosomatic Unit for treatment. The hospital staff easily identified family stressors that might account for Teri's emotional problems. Her parents had recently divorced; her father had lost his job as business executive; and her mother, who lived in another state, allegedly had a serious addiction problem. At the end of 2 months of treatment, Teri remained malnourished and had made "no progress" in treatment. The staff contemplated initiating intravenous feeding in the face of her progressive weight loss. They prepared to transfer Teri to the surgical ward for placement of a venous feeding line. Only then did a senior pediatrician sent to screen her for transfer ask, "Has anyone evaluated her for Crohn's disease?" Several weeks later, Teri went home from the hospital minus a segment of inflamed intestine and taking anti-inflammatory medication. She continued to do well in response to the treatment for Crohn's disease.

Teri Slim had twice been evaluated by physicians outstanding in their respective fields, and

her care took place under continual supervision by well-trained psychiatrists slow to diagnose her physical illness and quick to refer her to an inpatient psychiatric treatment program. Crohn's disease does present diagnostic challenges, but so do a host of other medical problems, ranging from neurological disorders to endocrine problems, that seem to manifest themselves chiefly through symptoms that might mistakenly be regarded as psychological (e.g., hallucinations, aberrant behavior, appetite loss, agitation, and mood swings). Successful diagnosis and treatment of such patients requires a close, collaborative, and collegial relationship that includes good integration of social, psychological, and medical care.

Typically, mental health professionals working in medical settings will be employed under the supervision of physicians (e.g., in departments of psychiatry or pediatrics). At other times, they may be administratively organized in a separate department (e.g., medical psychology, social work, or family services). Wherever they work, mental health professionals must take care not to surrender their professional integrity or standards.

Case 15–27: Bertram Botch, M.D., served as the chief of neurology at a pediatric hospital and often chaired interdisciplinary case conferences. Reporting on her assessment of a low-functioning mentally retarded child, Melissa Meek, Ph.D., presented her detailed findings in descriptive terms. Dr. Botch listened to her presentation and asked for the child's IQ. When Dr. Meek replied that the instruments used were developmental indices that did not yield IQ scores, Dr. Botch demanded that she compute a specific IQ score to use in his preferred report format.

Case 15–28: After sitting in on some lectures that Ralph Worthy, Psy.D., was giving to a group of medical students in regard to projective testing, the chief of medicine called him in to set up a workshop on the topic for medical residents. The chief told Worthy that he thought it would be a good idea to teach the residents how to use "those tests" and assumed that it could be done in "a half-dozen meetings or so."

One hopes that Drs. Meek and Worthy will not yield to the pressures described. Meek could politely, but firmly, attempt to educate Dr. Botch with respect to the inappropriateness of attempting to produce an IQ score in the situation. She can perhaps help to identify estimated ranges of scores or find other terms useful and meaningfully appropriate for his report, but she should not feel coerced or bullied into contriving the digits Dr. Botch seems to want.

Likewise, we hope Dr. Worthy will attempt to educate his chief regarding the nature of personality assessment and the inappropriateness of thinking that six lectures will enable anyone to use such techniques competently. He might explain that knowledge of personality theory, abnormal behavior, psychotherapeutic interventions, and psychometrics all play integral roles in using these tools effectively.

These situations may, of course, generalize to any context in which one's employer does not understand the applicable theory and practice or a cooperative team effort is required for effective and successful work. Mental health professionals must take the lead in defining the appropriate role for their services. They must also remain prepared to recognize and uphold appropriate professional standards.

Independent Practice

Over 30 years ago, Taylor (1978) presented the idealized portrayal of the independent practitioner as living a life of luxury and self-indulgence and working less than full time for \$60 an hour treating only movie stars, the wives of corporate executives, and a few high-level bureaucrats. At least that was the fantasy or myth of the independent practitioner's lot prior to the advent of managed care (Appelbaum, 1992; Lewin, 1974; Taylor, 1978). Rumors still persist that such luxuriously paid independent practitioners are out there, although we never seem to meet any of them.

The realities of independent practice are far less alluring today than the fantasies of the past might suggest. The \$60 rate that seemed impressive in 1978 would translate to approximately

\$217.32 in 2015 dollars when corrected for inflation (see Chapter 12). Conversely, the typical reimbursement rate for a 45- to 50-minute "hour" of verbal psychotherapy paid by Blue Shield in Boston, Massachusetts, in 2014 (approximately \$100 for a doctoral-level psychotherapist and \$75 for a master's-level therapist) translates to a 1978 value of just under \$28 and \$21, respectively. The vicissitudes of dealing with managed care plans (e.g., gaining access to provider panels, incremental documentation of service needs, requests for additional sessions, reduced payments, etc.) have also made the small-business management of an independent practice far more demanding. In many ways, individual and small-group independent practices have become more taxing than the work of mental health professionals at larger agencies, clinics, or hospitals. True, the independent practitioner is his or her own boss, but that must be balanced with overhead costs, employee relations (e.g., with a receptionist, answering service, etc.), backup coverage, billing, advertising, and a host of other mundane, but necessary, chores. In addition, a kind of professional loneliness can afflict the independent practitioner, especially when isolated in a small office with no easy access to colleagues (Appelbaum, 1992; Barnett, Zimmerman, & Walfish, 2014).

Little has been written on the ethical problems faced by the independent practitioner, although a number of the examples cited throughout this volume certainly apply. The greatest problem in the ethical sense is probably related to the fact that the independent practitioner must be both a professional and an entrepreneur to survive, roles that are not always congruent (Appelbaum, 1992; Barnett et al., 2014; Bennett, 2005; Hixson, 2004; Mikalac, 2005). As a solo practitioner, you are in charge of planning and successfully managing the practice, all documentation and record keeping, dealing with third parties, protecting confidentiality, managing practice finances, staff training (if you have any staff), office/employment policies, advertising and marketing, and someday the closing of a private practice in full compliance of record maintenance (Bradley, Hendricks, & Kabell, 2012). In

addition, the absence of peer collaborators may lead to less-social comparison of a professional nature and a resulting failure to always think carefully about the manner in which one practices or manages cases.

The independent practitioner who may have an administrative assistant or other employees who require careful supervision generally does not have the luxury of paid vacations or sick days and is far more susceptible to the mundane case management headaches of working with emotionally troubled people (e.g., the client who does not pay bills or often fails to keep scheduled appointments). The material in this volume that deals with psychotherapy, managed care, advertising of services, higher risks for inappropriate role blending, and employee relations all applies directly to the independent practitioner. However, some unique ethical problems also come up from time to time.

Case 15–29: Napoleon Solo, M.S.W., practiced psychotherapy on his own in a private office. An automobile accident disabled him for a period of 3 months. During that time, no coverage was available for any of his clients.

We hope Mr. Solo had the foresight to take out adequate disability and office overhead insurance to cover his personal financial needs during the recovery period. He apparently did not consider any means of providing backup for his clients, however, and clearly had no ability to do so easily from his hospital bed. Depending on the clients' individual needs, this could present a serious ethical oversight.

In the next case, Dr. Taylor's account of his humorous experience (Taylor, 1978) illustrates that the independent practitioner never knows precisely what to expect when a prospective client comes through the door.

Case 15–30: A young woman appeared in the office of Robert Taylor, Ph.D. Dr. Taylor noted that she seemed to become increasingly uneasy with the surroundings and the direction of his questions. Finally, she interrupted and made the red-faced confession that she had thought she had made an appointment at a gynecologist's office.

The therapist must prepare to evaluate each client and recognize that he or she may not be the sort of person the client really seeks or needs and must stand ready to make appropriate referrals as needed (Appelbaum, 1992; Barnett et al., 2014; Walfish & Zimmerman, 2013).

Pastoral Counseling

Pastoral counseling presents some unique work-setting issues for several reasons; not the least of these is widely varying training. Some members of the clergy are trained as psychologists, psychiatrists, and social workers. Others receive minimal pastoral counseling training that integrates basic counseling skills with religious and moral philosophy content (Dueck, 1987; Erde, Pomerantz, Saccoccia, Kramer-Feeley, & Cavalieri, 2006; Foskett, 1992; Merrill & Trathen, 2003; Richards & Bergin, 2005) but no training in professional ethics for psychological or psychotherapeutic practice (Bleiberg & Skufca, 2005; Miller & Atkinson, 1988). Still others have little or no formal training in psychodiagnostics or psychotherapy and focus chiefly on a religious- or spiritually based approach. The problem is well illustrated by a guidebook, intended for "Christian counselors of all sorts," *Counselor's Guide to the Brain and Its Disorders: Knowing the Difference Between Disease and Sin* (Welch, 1991). The volume attempts to explain the functions of the brain, organic and functional psychopathological disorders, and issues of moral responsibility from a framework that is "thoroughly biblical." One chapter discusses "The No. 1 Culprit: Licit and Illicit Drugs." Overall, the general standards and orientation of pastoral counseling, as a field, are far less rigorous than graduate training for psychotherapeutic practice (Bleiberg & Skufca, 2005; Erde et al., 2006; Richards & Bergin, 2005).

Some dilemmas are as follows: What options does a pastor have if a parishioner's right to confidentiality and self-determination conflict with the goals of their church? What happens if, during a counseling session, a married elder divulges having an affair with the organist? What if a board member reports alcoholism

and spousal abuse? Merrill and Trathen (2003) thoughtfully addressed these and other multiple-role conflicts that confront pastoral counselors in church-based settings.

Other issues arise when the client or counselor fails to clearly delineate roles between the pastoral function and more secular psychodiagnostic or psychotherapeutic needs (Craig, 1991; Miller & Atkinson, 1988). We agree with the viewpoint that clergy trained as psychotherapists should not attempt to function in both roles for the same clients.

Case 15–31: An ethics committee received a complaint from George Gothic, whose psychotherapist, Reverend Dan Damien, D.Min., was both an ordained minister and a licensed psychologist. Dr. Damien had recommended that Gothic undergo an exorcism to relieve his emotional distress. Gothic had taken offense and described Dr. Damien as “a quack in preacher’s clothing.” When approached for an explanation by the ethics committee, Dr. Damien explained that he knew Gothic needed such treatment because “his face contorts in a gargoyle-like tic whenever God is mentioned.” When questioned further on the validity of his diagnosis, Damien denounced the members of the ethics committee as “a bunch of Godless heretics.”

The ethics committee had serious questions about Dr. Damien’s competence as a psychotherapist but could not pursue their investigation adequately when he ceased replying to their inquiries. As a result, he was expelled from the organization for not responding.

Case 15–32: Simon Shifty, L.M.F.T., found himself called before a licensing board for failure to report child abuse as mandated under state law. Mr. Shifty, who was also an ordained minister, had provided family therapy to a couple who regularly and severely beat their children with leather straps for perceived religious infractions. The case came to public attention when one of the badly beaten children collapsed at school. Mr. Shifty had known about the beatings and about the mandated reporter status of licensed marriage

and family therapists in his state, but explained to the licensing board that clergy were not covered by that statute because of the constitutional separation of church and state.

The licensing board was not impressed by Dr. Shifty’s constitutional argument. The board noted that he was functioning as a licensed marriage and family therapist, not a member of the clergy, when performing family therapy, as evidenced by his clinical case notes and bills to the family’s health insurer. The board noted that he could not be functioning simultaneously with one set of clients as both a spiritual counselor and licensed marriage and family therapist.

In a very interesting self-reflection and case study, a psychiatrist (Michel, 2011) described the therapeutic evolution of a patient with a mood disorder who decided to convert to Christianity after discovering his Christian beliefs via a Google search she had done on him. She invited him to her baptism, triggering considerable thought and collegial consultation (including with members of the clergy who encouraged him to attend). Ultimately, and with some angst, he decided not to.

Each work setting has unique aspects, although those discussed here present special challenges for the mental health practitioner or behavioral scientist. A diverse collection of essays by a range of mental health professionals across many contexts can be found in the edited volume by Johnson and Koocher (2011). The key issue common across settings involves the need to remain mindful of the ethical duties owed to differing categories and levels of clients. By focusing on the welfare of the most vulnerable parties in a client hierarchy, a practitioner should be able to determine the most appropriate ethical course of action.

WHAT TO DO

- When entering a work setting for the first time, familiarize yourself with the special needs and demands of the job. This includes consulting with colleagues about the ethical

pressures and problems unique to that type of work setting.

- When a work setting demands special qualifications or competencies, mental health professionals should be exceptionally careful to meet these standards prior to beginning work in that context.
- Consultation with colleagues experienced in the specialized setting will often prove the best way to make that assessment.

WHAT TO WATCH FOR

- In complex service delivery or consultation systems, the usual professional-client relationship may become blurred. Take the lead in defining your roles and obligations to each level of client served.
- Clarify your role expectations with all relevant parties from the outset of professional contact.
- The matter of whether to work for reform within an unethical institution or whether to “blow the whistle” in public often becomes a matter of personal judgment and one’s conscience. A mental health professional should not, however, cooperate as a party to unethical behavior.
- Carefully consider any duty of confidentiality owed to a client (including a client organization) before making public disclosures about that client.

WHAT NOT TO DO

- Do not fall prey to an employer’s assertions that “professional ethics codes don’t apply here.” A mental health professional is never exempted from any portion of his or her association’s ethics code by virtue of an employer’s dictum.
- Do not let yourself become confused when you have more than one professional identity. Mental health professionals who have trained in another profession (e.g., health care provider and member of the clergy) must clearly delineate their role for

themselves and explain to their clients the professional capacity in which they are providing services.

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16

Scholarly Publications and the Responsible Conduct of Research

Your manuscript is both good and original, but the part that is good is not original, and the part that is original is not good.

Samuel Johnson

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BROKEN TRUST

All would agree that honesty and competence are essential to the advancement of knowledge.

Unfortunately, not every scientist conforms to the established rules and values. Violations range from minor to severe, but the scientific record is damaged regardless.

Betrayal of the Public Trust

Concerns about the rights of research participants, scandals involving reports of plagiarism and scientific misconduct, conflicts of interest among scientists and big businesses, and a creeping reluctance to accept the pronouncements of those claiming expertise have fostered increased public scrutiny. Stunning high-profile abuses that capture media coverage further erode the public's confidence in science. Consider these egregious examples:

Case 16–1: The publicity-hungry but ultimately disgraced South Korean scientist and veterinarian Dr. Woo Suk Hwang, gained worldwide notoriety when he claimed to have successfully cloned close to a dozen human embryos (Onishi, 2006). Articles touting stunning discoveries by Hwang and his team were published in the prestigious journal *Science*. Whistleblower Young-Joon Ryu, a key player in the lab, later disclosed errors and fraudulence, only to be forced into hiding and out of work for a year for bringing down a national hero (Cyranoski, 2014b). Nevertheless, all of Hwang's previous accomplishments, even Snuppy the cloned Afghan hound, came to be viewed with skepticism. A South Korean thriller movie, *The Whistleblower*, is touted as fiction, but chronicles the drama behind the scenes. As for Hwang himself, according to Shanks (2014), "the ambitious old fraud who once dreamed of being the first Korean Nobel Prize winner is recasting himself as a scrappy underdog." He is back at work and cloning dogs, mostly for clients from the United States, at \$100,000 a pup (Cyranoski, 2014a).

Case 16–2: Eric Poehlman, Ph.D., was the first academic scientist in the United States to serve prison time for misconduct not involving fatalities and to receive a lifetime ban on receiving federal research funding. Poehlman published articles containing bogus data over a 10-year period and submitted falsified grant applications that brought in almost \$3 million in federal grant money ("Research Specialist Sentenced," 2006). For example, only two individuals were included in a longitudinal study reportedly conducted on 35 menopausal women. Poehlman ultimately admitted guilt after 5 years of denying the charges, lying

under oath, and attempting to discredit those who came forward with evidence (Interlandi, 2006).

Case 16–3: Paul Kornak, M.D., was convicted of three felonies, including criminally negligent homicide, for falsely representing results of blood chemical analyses in a chemotherapy study. Kornack received a 71-month sentence in a federal prison and was ordered to pay \$639,000 in restitution to two drug companies and the Department of Veterans Affairs. He is also barred for life from receiving federal funding for research (Office of Research Integrity, 2013).

Case 16–4: In 1998, high-profile physician Andrew Wakefield published a paper in *Lancet* suggesting a link between the measles, mumps, and rubella (MMR) vaccine and autism. The article set off a massive vaccination scare despite the small sample size, methodological flaws, and misreporting of data. The data were ultimately deemed fraudulent, and the article has since been retracted (Godlee, Smith, & Marcovitch, 2011). However, despite a series of revelations published in the *British Medical Journal*, the antivaccination scare persists, leaving children at risk of contracting diseases and infecting others.

Case 16–5: A former Iowa State University researcher's work on an AIDS vaccine received \$19 million in grants from the National Institutes of Health. Independent tests revealed that Dong-Pyou Han spiked the rabbit blood with human antibodies to make it appear that his vaccine was a defense against the AIDS virus. Han faces criminal charges and has agreed to plead guilty (Leys, 2014, 2015).

Case 16–6: Dutch social psychologist Diederik Stapel, Ph.D., was found to have massively fabricated data on publications, ultimately resulting in 54 retractions (Retraction Watch, 2014). A report issued by the American Psychological Association (APA) detailed Stapel's trail of misconduct (Verfaellie & McGwin, 2011). One technique was to approach colleagues with a seemingly plausible proposition. He led colleagues to believe he collected as yet unanalyzed data in the colleagues' area of interest, and if the colleagues would do the analyses and write the report, he would receive coauthorship credit. With graduate students working on their theses, he would help set up elaborate

plans before data were supposedly collected by fictitious research assistants at secondary schools. Students were not allowed to contact the schools or to assist with data collection, but within a few weeks, an already-coded data set would appear. In the end, many journal publications and doctoral dissertations are likely based on false data without the knowledge of the collaborating author. Stapel ultimately returned his doctoral degree to the University of Amsterdam.

Case 16–7: An apparent record (172 and counting) for the number of article retractions issued for a single author belongs to Yoshitaka Fujii, a Japanese anesthesiologist. Over a 20-year period, Fujii reported data on patients he never actually saw. He also misled coauthors, some of whom did not even know he had listed them as an author (Akst, 2013).

Scientific misconduct discoveries are uncovered most often in biomedicine, where temptations to cheat may be high. This is not to suggest social and behavioral scientists are significantly more honest, but cheating may be more difficult to detect given that the data typically exist only in numerical form and the participants, whose identities are often unnecessary to record, are long gone.

When Researchers Are Betrayed

Researchers not only must contend with those within their own ranks who are dishonest, incompetent, and irresponsible, but also must endure three outside forces working against them. First, attempts to suppress, misrepresent, or discount scientific findings for political gain have become more prevalent in recent years. Examples include ignoring evidence of global warming and environmental deterioration. Furthermore, Congress has approved legislation that would allow the revocation of funding for federally funded research, thus allowing those with political agendas but no scientific expertise to meddle with the peer review process (Winerman, 2005). Finally, well-conducted, refereed research producing findings that clash with reality as we would like it to be rather than what it is may be suppressed or unfairly

criticized (Ricciuti, 2005). For example, an article in a journal owned by the APA presenting a meta-analysis of research on the effects of child sexual abuse set off a political firestorm (Rind, Tromovitch, & Bauserman, 1998). The authors noted that not all acts of abuse caused individuals to suffer longer term harm (e.g., an 18-year-old having consensual sex with a 17-year-old compared to the rape of a 5-year-old by an adult). Without fully digesting the contents of the article, journalists, politicians, and others unfairly accused the APA of supporting child sexual abuse. (For more on this complex series of events, see Albee, 2002; Garrison & Kobar, 2002; Lilienfeld, 2002; Ruark, 1999; Sher & Eisenberg, 2002; Sternberg, 2002.) In a less controversial incident, a reviewer balked at a research-based article finding that single parenting need not have an adverse effect on children's level of achievement. The reviewer was concerned that "the take home message for general readers would be that 'single parenting does not matter,'" thus trivializing the problem (Ricciuti, 2005, p. 20).

This chapter briefly addresses some of the more salient features with ethical implications in scholarly writing and social behavioral research. Newer work tends to mostly refine research standards (e.g., special considerations for research with specific populations, such as victims of violence) and the challenges faced when conducting and publishing research online.

PUBLISHING ISSUES AND ABUSES

Publication Outlets for Scholarly Work

Knowledge is shared and advanced through scholarly books and journals and, with increasing frequency, electronically. The primary purpose of scholarly publishing outlets is to disseminate useful discoveries as soon as practicable, sometimes as quickly as a few months following the completion of the study.

Despite what one might assume to be a sophisticated and collaborative process, scientific writing and research publication are, in fact, fraught with the potential for intense conflict and spiteful disputes. Why smart

people have such problems here may seem curious. The main reason is that the stakes are high for those who want to advance their careers. Publication credits are often required to gain entrance into graduate school or to land an attractive postdoctoral appointment, to obtain or retain a job, to earn a promotion, or to be awarded grant funding. Publications also elevate researchers' status among their peers and may even confer more widespread fame. And, whereas publications in scholarly outlets alone carry no direct monetary gain, and online open-access journals actually charge authors fees to publish their work, scientific findings can sometimes be the basis for profit-making partnerships with mainstream business ventures.

The competition to "get published" can interject unhealthy features into the scientific enterprise. A focus on quantity rather than quality may prompt some researchers to pursue projects that can be completed rapidly rather than tackling more noteworthy undertakings or studying a subject matter in more depth. Unfortunately, the peer review process does not protect against unsound findings entering the scientific record. The Third International Congress on Biomedical Peer Review and Global Communications (1997) reported that papers containing errors (especially in statistical design and analysis), plagiarized papers, and papers based on fraudulent data have been published in peer-reviewed journals. Other criticisms include the tendency for authors to inflate the importance of their work and failing to provide sufficient discussion of study limitations. In fairness, we would note that journal editors and reviewers are not in a position to make such assessments without more information than fits into a few pages of manuscript. Authors are cautioned to "write tightly," often feeling that they have to gloss over important information and discussion points because of manuscript length restrictions, creating a sort of Catch-22. (For more on scholarly journal editors and their relationships with authors, see Chapter 10.)

Sadly, considerable work posing as peer-reviewed science is clogging the virtual literature with papers having undergone no real

scrutiny. Enter the global industry of online open-access journals, only some of which are fully legitimate. These questionable publication outlets sport fancy-sounding names, similar to diploma mills. In 2013, a biologist and science writer conducted an elaborate sting operation on the burgeoning open-access journal empire (Bohannon, 2013). He wrote a paper that even a first-year chemistry student should have spotted as flawed and preposterous, sent it out 255 times using slightly different fictitious names from fictitious institutions. Acceptance of this bogus article was the norm compared to the traditional peer-reviewed publication outlets, where the rejection rate can exceed 90%. Of the open-source journals, 157 accepted Bohannon's paper, mostly the so-called predatory journals that prosper through hefty fees charged to the authors. The average time lapse to acceptance was 40 days, considerably faster than traditional peer-reviewed journals. Bohannon's (2013) fascinating saga is available online.

Predatory journals are on the increase. See Beall's well-defined list of criteria for determining predatory open-access journals as well as their often elegant-sounding names (Beall, 2015). Today's evaluators of individuals' scholarly records—be they personnel committees or prospective employers—would do well to review publication outlets listed on résumés carefully. This is not to say that legitimate scholarly titles that provide heretofore unheard-of easy access do not exist. The APA, for example, accepts manuscripts for the *Archives of Scientific Psychology*, an open-access online journal free to anyone with an Internet connection. Authors will submit their full data set as well as other information, including ways to explain their work to the general reader. As there are no paid subscribers to offset costs, authors will pay a submission fee up front and an additional fee if the article is published (Cooper & VandenBos, 2013).

A few scientists have found another cheating inroad made possible by the digital age. Unethical authors attempting to enhance their chances of gaining acceptance exploit the common request by journal editors to suggest names of experts who may be willing to review their submission. The unscrupulous authors

offer names with contrived e-mail addresses that return to their own inboxes. They then submit glowing reviews of their own submissions. Such chicanery obviously augers for more vigilant review selection procedures (Akst, 2012; Fischman, 2012).

Assigning Authorship Credits

The project is done. So, now it may seem like a relatively straightforward procedure to decide who deserves authorship credit and in what order to list multiple contributors—not so. Research has become more specialized in recent years, often requiring teams composed of many people who have no or minimal overlapping skills. Occasionally, a single article can list over 100 individuals, all of whom made critically important contributions. Because of the potential boost to one's career, bitter disputes over the assignment of publication credits are common. Over a fourth of the respondents to large surveys believed that they had fallen victim to unfair or unethical authorship assignments (Sandler & Russell, 2005) or knew of disputed incidents involving authorship and other questionable publication matters (Keith-Spiegel, Sieber, & Koocher, 2010).

Senior (first-listed) authorship ranks as the most coveted position. Why the fuss over whose name appears at the top? It turns out that the first-listed individual is assumed to be the major contributor as well as the name by which the work will be indexed (Fine & Kurdek, 1993). "Junior" (second and further-listed) authors have become upset when individuals—usually those with the power and authority over them—claim the top position for themselves, even though they were minimally involved in the project (Holaday & Yost, 1995; Oberlander & Spencer, 2006).

Some contributors complain that they received footnote credit or no acknowledgment whatsoever when their involvement warranted a junior authorship. Ethics committees have agreed that sometimes more powerful and sometimes exploitative researchers disadvantage junior authors. Publications arising from students' theses or doctoral dissertations

should normally list the student first (APA: 8.12; American Association for Marriage and Family Therapy [AAMFT]: 5.7; American Counseling Association [ACA]: G.5.f.). But, at other times, honest differences in opinion about the value placed on each other's contributions are at issue. We have seen cases of graduate students alleging that thesis and dissertation supervisors insisted on being listed as coauthors on any published version of the students' project. Whereas students appear to view their supervisors as fulfilling the obligation to facilitate their professional development, supervising professors may see their contributions as essential to acceptable publication quality. Ethics committees have agreed, however, that supervisors have sometimes taken unfair advantage of their students' work.

Case 16–8: Amy Shutout completed her master's thesis under the supervision of Jack Swallowup, Ph.D., within the framework of his programmatic line of inquiry. Dr. Swallowup provided office space and computer access. He also introduced Shutout to a colleague who could help her enlist participants for her survey. Swallowup approved the design and read drafts of the work. After completion, Swallowup insisted that his name appear as the senior author on a version to be prepared for a scholarly journal. Shutout felt exasperated because she believed that Dr. Swallowup was primarily interested in getting himself another publication by using a student to do the grunt work and exploiting the thesis requirement. She asked an ethics committee for an opinion.

Misappropriation of authorship and exploitation of students by senior faculty, as illustrated in this case, undermine the meaning and integrity of the authorship process (Wagena, 2005). Thesis advisors are expected to facilitate their student's projects in whatever ways they can. However, things are not always as they appear to be, as is illustrated in the next case.

Case 16–9: Hang Tight, D.S.W., agreed to work on a research project with an initially enthusiastic graduate student, Flashin Pan. Dr. Tight helped Pan strengthen the design and arrange for data

collection. Dr. Tight also supervised the data analysis. But, Pan quit coming around. Tight intercepted Pan in the hallway to inquire about preparing the study for publication. Pan claimed he had been very busy but would drop by the next day. He never showed. In the meantime, Pan graduated from the program and left town. Dr. Tight waited 6 months before deciding to write the article himself, giving Pan a footnote credit for early work on the project. When the article ultimately appeared in a respected journal, Pan complained to an ethics committee that Dr. Tight stole his project.

McCarthy (2012) reminded us that the act of supervising student research presents an inherent conflict of interest. It is the supervisors' responsibility to educate and enhance the growth of their more vulnerable students while also advancing their own position in the field, two goals that are not always compatible. However, almost every researcher we know has at least one story to tell about a student who abandoned what started out happily as a joint venture. How aggressively the student should be sought before proceeding independently is a matter of judgment. An ethics committee exonerated Dr. Tight, agreeing that Pan had not followed through in a timely manner. In a case with similar features, a student sued the university for over a million dollars and won. However, when the record revealed that the student had greatly exaggerated her involvement in the project, the decision was reversed (Woolston, 2002).

Disagreements can arise when the amount of time devoted to a project is tossed into the mix.

Case 16–10: Job Tedious worked for 3 years at an agreed-on hourly rate for Dax Plop, Ph.D. Tedious administered a structured interview to parents of premature babies and transcribed the sessions into a computer database. Tedious became upset because he was not listed as an author on the final manuscript submitted for publication in a prestigious journal. He argued that he had put in at least 10 times more hours than anyone else associated with the project and therefore deserved at least a junior authorship. Dr. Plop argued that a footnote credit was proper because Tedious was paid to perform supervised, routine procedures.

Dr. Plop did not act improperly in acknowledging Tedious in a footnote because of the nature of the work he performed. Tedious had no involvement in the formulation of the design, methods, analyses, or manuscript preparation, all of which comprise primary criteria for authorship credit. Time spent on a project per se is not a significant factor in determining authorship credits. Yet, although Plop may not have been acting unethically, he could have structured this arrangement far better. This case illustrates the wisdom of reaching agreements about what each person can reasonably expect in terms of credit before the research or writing collaboration begins, allowing for addressing any modifications later (Fine & Kurdek, 1993; Hopko, Hopko, & Morris, 1999).

We might note that errors in the opposite direction also have ethical implications. "Gift" or "guest" authorships, offered as a favor to enhance a student's application to graduate school or to advantage an untenured colleague, appear on the surface to be generous gestures. However, to the extent that the authorship was unearned, the research record has been corrupted, and others may be unfairly disadvantaged. For example, in a competitive employment situation, the applicant with an unearned authorship could unfairly prevail over others who were just as (or more) qualified.

Assigning authorship to a senior researcher who had minimal involvement in the work for the purpose of possibly enhancing the potential for publication constitutes another inappropriate form of gift authorship. In a survey conducted by Al-Herz, Haider, Al-Bahhar, and Sadeq (2014), a third of the respondents admitted to including an undeserving author on a paper. The main reasons were to be complementary, to avoid work conflicts, and to boost the chances of the article's acceptance. Other reasons included loyalty or feelings of obligation, pressures to publish, and power differentials (Geelhoed, Phillips, Fischer, Shpungin, & Gong, 2007) as well as rewarding providers of resources or honoring one's mentor (Steneck & Zinn, 2014).

In an attempt to dissuade unearned authorships, the International Committee of Medical

Journal Editors (ICMJE, 2014) recently added an intriguing fourth criterion to its definition of authors and contributors. Authorship credit must involve

1. Making substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; and
2. Drafting the work or revising it critically for important intellectual content; and
3. Giving final approval of the version to be published; and
4. Agreeing to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

So, according to the ICMJE, an author must meet the generally established definitions of authorship as well as take on a hefty accountability role. It would now be difficult to include anyone's name who did not qualify, given that doing so would violate a primary condition of authorship and hence be unethical.

Professional ethics codes do address credit issues. Authorship credits are to be assigned in proportion to authors' actual contributions. Minor or routine professional contributions or extensive nonprofessional assistance (e.g., typing a complicated manuscript, coding data, or helpful ideas offered by a colleague) may be acknowledged in a footnote or in an introductory statement (APA: 8.02b; AAMFT: 5.8; ACA: G.5.d; National Association of Social Workers [NASW]: 408.b).

A trend that may eventually catch on is the concept of "contributorship." The term *authorship* is actually somewhat misleading in today's science because the individual who delivered the most substance to a project may not have written a word of the manuscript. Increasingly, journal editors require a description of each listed author's role. Such published listings offer readers the most accurate description of how the project developed. Taylor and Thorisson (2012) summarized the problems with using the term *authorship* in today's collaborative,

sophisticated world of science. These include inadequate definitions regarding what *author* means, diverse authorship conventions among different disciplines, increasing numbers of players associated with the creation of the project, and the damaging impact of authorship disputes.

Plagiarism and Unfair Use

Plagiarism, the act of passing the work of someone else off as one's own, derives from the Latin *plagiarius* meaning "kidnapper" (Hawley, 1984) and is specifically condemned in most ethics codes (APA: 8.11; AAMFT: 5.8; ACA: G.5.b; NASW: 4.08). Plagiarism can range from careless paraphrasing (very common) to intentional copying of chunks or even an entire work without citing the original source. If the copying is extensive or if the original author is economically disadvantaged, legal issues pertain through federal copyright infringement statutes (LaFollette, 1992). "Who owns what" has become an even more significant concern as scientific and economic interests merge.

Some younger professionals may have become desensitized to the seriousness of plagiarism because, as students, they accessed information from the Internet and often passed on material, basically unaltered, as part of their assignments (Whitley & Keith-Spiegel, 2002). However, even famous authors and academics who should have known better have been caught copying from previously published works created by someone else. Occasionally, the practice is chronic, as the next case reveals.

Case 16–11: Rob Baggit, Ph.D., was exposed after a decade of translating articles by Argentinean scholars appearing in Spanish language journals and publishing them in English language journals under his own name.

Some might say that Dr. Baggit was a scoundrel but did no real harm. After all, he only duplicated the research record in another language, thus broadening the audience that could partake of the information. However, the actual person we call Baggit gained employment and

won promotions based on his bogus publication record, thus giving him an undeserved advantage over others.

Obvious instances of plagiarism, in which large amounts of material were copied verbatim, are easy for ethics boards to adjudicate because the evidence usually exists in tangible form. Interestingly, the most common source of uncovering major acts of plagiarism is neither by the public nor by other seasoned scholars, but by students conducting literature reviews for their own research papers or theses.

Violation of “fair use” standards is related to plagiarism but is more likely to occur unintentionally. Scholarly writings are usually allowed to quote short sections of properly cited works by others without explicit permission from the author or owner of the copyright. However, fair use can be exceeded, even when the material is meticulously attributed, as is illustrated in the next case involving “mosaic plagiarism.”

Case 16–12: Armond Gatherup, L.M.H.C., self-published a small book on self-esteem. He quoted, with correct attribution, over 80% of the content from 30 other sources. One of the authors he cited sent a copy of the book to an ethics committee, complaining that Gatherup had used her work as well as that of many authors as a means of crediting himself with a book that others, in effect, actually wrote.

Less clear-cut cases alleging plagiarism or unfair use are based on brief or occasionally similar passages, heavy paraphrasing, or unattributed previously published ideas. These complaints are more difficult to uphold conclusively. The next case illustrates why.

Case 16–13: Ticked Off, Ph.D., complained to an ethics committee that Kinda Like, M.D., used a number of his previously published ideas, including a few similar sentences, in Like’s article on community alcohol abuse programs. Dr. Off claims he should have been cited. The committee noted the similarity in ideas and an occasional resemblance in wording. Dr. Like, however, adamantly denied

using or even having read Off’s work, provided the full text of other cited articles as her primary sources, and asserted that the occasional wording similarities were coincidental.

Writers or researchers working in the same specialty area may cull notions from each other and even adopt similar ways of expressing themselves. This can render cases based on related written material impossible to definitively unravel. Although Dr. Like probably had access to Off’s already-published work, it cannot be proved that she ever read it.

Plagiarism and unfair use can also result from sloppy scholarship. Authors often use (or are inspired by) the work of others and keep notes consisting of direct quotations as well as their own original notes. Or, they hire students to take notes for them, again possibly blending actual quotes with original notations. What is original and what is not can become easily blended when using careless preparation techniques.

Case 16–14: Ina Tentive, Ph.D., was chagrined to be called before an ethics committee to explain her use of multiple sentences from the works of others. She explained how her graduate assistant was assigned to pull the relevant existing literature and then compress it. Without her awareness, the assistant had often lifted sentences straight from the reference materials. Dr. Tentive noted that they were well written and often used her assistant’s notes verbatim, not realizing they were direct quotes. Her assistant admitted that he prepared considerable material verbatim because he did not fully understand his assigned task. In the meantime, Dr. Tentive’s reputation as a scholar took a smack when the article was retracted.

In the actual case, Dr. Tentive and the student appeared before the APA ethics committee. The committee found their story plausible and did not sustain a plagiarism violation. However, Dr. Tentive was reprimanded for careless scholarship and admonished to more carefully direct and supervise her assistants in the future.

As the race to garner publications continues to heat up in the competitive academic and research markets, the rate of self-plagiarism is rising. Self-plagiarism refers to copying oneself without attributing the previous source(s). On the surface, this may seem innocent; after all one is citing one's own work. But, it can mislead readers, who assume the material is new and may infringe on the original publisher's copyright. A similar practice known as redundant publication involves submitting the same (or only slightly altered) papers previously presented in significant outlets without the editors' or publishers' informed permission. In addition to copyright infringement, redundant publications waste peer reviewers' time, take up precious journal space, and mislead readers to assume they are looking at a new database (Roig, 2013). When a work is clearly labeled as a revision, such as this book, still-relevant material can reappear along with updated material.

Another frowned-upon practice is referred to as salami (sometimes bologna) publication, whereby the author slices a single research study into smaller, seemingly independent, articles. The motivation is typically to increase the number of one's publications. Ethical issues apply because the perception of the value of the findings may be distorted, and editors' and reviewers' time and resources are wasted when a single article would have done the job (Steneck & Zinn, 2014).

Finally, just as the Internet has made it easier than ever to find and download material to claim as one's own, it has also never been easier to detect. Institutions can subscribe to antiplagiarism services, such as TurnItIn.com, although simply googling a few words often instantly locates original material.

Publishing Case Studies and Narratives for Professional Consumption

Many mental health professionals welcome learning from the qualitative analyses of stories, interviews, field studies, case notes, journals, narratives, and other sources of life experiences. Some works explore symptoms,

suggest treatments based on successful outcomes, or illustrate and enliven theories (Patterson, 1999).

Publishing material based on interactions with clients or others is not intrinsically unethical, but issues regarding informed consent, confidentiality, and privacy invasion pertain. Although carefully disguising stories by removing all identifying information often provides a satisfactory solution, therapists who publish detailed articles about their clients must remember that when writing about a single person or one family, the risk of "outing" them remains ever present (see also Chapters 6 and 14).

Case 16–15: Stark Naked saw a chapter written in a book on exhibitionism by Bryan Sneaky, L.M.F.T., a therapist he once consulted. The chapter described a man who occasionally ran through the streets of Brooklyn wearing nothing but a pair of tennis shoes and an old Dodger's cap. After he was apprehended, the local paper carried a story about the "Dodger Flasher." Dr. Sneaky's chapter used considerable material taken directly from therapy notes with Mr. Naked. Naked contacted an ethics committee claiming readers could easily identify him and learn far more demeaning information about him. In his defense, Mr. Sneaky produced the lengthy initial contract, signed by Naked. It contained two sentences that read, "Mr. Sneaky writes articles and books about various counseling issues. I agree to allow Mr. Sneaky to use information about my counseling sessions as long as my name is not revealed."

Perhaps in many cases no one other than the clients themselves could identify who the therapists had described. Nevertheless, seeking a current or former client's specific authorization of the actual content would prove a wiser course of action. Furthermore, even if extremely detailed descriptions, such as essentially a verbatim transcript of therapy notes, appear in disguised contexts, the courts could find in favor of the offended client. Mr. Naked may have a basis to take legal action if he chooses to do so even though his name was not used.

RESEARCH ON HUMANS

Interest in research ethics surged shortly after World War II when the Nazis' obscene interpretation of what constituted legitimate science and the criminal acts they committed in the name of science became known (Spitz, 2005). Concerns accelerated with revelations of questionable and risky procedures used on human beings without their voluntary and informed consent in other countries as well as the United States. The federal government began creating research policies in the 1950s. Institutional review boards (IRBs) became established at each site anticipating or receiving federal funds to educate researchers and to ensure that research followed federal policy regarding the ethical treatment of participants.

Researchers must now adhere to high standards of care, many of which run parallel to those of mental health service practitioners. However, there are important differences. First, clients in need of psychotherapeutic interventions usually present themselves for services and already have a preconceived notion of what they will receive. Research investigators, on the other hand, must usually seek people to study. Participants do not always know or fully understand what is going on or even that they are being studied. Second, when offering therapeutic and assessment services, meeting clients' needs is the sole purpose of the activity. Data collection for research purposes, on the other hand, is the means by which the investigators' goals are achieved. In general, then, the therapist holds the interests and welfare of each individual as primary, whereas the researcher contends with the motivation also to fulfill personal agendas that can, without constant self-monitoring, overshadow the rights and welfare of individuals under study. Finally, whereas therapy clients pay us for our time so that we can help them, research participants typically volunteer their time to help us. Herein lie the major reasons why research participants deserve the utmost respect and care.

Even the most proficient researchers face serious dilemmas requiring thoughtful decision making. Quality science and ethical research practices typically provide the best results,

but scientific merit and ethical considerations are sometimes at odds, requiring the sacrifice of some measure of one to comply with the requirements of the other. For example, fully informing the participants of the purpose of the study may weaken or distort scientific validity. The privacy of vulnerable people may be invaded in long-term follow-up studies designed to evaluate and improve treatment techniques from which they and others may eventually benefit. Balanced placebo designs may require misinforming participants to reduce the effects of expectancies. Participants in a control group could be denied a valuable experimental treatment, but without a control group, that treatment could not conclusively be proven superior. (For excellent material on mental health research ethics and case examples, see DuBois, 2008.)

Scientific Misconduct

The scientific enterprise is built on the premise that truth seeking is every researcher's primary motivation. Reviewers of grant proposals and papers for publication accept on faith that researchers subscribe to the highest standards of integrity. And, fortunately, researchers themselves value the ethical standards to which they are held (Keith-Spiegel, Koocher, & Tabachnick, 2006; Roberts & McAuliffe, 2006). Unfortunately, other motives have prompted some researchers to cheat.

Scientific fraud, mistakes, tensions, and other hanky-panky in the laboratory have, perhaps surprisingly, spawned numerous riveting nonfiction books detailing the actions of researchers accused of behaving badly. This genre sends a chilling message to the public readership by highlighting the far-flung damages and harms caused when those who are supposed to devote themselves to true discoveries are accused of wrongdoing. *The Baltimore Case: A Trial of Politics and Character* (Kelves, 1998) is a fascinating account of David Baltimore, a Nobel Prize winner in physiology/medicine and his unwavering support of an accused coauthor. *Plastic Fantastic: How the Biggest Fraud in*

Physics Shook the Scientific World (Reich, 2009) tells of Jan Hendrik Schon, a physicist at Bell Laboratories, whose cutting-edge data and devices resulting in *Science* and *Nature* publications were fake. *Science, Ideology, and the Media* (Fletcher, 1991) considers the charges that social scientist Sir Cyril Burt fudged his famous identical twin data. The not-so-pretty backstories of searching for the AIDS virus are chronicled in *The Race to Discover the AIDS Virus: Luc Montagnier vs. Robert Gallo* (Kallen, 2012), and *Science Fictions: A Massive Cover-up and the Dark Legacy of Robert Gallo* (Crewdson, 2002). The atmosphere and intriguing happenings during the discovery of the structure of DNA, including the role of Rosalind Franklin, a name too few know, are uncovered in *The Double Helix: A Personal Account of the Discovery of the Structure of DNA* (Watson, 1968), *What Mad Pursuit* (Crick, 1988), and *The Dark Lady of DNA* (Maddox, 2002). Other works contain short stories about scientists who fell from grace, such as *False Prophets: Fraud and Error in Science and Medicine* (Kohn, 1986); *Impure Science: Fraud, Compromise, and Political Influence in Scientific Research* (Bell, 1992); and *On Fact and Fraud: Cautionary Tales From the Front Lines of Science* (Goodstein, 2010). These accounts remind us that science can be messy, and that scientists are human beings dealing with the same stressors, temptations, needs, and sometimes emotional and moral impairments.

Recurring themes in unmasked data fraud involve perpetrators who were lax in the supervision of the data gathering and analysis and excessively ambitious with previous records of prolific writing. Usually present is an intense pressure to produce new findings. Researchers who publish first are credited with a “discovery,” and showing good progress is essential to continued grant funding. In fact, one reason many researchers may jump ahead of their actual findings by reporting bogus or manipulated data is because they sincerely believe that they already know what actual data would reveal.

Additional elements present within the scientific enterprise itself can tempt researchers

to deceive. A project that fails to produce significant findings may not gain acceptance for publication due to a bias against publishing statistically insignificant findings. Or, legitimate data may never be reported because a financial interest in a particular outcome failed to materialize. The organizational culture in which researchers conduct their studies can also contaminate science. That is, when a researcher sees others behaving unethically as a way of getting ahead in a competitive environment and those with the authority to take action turn a blind eye, undue moral pressure is exerted on those who would otherwise behave ethically (Keith-Spiegel et al., 2006). Sometimes, those in authority behave in an overly restrictive, unresponsive, biased, unfair, or offensive manner that inhibits the inclination to do sound research, thus inviting rule breaking.

Case 16–16: Nancy Icarus, Ph.D., had always prided herself on a commitment to conducting ethical research. However, the IRB at her university was unreasonable in its demands in a way that unduly restricted her ability to do work in her specialty area. Several members obviously had no understanding of her field. Furthermore, the memos the IRBs issued were arrogant and rude. In frustration, she went ahead and conducted her research while misleading the IRB about what she was actually doing.

Ethical standards demand that when research requires approval by an institution, the information in the protocol must be accurate. Paradoxically, however, IRBs charged with upholding the responsible conduct of science may actually encourage deceit. We may have some sympathy for Dr. Icarus, who ran up against a wall and broke the rules to get around it. In the meantime, however, such research is not being properly monitored as required by federal policy. Participants’ rights could be slighted, but the institution may never know of it. Unfortunately, charges that IRBs are unreasonable, unresponsive, and incompetent are not uncommon (Giles, 2005; Keith-Spiegel & Koocher, 2005).

Types of Research Wrongdoing

The most frequently discussed forms of research wrongdoing are *fabrication* and *falsification*. Along with *plagiarism*, this trio of dishonest acts forms the official definition of scientific misconduct known simply as FFP. Similar to plagiarism, the purposeful creation of unsound data is considered among scientists and scholars as a grievous ethical violation (see APA: 8.10a; AAMFT: 5.6, 5.8; ACA: G.4.a; NASW: 502.n). The consequences of making invalid data public are, however, far more serious than simply duplicating the work of others (i.e., plagiarism) because the spurious conclusions contaminate the research record. Conducting good science requires a process of building on previous work. Time and effort become wasted when unquestioning researchers pursue inquiries based on earlier reported findings they do not realize are bogus. Application of findings based on tainted data can cause serious harm. For example, two critics of cardiologist Don Poldermans suspected his tainted published research assertions were responsible for 800,000 deaths (Vogel, 2014).

Does actual harm result only as a result of fraud in the biomedical sciences? This is not necessarily the case. Dishonest social and behavioral scientists can seriously disadvantage people as well. In a case that came to light in the late 1980s, the federally funded research of psychologist Stephen Breuning reported findings based on data that were never collected. This case is especially disturbing because Breuning's findings became a basis for actual treatment decisions before his work was discredited. The fraudulent reports were also then used as a basis to determine drug therapy for institutionalized cognitively impaired persons, a treatment later proven detrimental based on the results of competent research conducted by others (Bell, 1992; Committee on Government Operations, 1990).

In mental health research, the consequences are usually less dire, but nonetheless far reaching. For example, if a researcher proposing an experimental therapy technique "trims" data, and the contaminated findings appear in a

reputable journal, the results may be applied by unsuspecting clinicians. By the time someone notices clients are not improving (or their conditions are worsening), serious setbacks could occur. Or, if a developer of a psychodiagnostic assessment alters the validity data, people could be misclassified using what is erroneously believed to be a well-founded predictive instrument. To the extent that such results are used to determine diagnoses or treatment or to decide who should not be hired or who is shuffled into some inappropriate category, people's lives can be adversely affected.

Several less frequently discussed acts can also distort the scientific record to the same degree as fabrication or falsification, as listed in Box 16-1. For example, a researcher may purposely select those with only the mildest symptoms of a diagnostic category to bolster the chances of "proving" that a particular therapy works. Or, conversely, participants with the most severe symptoms may be purposely placed in the control group so that the experimental group will appear to fare more favorably by comparison.

Relying on secrecy to get ahead, refusing to share data, and withholding details in methodology or results run against the grain of scientific integrity because they make it more difficult or impossible for anyone else to successfully pursue that same line of inquiry (Grinnell, 1992; Martinson, Anderson, & de Vries, 2005; Sieber, 1991a, 1991b). "Data torturing" is another ignoble practice, involving analyzing the same data many different ways until one finds statistical significance (Whitley, 1995). These ethically questionable acts may be more likely to occur when the source of financial support has an interest in obtaining findings favorable to the source's predetermined desired outcome.

Data are often collected by assistants, some of whom may not be fully socialized into the values of science and the importance of accuracy. Academic dishonesty is rampant, so the same unfortunate mindset may reveal itself when collecting data without sufficient oversight. Thus, lax supervision of assistants is irresponsible and carries potential consequences. The next case illustrates "curbstoning," occurring when data collectors sit on a curb (or, more likely,

Box 16–1 Types and Examples of Scientific Wrongdoing

Fabrication: The main type involves inventing data (“dry labbing”).

Falsification: Examples include “smoothing” or “cooking” actual data to approach more closely the desired or expected outcome and dropping collected data points (“trimming”) to delete unwanted outliers that elevate calculated error.

Plagiarism: The main types are substantial copying of another’s work without appropriate attribution or misappropriation of intellectual property.

Incompetence: Examples include poor research design, methodology, or statistical procedures; inappropriate selection or use of a study technique due to insufficient skills or training; and just plain ignorance.

Careless work habits: Examples include sloppy record keeping, haphazard data collection, cutting corners, and inadequate monitoring of the project’s progress.

Intentional bias: Examples include rigging a sample to maximize support for hypotheses, withholding methodological details, and deceptive or misleading reporting of data or its interpretation.

Questionable publication practices/authorship assignments: Examples include publishing a paper or parts of the same study in different publication outlets without informing the readers, undeserved “gift” authorships, coerced authorship, and omitting someone who deserved an authorship or other form of credit.

Inadequate supervision of research assistants. Examples include giving assistants more responsibility than they are able or willing to handle and insufficient supervision of assistants’ work.

Failure to follow the regulations of science. Examples include sidestepping or ignoring the IRB or its directives; circumventing or ignoring human subject requirements with regard to informed consent, confidentiality, or risk assessment; inadequate care of research animals; and violating federal research policy.

Difficult or stressful work environment that could have a negative impact on the conduct of research. Examples include mistreatment or disrespectful treatment of subordinates, sexual harassment or other form of exploitation, playing favorites and other factors that create poor morale or acting out by subordinates, using one’s position to exploit another, and conflicts with the administration or administrative policies.

A dishonest act indirectly related to being a researcher. Examples include unreported conflict of interest, such as a financial interest in the outcome of an experiment; misuse or misappropriation of grant funds; and inflating, distorting, or including bogus accomplishments on a résumé.

Biased reporting of results involves presenting the findings in such a way that they appear far more significant than they actually are, thus misleading readers.

Adapted from *Responding to Research Wrongdoing: A User Friendly Guide*, by P. Keith-Spiegel, J. E. Sieber, & G. P. Koocher, 2010. Retrieved from http://www.ethicsresearch.com/images/Method_Results_July_22_2010_a.pdf

elsewhere) to fill out questionnaires or other data forms without ever connecting with members of the actual study sample.

Case 16–17: Imina Hurry, an undergraduate student, was to approach 100 willing adult individuals

and ask them to rate their fear of contracting the Ebola virus on a scale of 1 to 10 as part of a collaborative arrangement with Ms. Hurry’s supervisor, Trustem Toomuch, Ph.D. Ms. Hurry needed to catch a train to visit her mother and decided to stop after obtaining 25 ratings and just enter in

the same ratings three more times. Dr. Toomuch became suspicious on noticing four exactly the same strings of numbers and confronted Ms. Hurry, who tearfully confessed.

This case illustrates two unfortunate consequences. First, we do not know how well Ms. Hurry was prepared, or if Dr. Toomuch gave too-casual instructions because he assumed the task would be executed properly. We can assume the assistant will face discipline that might have been avoided had she been fully acculturated to the importance of honesty in science. Second, possibly impure findings might have been disseminated. Fortunately, Dr. Toomuch took the time to carefully review what the student submitted.

One may be tempted to assume that such inaccuracies, purposeful or not, will be discovered, but we cannot count on it. Whereas errors in alleged scientific advances are assumed to self-correct eventually through others rerunning the same study, funding sources typically do not support duplicated research projects, and the resources to replicate on one's own without support rarely are available. Furthermore, most scholarly journals do not readily publish replication studies. Thus, there is little incentive for researchers to repeat the work already reported by others. There are those who are currently advocating for replication research, not only to see if a primary work holds up but also to update the phenomenon under study (Novotney, 2014). For example, study results about attitudes toward certain groups may be outdated as people's tolerances change. And, although misconduct is not at issue, older work did not have the benefit of modern research methods. It is interesting to note, however, that a collaboration among 36 laboratories replicated 10 of 13 psychology experiments, suggesting that concerns about replicability may not be as serious as some suggest (Yong, 2013).

Incidence

In a now-classic survey of doctoral candidates and faculty members from 99 departments, anonymous responses to questions about

knowledge of instances of scientific misconduct revealed that over two thirds of the graduate students and about one half of the faculty had direct knowledge of the commission of some form of scientific misconduct. Most did not confront or report it, usually from fear of reprisal (Swazey, Anderson, & Lewis, 1993). A more recent study suggested that the situation has not improved. Although very few of the several thousand scientists responding to an anonymous survey disclosed committing more serious research sins of fabrication or falsification, one of every three admitted to committing an act that could be labeled as questionable (Martinson et al., 2005). Similarly, Keith-Spiegel, Koocher, Tabachnick, Sieber, and Butler (2010) found that 84% of their large national survey of National Institutes of Health (NIH) principal investigators (PIs) either observed or had personal knowledge of at least one instance of research wrongdoing. Contrary to reports of others, almost two thirds of those PIs claimed to have taken action, perhaps because these respondents were more likely to be in positions of authority. Finally, Bhutta (in Bhutta & Crane, 2014) outlined disturbing data revealing that the number of retracted articles due to misconduct (controlled for repeat offenders) has risen 11-fold since 2000.

In light of disturbing reports, what credibility should the public place on researchers' work? The public's generalized distrust could have disastrous consequences for everyone. Scientists are as dependent on the public for continued support as society is on their valuable, legitimate contributions. Although part of the problem is a system of rewards that implicitly encourages dishonest and irresponsible scientific practices, researchers must remain true to the search for truth if the entire scientific enterprise is to remain stable and healthy. In response to a growing concern about scientific dishonesty, the Public Health Service established the Office of Research Integrity (<http://ori.hhs.gov/>) to direct activities focused on research integrity on behalf of the Department of Health and Human Services (DHHS; with the exception of the Federal Drug Administration). This office creates policies and regulations with regard to preventing,

detecting, and investigating scientific misconduct as well as providing numerous educational materials concerning the conduct of responsible research (see Steneck & Zinn, 2014).

Difficulties in Detection

Most of the highly publicized data scandals occur in biomedical research laboratories. Most social and behavioral research does not involve chemical analyses, tissue cultures, change in physical symptoms, or similar “hard” documentation. Social science data often take the form of numerical scores from questionnaires, psychological assessments, or performance measures or qualitative data based on interviews or behavioral observations. Such data are relatively easy to generate, fudge, or trim. We can hope that social science researchers are motivated by the responsible quest for truth, but it is disquieting to note that the same publish-or-perish and grant-seeking pressures exist for social and behavioral scientists working in competitive settings, and that recognition is an ever-present allure for many regardless of their specialty. It does seem clear that far more serious and worrisome and “gray area” misbehavior occurs than is discovered and reported (De Vries, Anderson, & Martinson, 2006; Titus, Wells, & Rhoades, 2008).

The practice of fabricating data may start when researchers are students (Whitley & Keith-Spiegel, 2002). Davidson, Cate, Lewis, and Hunter (2001) were startled to find that among a large group of students across several majors, only one student indicated never having manipulated data in laboratory reports. These authors opined that students are admonished to find “the right answer,” and that this expectation contributes heavily to a willingness to cheat. Instead, Davidson and her colleagues (2001) argued the goal for students should be allowing for a fair test of hypotheses.

Social media may become an unexpected source of discovering scientific wrongdoing. Two papers published in 2014 in the prestigious journal *Nature* touted the so-called STAP method for more easily creating stem cells. Biologist Paul Knoepfle’s blog revealed

differences in opinions regarding the veracity of the discovery. Others posted reports of failed attempts to replicate the technique. Within months, the RIKEN Institute in Kobe, Japan, began an investigation that resulted in a finding of misconduct by the lead author, Haruko Obokata. Obokata apologized and resigned. Nature subsequently retracted both articles (Locke, 2014).

It is possible for innocents to be caught up in a research fraud scandal and suffer the same consequences as the guilty perpetrator. Diederik Stapel, whose nefarious deeds were described at the beginning of this chapter, enticed potential collaborators by providing data for colleagues to analyze and work into a publishable manuscript. Certainly, not all, if any, were complicit in knowing that the numbers Stapel supplied were bogus, but their names are forever associated with him and his fall from grace. Being innocent but associated with a guilty perpetrator can be devastating, as was profoundly and sadly illustrated in the next case.

Case 16–18: Yoshiki Sasai, the deputy director of the Center for Developmental Biology at RIKEN in Kobe, Japan, was a coauthor on two articles published in *Nature* that were eventually retracted. The images provided by the senior author Haruko Obokata (see previous discussion) were found to have been manipulated. Despite being cleared of any wrongdoing, Sasai faced heavy criticism in the media and by his peers. He was hospitalized and eventually committed suicide (Master, 2014).

Two investigators chose to fight back when the individual allegedly responsible for misconduct tainted their reputations. Piero Anversa and Annarosa Leri at Harvard Medical School and its affiliate Brigham and Women’s Hospital (BWH) are suing the school, its dean of faculty, and BWH’s president for what they claim was a procedurally and legally flawed misconduct investigation resulting in damage to their reputations. Although they do not deny that articles appearing in *Circulation* and *Lancet* included fictitious data, they point to Jan Kajstura, a former member of Anversa’s lab,

who they say altered the data from mass spectrometry experiments performed at Lawrence Livermore National Laboratory (LLNL) in California. It was an LLNL researcher who noticed that the *Circulation* paper contained more data points than he provided. Anversa and Leri claim to be totally unaware of any misconduct. The suit has not played out as of this writing, but it may have major implications for how investigations are carried out in the future (Servick, 2015).

Finally, just as engaging in sexual activity with psychotherapy clients has been criminalized in several states, there is talk of making serious scientific misconduct a punishable crime (see Nuwer, 2014). According to Bhutta (in Bhutta & Crane, 2014), the fallout from research fraud on human health and clinical practice can be extensive and is rapidly accelerating. He noted that of the 2,047 retracted biomedical research articles indexed up to May 2012 by PubMed, 67% were due to scientific misconduct and the rest due to other wrongdoing, including duplicate publication and plagiarism.

It could be argued that the ruination of a guilty scientist's career is punishment enough. Yet, perpetrators have stolen untold millions in taxpayer money, and at best they wasted participants' time and at worst harmed them. They have contaminated the knowledge stockpile to the detriment of other researchers attempting to follow the same line of inquiry. Should expanding the punishment take hold, however, discerning the difference between intent, ignorance, or simply making an honest mistake would complicate many suspected prosecutions of research fraud.

Competency to Conduct Research

Research conducted in the mental health field deals with such issues as the status of mental health and epidemiology as well as the prevention, causes, and treatment of emotional and mental disorders, all of which raise special ethical issues regarding such matters as additional consent procedures and other safeguards (DuBois, 2008). The conduct of research in

the mental health field requires special competencies beyond that covered in basic research methodology courses.

Data analysis techniques have become extremely sophisticated in the last decades, made possible by the capabilities of high-speed computers. Many mental health practitioners who conduct research have not received extensive training in complex methodology and study design. We strongly advise including someone with expertise in design and statistics on any research team, at least as a consultant. No meaningful information can possibly result from poorly formulated studies or improperly collected or analyzed data. The use of human beings or animals in research can never be justified on any grounds if the study design is flawed. The scientific record also becomes tarnished when poor quality work is dumped into the scientific literature.

Ideally, the editors of scholarly journals weed out most incompetent submissions. But, shoddy work slips by for a variety of reasons, such as inadequate or biased reviews. The more critical the topic (e.g., heart disease as opposed to heartburn), the more willing manuscript reviewers may be to overlook or underrate methodological flaws (Wilson, DePaulo, Mook, & Klaaren, 1993). Just as anyone can now self-publish a book without undergoing any form of outside scrutiny, so can almost any research study find an online publishing outlet in an open-source online journal, as discussed previously. (See Chapter 2 for more detailed discussions of competency.)

Consent to Participate

The basic obligation of the responsible researcher is to enter into a fair and clear agreement with research participants. The requirement of consent as a protection for participants first appeared in the Nuremberg code, published in the United States in the *Journal of the American Medical Association* in 1946. Adopted after the war crimes trials of 23 Nazi physicians indicted for crimes against humanity, the code includes the essential elements of consent. Consent to participate requires

legal capacity to give it, freedom to decline participation without coercion, and sufficient knowledge about the nature of the study to make an informed decision (Capron, 1989). Although never used as a legal precedent, the Nuremberg code is the basis from which subsequent codes and policies were developed (see APA: 8.02, 8.03; AAMFT: 5.3, 5.4; ACA: G2a, 2e; NASW: 5.02.e).

Consent, however, is not as simple as someone saying, "Yes, I'm in." Truly informed and voluntary consent requires consideration of several factors. These include the following:

- Competence of the participant to give meaningful consent
- Quality and appropriateness of the consent forms (e.g., readability)
- The potential for participants to misinterpret the study purpose (e.g., assuming the study will result in therapeutic benefit when that was not the purpose or intent)
- Cultural factors that might alter how consent should be sought (e.g., language or reading barriers, trust issues)
- The potential effect of offering compensation or potential for benefit as a result of participation
- Risk factors that influence consent (e.g., potential for physical or emotional discomfort or data access by others not involved in the study)
- Developmental factors (e.g., gaining assent from children, adolescents, and the fragile elderly)
- Participant vulnerability (e.g., incarceration, institutionalization, victims of abuse, trauma survivors)
- Safeguards when study populations cannot give meaningful consent (e.g., seriously mentally ill, comatose)
- Relationships between the researcher and the participants as they have an impact on gaining voluntary consent (e.g., one's own clients or students)
- Any consequences of obtaining post hoc consent during debriefing when features of the study were initially withheld (e.g., feeling anger over being misled)

It is now well accepted that, with a few carefully proscribed exceptions, research participants must know the nature of their volunteering and agree freely to do it. The only consent issues remaining open or in flux focus on specific applications, such as how to deal with consent issues when conducting research online, gaining appropriate consent from specific populations (e.g., suicidal or delusional individuals), better understanding cultural influences on the consent process, and continuing to wrestle with how to gain consent or something close to it with populations who cannot consent for themselves.

Voluntariness

Because a person's decision to participate in a research project can be manipulated in both subtle and blatant ways, many complex factors make it difficult to ensure completely voluntary research participation. A researcher can be persuasive without conscious intent. For example, solicitation by someone perceived as prestigious and an authority may itself be persuasive. Influence is especially likely if the researcher is enthusiastic and likable or if the potential participant is vulnerable, deferent, or in need of attention. People desperate for a solution to a personal matter that relates to the subject under investigation may overlook any risks. Groups such as inmates, students, or employees of the organization sponsoring the research may feel pressured to participate for fear of retribution, even when explicitly told they are free to decline without penalty. Many of the people who are sought for participation in the social and behavioral sciences are troubled, in need of assistance or resources, or in a weaker bargaining position compared to the researchers.

The explicit offer of rewards, monetary or otherwise, is a sensitive matter that can affect a decision to participate in research. Offering to pay participants a small amount to offset inconvenience and transportation costs is unlikely to be considered coercive. Ethical issues arise when the reimbursements or rewards for participating are significant enough to

influence consent decisions (APA: 8.06a, 8.06b; NASW: 5.02.e).

Case 16–19: Edward Noharm, M.D., complained to a university IRB that a sponsored project involved excessively enticing tactics. To obtain a control group for a hospitalized experimental treatment group of infants, the researchers approached parents in a low-income neighborhood and offered them several hundred dollars if they would allow their babies to undergo periodic laboratory tests, some of which involved inducing discomfort. Dr. Noharm argued that the control group of healthy children could in no way benefit from the study, and that the offer to financially limited parents of such a large sum constituted a persuasion that could override concern for their babies' best interests.

Case 16–20: Mimi Dogood, Psy.D., complained to a state legislature that prisoners were being subjected to poorly designed, intrusive experiments in return for \$10 a day. Ironically, the prisoners objected to her intervention, noting that the money kept them supplied with cigarettes, candy, and other small items that enhanced the quality of their otherwise-routine lives.

Case 16–21: Children who knew they were going to participate in research were asked if they would be willing to eat a piece of baked mouse if it would help solve world hunger. To the investigators' surprise, almost all agreed to do so.

All three cases were adapted from true occurrences. The first two illustrate how people of limited means or opportunity may accept attractive enticements that others with greater resources or freedoms would see as trivial. The third was based on research conducted by Keith-Spiegel and Maas (1981). No baked mouse was ever served to the children, of course, because the point of the study was to evaluate altruistic pleas; the surprising level of effectiveness of a fervent appeal on a vulnerable population was clearly demonstrated. In the same study, a majority of the children would also agree to have their eye poked with a glass rod when the research purpose was described as finding ways to help blind children see again.

Some participants may discount any potential risks in the hope of securing needed benefit. Or, they may believe that needed services are contingent on participation in research. Researchers must be careful not to engage in "hyperclaiming," that is, suggesting to potential participants that the study will reach goals that are, in fact, unlikely to be achieved (Rosenthal, 1994).

Researchers should never create guilt feelings in those who decline to participate in a research project. In its nastiest form, a researcher may actually hint that refusal to participate suggests selfishness or lack of caring about others who could be helped, thanks to the "good people" who have agreed to be part of the study.

Can research participants withdraw their previous decision to participate? Despite the disappointments that researchers undoubtedly experience when participants change their minds midcourse (especially if this occurs well into a complicated or longitudinal study), the right to withdraw should be honored (APA: 8.02; AAMFT: 5.4; ACA: G.2.a.9; NASW: 5.02.h). This right to disengage from a study should be made explicit during the initial consent phase. Rare exceptions involve needed interventions available only in a research context.

Knowledge and Understanding

Gaining informed consent is a critical communication process during which an agreement is reached (Fisher & Vacanti-Shaw, 2012). For research participants to understand what they are being asked to agree to do, they (or their surrogates) must have the capacity to comprehend and evaluate the information that is offered to them prior to actual participation. Perhaps because of liability fears, consent forms are becoming overly long and detailed, which increases confusion and dampens the willingness to participate (e.g., Albala, Doyle, & Appelbaum, 2010).

Case 16–22 Sue Dontgettit complained to the research office at her university that a study conducted by Hy Wordlevel, Ph.D., subjected her to an upsetting experience by asking embarrassing

questions about her childhood relationships. Dr. Wordlevel produced Dontgett's signed consent form as a defense. Ms. Dontgett contended, however, that the wording of the form was confusing to her and included terms like "participatory negative junctions" that she did not understand.

Ms. Dontgett might have asked questions (assuming she was invited to do so, as she should have been, see APA 02: 8.02; ACA: G.1.a.6) or declined to involve herself in something she did not understand. But, participants may not have sufficient self-efficacy to admit confusion or a lack of comprehension, especially if they do not feel in control of the situation. Researchers must recognize that a signed consent form is *not* synonymous with informed consent. If the individual did not fully grasp what he or she signed, informed consent has not occurred. Unfortunately, it has been documented that legally competent adults can have minimal understanding of what they agreed to do (e.g., Cassileth, 1980; Sieber & Levine, 2004; Taub, Baker, & Sturr, 1986).

Individuals who have trouble with the language, for whatever reason, require special consideration. Non-English-speaking participants have the right to translations, although translations are not always sufficient to enable complete understanding given that many languages do not translate smoothly; slang words and idioms complicate the matter further (e.g., Kithinji & Kass, 2010). Individuals with poor reading skills or other disabilities should also receive special assistance.

When participants lack the legal capability to give consent, permission (i.e., a proxy agreement) must be obtained from authorized others. Nevertheless, except for infants, nonverbal children, and seriously impaired uncommunicative individuals, offering participants some explanation of what they are being asked to do should be attempted. In addition, if practical, their proactive assent should be sought. For example, although parents are involved, most adolescents want to also sign consent forms themselves (Grady et al., 2014).

It is our position that even if permission has been obtained, an individual who expresses lack of desire or interest in participating should be excused unless there is a very compelling reason, such as a likelihood of direct and indicated therapeutic benefit, to override the participant's wishes. After all, a fussy or begrudging person will not likely provide valid data.

Finally, we note that consent forms protect researchers and their institutions, allowing for a "record of agreement" should the participant complain later (Sieber & Levine, 2004). It has been argued that consent forms protect the researchers and their sponsoring institutions but could be a threat to certain populations, such as criminal offenders, should the data ever be subpoenaed (Roberts & Indermaur, 2003). However, formal consent procedures are not always required for some types of data collection methods, such as so-called minimal risk research when the project is highly unlikely to cause any harm or distress. Examples include anonymous questionnaires, naturalistic observations, and some types of archival research or review of data collected for nonresearch purposes with participant identities removed (DHHS, 2005). In addition, formal consent agreements are typically unnecessary for service and program evaluations in educational settings or for job or organizational effectiveness as long as there is no risk to employability and confidentiality is protected. We suggest keeping a record of how the research was conducted whenever written informed consent is not required just in case clarification is later sought (see APA: 8.05; ACA: G.1.d; NASW: 5.02.g).

Deception

Some pretext in conducting research may occur unintentionally and unavoidably. Despite a researcher's plan to disclose all aspects of a study's purpose, some features will remain unexplained. It is the *purposeful* use of deceptive techniques that remains controversial.

Intentional deception techniques range widely from outright lies or concealment of risks to mild or ambiguous misrepresentations or omissions. Types of deceptions described by

Gross and Flemming (1982), Kimmel (1996, 2012), and Sieber (1982a) include the following:

- *misinforming participants* (e.g., offering inaccurate information during the consent phase that might have influenced the decision to participate);
- *concealing information* (e.g., leaving out relevant information during the consent phase that might have influenced the decision to participate);
- *enlisting confederates* (e.g., “stooges” pose or interact with the participants in some predetermined way);
- *making false guarantees* (e.g., failing to maintain confidentiality or not ultimately providing a promised prize or compensation);
- *misrepresenting one’s identity* (e.g., referring to oneself falsely as a medical doctor or a journalist);
- *creating false feedback* (e.g., giving participants inaccurate performance or untrue evaluations);
- *concealing observations or recordings that could prove harmful to those being observed; and*
- *not informing participants that they are being (or have been) assessed or observed for research purposes*

Packing all of these deceptions in one brief scenario poses a challenge, but the next contrived case offers a far-fetched attempt.

Case 16–23: To test the hypothesis that women are less likely to engage in a mildly humiliating act for money than men and that younger people are more gullible than older people, a confederate of the researcher approaches male and female strangers in a mall food court. He says to the unsuspecting research participant, “See that guy over there? If you walk over to him and loudly oink like a pig, he will give you a \$100 bill. See? I just got one” (he flashes a genuine \$100 bill). The confederate disappears to observe what happens from a distance. The experimenter waits for takers. If anyone comes up and oinks, he just looks at him or her in puzzlement and does whatever else is necessary to convince the individual that

he does not hand out \$100 bills, and that they must have been accosted by a practical joker. He then records the sex, approximate age, and other observable features of the “oinker.” No attempt to debrief the hapless participant is made.

Of course, deceptions differ in severity and the potential for negative effects. According to Kimmel (2012), severe deceptions are those creating false beliefs about issues and beliefs of central importance to the participants or when self-esteem or perception of self is damaged or degraded. Severe deceptions may cause both an immediate negative affect and long-term harms. Mild deceptions create false beliefs about matters of relative unimportance to the participants and perhaps cause only momentary disappointment or confusion during the debriefing stage, upsets that an empathic and skilled debriefer should be able to ameliorate. For severe deceptions, the participant may be fully informed during the debriefing but not disabused (Holmes, 1976). Indeed, the debriefing session itself may inflict information that causes or exacerbates harm (see Case 16–26). To lump studies using deception into a single pot, as if they all had a potential to inflict equal degrees of wrongs, would be an error.

Arguments favoring the use of deception usually involve protection of the validity of the data by intentionally manipulating the actual purpose of an experiment to avoid the participants’ conscious reactions (Broder, 1998). Thus, as Kimmel (2012) put it, “The primary justification for using deception in laboratory settings has been a purely methodological one—that if researchers conformed to the letter of the law regarding informed consent and did not deceive participants at all, then many investigations would be either impossible to conduct or would result in biased findings” (p. 401).

Critics argued that deception compromises the consent agreement. Furthermore, allowing it condones lying. Some fear that such research causes the public to regard social scientists as manipulative, exploitative, and suspicious. Knowledge of such techniques might prompt second-guessing regarding what the study is really about, thus distorting the participants’

behaviors in ways that sabotage the true purpose (Hertwig & Ortmann, 2008). Others alleged that such techniques provide quick, noncreative, and undesirable shortcuts to more careful and creative experimentation. And, finally, degradation, embarrassment, anger, disillusionment, and other harms and wrongs can potentially occur when participants are duped.

The APA ethics code explicitly, although cautiously, allows the use of deception in research. The code admonishes researchers to ensure that a study using deception has scientific or applied value (in contrast to our fictional Case 16–23, which would be difficult to justify). Effective alternatives must have been considered but proven unfeasible (APA: 8.07a). Further, deceiving participants about aspects of the study that might otherwise alter their consent to participate (such as the potential for physical discomfort or risks or other unpleasant experiences) is disallowed (APA: 8.07b). In those very rare cases when scientific or humane reasons exist for delaying or withholding information altogether, researchers should minimize any possible risks (APA: 8.08b). The NASW code addresses deception without using the term, mandating that research should not be conducted without consent procedures unless a rigorous evaluation determines scientific, educational, or applied value and alternatives are not feasible (NASW: 5.0.g). Similarly, while not invoking the term, the ACA code requires members to seek consultation whenever deviations from standard practice may be necessary (ACA: G.1.d) and must take reasonable precautions to avoid causing emotional, physical, or social harm (ACA: G.1.e). The AAMFT does not directly approach the issue of deception, but admonishes its members to pay careful attention to the ethical acceptability of any research and encourages consultation (AAMFT: 5.2).

Pascual-Leone, Singh, and Scoboria (2010) developed the *Windsor Deception Checklist*, consisting of 10 questions researchers should reflect on before conducting research using deception. Examples include accounting for all reasonable costs and benefits and feeling assured that the benefits outweigh the costs,

exploring whether misleading the participants could be further minimized, and reassessing the proposed technique to make sure any risks were not overlooked. Whereas every investigator should weigh the potential costs before conducting research involving deception, Ortmann and Hertwig (1997) pointed out that the assessment of benefits and loss is usually left to the investigators, whose self-serving biases may color their decision making.

Complaints about deception rarely come to the attention of ethics committees. We can offer a couple of examples in which one or more participants objected.

Case 16–24: When volunteers arrived at Elmo Gotcha's laboratory, they were told that they would be asked to carefully examine some objects and would later be tested on what they saw. Items included a flashlight, several hand tools, a teddy bear, and a suitcase. When students opened the suitcase, they found a 2-foot long energetic garden snake. Mr. Gotcha recorded each student's response. He wrote a paper that classified college students' reactions to "unexpected events," emphasizing that the snake was totally harmless.

Researchers probably differ in their judgments of the potential for emotional distress. In this case, the data suggested that many participants' responses to the snake were highly unfavorable. In the next case, we touch on an especially important factor when it comes to deciding whether deception was ethical.

Case 16–25: Tillie Testy was outraged about a study unwittingly conducted on her and her classmates by Henry Sneak, Ph.D. The students were told they would be taking a multiple-choice test on a given day that would cover assigned readings. On exam day, the teaching assistant entered the room, explained that Dr. Sneak was taken ill and had been unable to prepare the test, but was able to create an essay question to substitute. The assistant wrote the question, which was totally unrelated to the assigned readings, on the board. After 10 minutes, Dr. Sneak entered the room and explained that he was doing a study on the effects of confusion and stress and asked the students to

fill out a brief questionnaire. He then handed out the real exam and told the students to “carry on.”

Ms. Testy was upset not only because she was tricked but also because she was forced to take an actual exam immediately following what was, for her, an apprehensive 10 minutes. An ethics committee agreed that it was unfair to expect students to perform on an exam that would count toward a course grade immediately after a manufactured, nerve-racking disruption. Further concerns were expressed by the ethics committee because the study was judged to be poorly conceived and unlikely to contribute useful knowledge.

Researchers who utilize deception are obliged to come clean with their participants in a timely fashion after data collection. They must also attempt to correct any misconceptions or supply any information purposely withheld. Telling the truth, however, does not necessarily mean that participants will automatically feel good about what was done to them. This process should occur in a sensitive and educational manner so that the participants can understand and accept the reasons offered, including why deception was necessary. Any participant should be allowed to withdraw the data they contributed on learning that they were deceived, thus giving what might be described as a “post hoc consent” opportunity (APA: 8.07c, 8.08a; ACA: G.2.g). Ideally, all anxieties are alleviated. But, this does not always happen.

Case 16–26: Tempty Snookered was stunned to learn that she had agreed to commit a dishonest act as part of a research study. A confederate of the researcher managed to convince Tempty to engage in a less-than-honest enterprise. She was to go around asking professors if they had any textbooks they did not want, explaining that she was trying to build her personal library, but then handing them over to a confederate who would sell them and split the take with her. Ms. Snookered was later informed that this was only a study of effective persuasion techniques, and that the books were all donated to the library. Nevertheless, she was so upset that she transferred to another college at the end of the term,

fearing that others would know that she had been willing to lie to her professors.

If researchers maintained confidentiality, as they are supposed to, Snookered probably had nothing to be concerned about. Some social influence techniques are known to be extremely persuasive, and the researcher likely forgot about singling out Snookered as a “known individual” as soon as her data were recorded. Nevertheless, this case illustrates how research participants can remain upset even when they have no actual reason for concern. These last three cases also illustrate how participants can be debriefed but not disabused.

The use of deception with child participants raises especially difficult issues. Parents should be fully informed of exactly what their children will experience, and special precautions are essential to ensure that children leave the experimental session feeling at least as whole as they did when they started. This might require the need for additional sessions, for example, adding a play period in which the “confederate” who purposely provoked the children’s anger is able to repair the relationship (see Hubbard, 2005).

Debriefing may be withheld under certain circumstances. One commonly stated reason is to avoid contaminating the sample if word of the actual purpose began to circulate by previously debriefed participants, although completely forgoing truth telling for methodological convenience is not considered ethically acceptable (Sommers & Miller, 2013). It may be cumbersome and logistically challenging, but ways to cautiously and sensitively follow up with participants after completing data collection can be implemented (e.g., phone calls, special meetings, or direct personal contact). However, this does not always turn out well.

Case 16–27: Researchers at a large Midwestern university were interested in conditions under which individuals could be scammed online. Fake phishing e-mail messages were sent to hundreds of students, using e-mail senders’ names of participants’ known contacts, gleaned from social media accounts. The majority of students succumbed

to the attack when they believed the e-mail was being sent to them by a friend. Participants were debriefed by e-mail and allowed to comment. Many were angry and upset and denounced the study as unethical, illegal, and useless. Over two dozen students issued formal complaints. Subsequently, the researchers successfully convinced the IRB to allow their line of research to go forward without the necessity to debrief, given that the participants were not actually put at any risk (Finn & Jakobsson, 2007).

We should note, in all fairness, it is possible that participants may sometimes benefit from participating in deception studies by learning something useful about themselves or gaining a better understanding of science (Kimmel, 2012). Several studies revealed that participants do not necessarily feel wronged on learning the full purpose of the study (e.g., Christensen, 1988; Sharpe, Adair, & Roese, 1992), especially when effectively debriefed (Smith & Richardson, 1983). Learning about people's vulnerabilities, temptations, and capacity for bad behavior provides valuable and useful information, but subjecting the actual participants to "inflicted insights" about themselves is difficult to justify. For example, conducting research that may help others to better understand the vulnerabilities to cyberattacks may be worth leaving participants in the dark about their part in contributing to that knowledge. Sommers and Miller (2013) recommended, however, that debriefing should be forgone only under a narrow set of circumstances, namely, when field research poses considerable practical barriers but researchers would not have qualms about debriefing if they could. To keep the participant pool naïve or to allow researchers to shield themselves from expected angry reactions are insufficient excuses.

One highly publicized case combined several key violations of the fundamentals of consent: failure to even seek consent, the use of deception, breaches of integrity, failure to cease the research when the unwilling focus of the study objected, and assaults on personal dignity. It seems worth describing that case here, at the close of our discussion on research

consent. Internationally known experimental psychologist Elizabeth Loftus became seemingly engrossed with discrediting a paper that reported on a case report involving unrecalled memory of childhood sexual abuse (Corwin & Olafson, 1997). What caused the psychologist to launch a secretive investigation of the case, while masquerading as a detective to interview principals and variously claiming it was "journalism" in an unsuccessful effort to avoid any regulatory scrutiny, may never be known (Loftus & Guyer, 2002a, 2002b). However, that she failed to seek consent from the now-adult victim, breached the privacy of an unwilling child sexual abuse victim, published reports after requests to cease from the victim, presented no valid rationales, and essentially blamed the victim for the resulting distress cannot be denied (Kluemper, 2014). A careful ethical analysis of Loftus's purported actions in the matter revealed nothing to provide ethical cover for her conduct (Koocher, 2014).

Cultural and Demographic Issues in Research

Social and behavioral researchers often study those who differ in some substantial way from themselves, such as in age, race, religion, sex, physical or mental status, country of origin, sexual orientation, social and economic status, and any number of cultural variables. When discussing research ethics, those from other cultures or subcultures used to be placed under the heading of "vulnerable populations." The implication that people from groups different from one's own are, by definition, vulnerable builds a bias of "less than" into the mental framing of one's work.

Researchers ignorant about the characteristics and customs of the study group and who, in addition, hold biases or stereotypical attitudes are likely to conduct poorly designed studies with results that not only are in error or misleading but also can cause social harm (sometimes referred to as "social injury") to the population under study. When comparing one group to another, as in much cross-cultural research, the assumption that the data are equivalent is not

always valid. Any measure, such as a personality test or an interview schedule, may be systematically biased.

Multicultural research is important despite the many ethics-related challenges, especially when it comes to the pressing need to better understand the mental health needs of and service availability to racial and ethnic minority groups (Fisher et al., 2002). Yet, to the extent that researchers, most of whom in North America are middle class and Caucasian, see their study target population as “not like me,” the (probably unintentional) potential for harm exists unless special sensitivities and competencies are cultivated and maintained. The responsibilities are made more complicated if the researcher does not speak the study population’s language. That includes honoring preferred communication modes when the participants are deaf (Pollard, 1992).

Just as therapists should attain cultural competencies to work with those who are significantly different from themselves, so must researchers do the same (see Chapter 5). According to S. Sue (1998) and D. W. Sue (1999), cultural competency describes the ability to work effectively with other cultural groups. The usually valued attributes of empathy and openness, for example, are not always culturally appropriate. One must take into account the history of race relations and discrimination. It is not enough simply to learn facts and figures (Philogène, 2004). The next case illustrates that point.

Case 16–28: Bette Nutrient, D.S.W., was fascinated with a particular Native American tribe for years, having read books and articles about it. She was concerned about a recent report detailing the lack of adequate nutrition in the tribe’s diet and the impact on the members’ physical and mental health. She wanted to contribute in a direct way by conducting a research-based intervention. She created a design and evaluation protocol, expecting to be welcomed with open arms on confidently presenting her plan to a tribal representative. She was stunned when she was summarily rebuffed.

Dr. Nutrient may have known everything books could tell her, but she was ignorant about

how members feel about what was perceived as a cocky outsider blustering in to tell them what is wrong with them and what to do instead. Nutrient failed to appreciate the problem and why it existed, how the tribe had been ignored by those who had already been approached on numerous occasions about a foul water source that was contaminating their crops, as well as how one should properly introduce themselves and their agenda to the tribal governance.

Just as we tend to mistakenly assume that everyone else views the world like we do, another prevalent false belief assumes that people classified into a particular cultural or demographic group are all alike. Stuart (2004) referred to applying a single label to a diverse group as the “myth of uniformity.” As a consequence, research designs may fail to allow for the study of important factors that differentiate among members *within* a particular population. Levine (1982), for example, discussed aging research and the ethical implications of ignoring social class, education, ethnicity, race, and sex as critical factors that contribute to the understanding of how people grow old.

Case 16–29: Kid Young, Psy.D., designed a study to test his hypothesis that adults over 65 exhibit declines in awareness of current events compared to individuals under 40. He received permission to administer a brief questionnaire in two nursing homes, a day care facility for elderly individuals diagnosed with early-onset Alzheimer’s disease, a bridge club, a Bible study group, and a senior dance club. He compared the merged results with a younger sample of students in business and English literature courses. He reported strong confirmation of his hypothesis.

Dr. Young plopped heterogeneous groups of older people into a single cohort (i.e., people over 65) as if they were all the same. Fortunately, no scholarly publication accepted the article, recognizing both the sampling errors as well as the fact that other well-conducted research revealed that most healthy older adults remain well aware of current events.

A blanket reference to race suffers from the same uniformity error. For example, Stuart

(2004) pointed to the prevalent but misleading use of the term *African American*, which lumps people of African heritage into a single group: "It implies that 33.9 million people share certain salient characteristics because of their ties with some 797 million people in Africa who live in 50 different countries and speak more than 1,000 different languages, unless, of course, their forbearers came from the West Indies, South America, or New Zealand" (p. 2). Stuart made similar points about the terms *Native Americans* and *Hispanics*.

Experimental methodology (including tests and assessments) may simply be inappropriate for some groups, or in some cultural settings, producing results that are misleading at best and at worst harmful. The next case illustrates the improper assignment of a dependent variable, likely resulting in unwarranted stigmatization of Black urban youth.

Case 16–30: Myron Myopic, M.S.W., wants to study differences in delinquent behavior between Euro American and Black American teenage boys in poor, underserved urban neighborhoods, using arrest records as the measure of delinquency. In this same neighborhood, local activists were documenting biased arrest patterns, mostly targeting young Black American men hanging out on street corners. The police mostly ignored young men of Euro Americans heritage engaging in similar behavior.

Current ethical regulations are not set up to handle the complexities of conducting research on diverse ethnic populations, and the need for such guidance is especially crucial in research with ethnic minority children and youth (Carpenter, 2001). The results of Mr. Myopic's study will appear to support a hypothesis that, within similar types of neighborhoods, young Black Americans have significantly higher delinquency rates than White Americans. Unless he understands the way of life and police profiling in that community, he will miss the flaw in his design.

Finally, full collaboration (as opposed to pro forma engagement) with the community from the very start is essential if most multicultural

and cross-cultural research is to be properly conducted. Researchers should try to identify beforehand which questions and issues are of importance and acceptable to the population under study. Forming community partnerships will avoid misunderstandings about such concepts as privacy and risk, resistance to being studied, any cultural meaning to offering participants compensation, and identify invalid measures or dependent variables. In addition, it is important to assess any benefits or possible stigmatization as a result of the group's participation (Carpenter, 2001). Lack of respect for the decisions made by local authorities was the main reason the Crees (hunting and trapping communities in northern Quebec) ejected seven of the eight researchers from their territory (Darous, Hum, & Kurtness, 1991). In addition, these authors noted how ensuring value to the community under study, remaining cautious and patient, maintaining flexibility, using qualitative and participative methods, and accepting and giving feedback are important features of successful cross-cultural and multicultural research (see also APA, 2003).

Ethical Issues With Vulnerable Study Populations

Research ethics standards apply best to samples composed of competent adults with well-developed senses of autonomy, thus allowing them to make fully informed decisions on their own behalf. The researcher's role is to approach these people in good faith and, if they agree to participate, cause them no harm. However, this may be the most difficult type of participant to procure because they are rarely readily available and willing. They are not institutionalized or found in groups in which researchers typically have bargaining power. Advantaged adults—with the exception of college students, organizational employees, and respondents to opinion polls and surveys—rarely become participants in social and behavioral research.

Fortunately, we have come a long way since the days when highly vulnerable people seemed ready fodder for the kind of studies that

now offend our sensibilities. For example, now referred to as *The Monster Study*, the theory that stuttering results from psychological pressure subjected orphan children to relentless belittling for a period of 6 months in an attempt to induce speech imperfections (Reynolds, 2003). Over 70 years later, some of the unwitting participants successfully sued the state of Iowa, claiming lifelong suffering and emotional fallout.

U.S. federal regulations (DHHS, 2005) specify populations that require special attention considerations because of their vulnerabilities. These include children, prisoners, pregnant women, mentally disabled persons, and economically or educationally disadvantaged persons. The problem with lists is that they suggest all who fall within the definition need special protection for any type of research. Yet, as Sieber (2012) pointed out, would pregnant women require special protections if asked to take a survey of preferred baby names? It is helpful to look at the underlying features of groups labeled as vulnerable when evaluating any needed protections, such as the ability to give informed and voluntary consent, any medical issues that might have an impact on participation, and the level of protection provided to minimize any potential risks. On the other hand, an otherwise-competent noninstitutionalized adult may be acutely vulnerable under certain conditions, such as experiencing deep grief over the loss of a child.

Many research populations of interest and available to mental health professionals are restricted or vulnerable in ways that do not allow a full measure of self-determination. These populations include children, the institutionalized, and those at high risk for some possibly preventable outcome. Some noninstitutionalized study populations pose additional vulnerabilities because of their mental or emotional condition, such as the chronically depressed. Others are vulnerable because of physical illness. Issues of confidentiality and stigma can pertain, for example, with participants who are HIV positive or victims of spousal abuse.

When research populations are incompetent to give meaningful consent, permission to

participate must be granted by appropriate persons (proxies). Persons with severe mental illnesses require special considerations. However, children comprise the population that receives the most attention with regard to proxy permission procedures. Legally, the researcher must obtain approval from the parents or legal guardians, but the ethical questions are not necessarily settled.

Case 16–31: Bernice and Benny Bubbly enthusiastically enrolled their 9-year-old son, Notso Bubbly, in a study on math readiness. As the researchers approached Notso, asking if he will be part of it, Notso says he wants to go home to watch his favorite TV show and does not want to take any tests.

How much the child's wishes to participate should be taken into account has been debated, eventually leading to the recommendation that the child's verbal assent be obtained along with parental permission for most types of research (Koocher & Keith-Spiegel, 1990). Notso Bubbly's reasoning might seem illogical or annoying to the researchers and his parents, but the quality of data gleaned from an unhappy little boy is probably not worth much either.

Other populations require special ethical sensitivities because they may be vulnerable to exploitation due to their restrictive, unstimulating environments. Mentally competent, but lonely or bored individuals residing in nursing or convalescent homes may be willing to engage in almost any activity in return for some attention or a change of routine. Attitudes toward prisoners may not be particularly compassionate and could translate into a justification for relaxing the ethical standards observed for others. Ethics codes do address the responsibility to take special care when conducting research on populations without full control over what decisions they make (APA 3.10. 4.02; AAMFT: 5.2; ACA: G.2.e; NASW: 5.02.f).

Social Science's "Fruit Flies"

Students enrolled in college and university introductory social science courses deserve

their own section because they remain an overrepresented cohort of participants in social science research, much like fruit flies are utilized in biomedical research because they cost almost nothing, are continuously multiplying, and are readily available. These mostly young people raise concerns that this sample of convenience—much as when the white rat was the stand-in to represent all animal species—is used to generalize to all adult humans. Wintre, North, and Sugar (2001) tracked the use of undergraduates in six representative journals for 1975, 1985, and 1995 and found them to account for over two thirds of the study populations, with no sign of decreasing.

Although this population is not normally thought of as particularly vulnerable, the way students are conscripted can involve coercion. Students are often recruited through “subject pools” and may be offered academic credit in their psychology courses, thereby creating a convenient, inexpensive study population. Coercion and related forms of exploitation can occur if alternative ways of satisfying course requirements are not offered, if the offered alternatives are noxious or excessively time consuming, if students receive no worthwhile feedback or educational benefit, or if no readily accessible complaint resource is provided. Ethics codes mandate available and equitable alternatives to research participation (APA: 8.04.a, b; ACA: G.2.b).

Case 16–32: Professor Bully Compel, Ph.D., allows his students to choose between participating for 10 hours in research conducted by himself and other faculty or writing a 10-page term paper on topics he assigns individually. Every semester, 100% of his students select the research option.

To be fully ethically responsible, the study design should build in a useful science lesson, as described in the next case.

Case 16–33: Doctoral student Herb Gendercluster was interested in seeing which group performed better on a complex task requiring the cooperation of all members to succeed. Small groups of all males, all females, or mixed

groups were compared. A 10-minute follow-up was built into the study time period during which Mr. Gendercluster described his idea and hypothesis, commented on each group’s performance (including what it did well and how it might have performed better), and overviewed the current research that supported the critical role of group cohesion and cooperation in today’s workplace.

Mr. Gendercluster’s student participants left with a better understanding of the purpose and relevance of what they just did. This type of “debriefing” need not be confined to research utilizing deception but rather encouraged as an educational component (Sharpe & Faye, 2009).

Still, Wintre and her colleagues (2001) believed that overreliance on college students should be discouraged by journal editors and grant application referees and, instead, reward work based on noncaptive, nonuniversity study populations. They also suggested imposing a new database label of “undergraduates” to focus attention to this issue and to base promotion and tenure decision on quality over quantity, giving extra weight to those whose work engaged other than students in institutions of higher education.

Balancing Benefits and Risks

Incidents of blatant disregard for the welfare of participants have led to closer scrutiny of potential risks before allowing a research project to go forward. A horrendous example involves the government-sponsored Tuskegee study, in which poor, black, syphilitic men in Alabama were left largely untreated for the purpose of understanding how this ravaging disease progresses. As many as 400 men may have lingered and died from a curable disease (Jones, 1981). How such a study could have been publicly tolerated from 1932 until the early 1970s remains a matter of debate and consternation (Mays, 2012).

As recently as the 1980s, over 100 unwary women with abnormal cervical smears were left untreated as a way to study the natural progression of this fatal disease. As a result, these women died of *in situ* carcinoma of the cervix at 25

times the rate of women who received treatment (Young, 2005). Other high-profile tragedies involve medical research at prestigious institutions in which the scientists' own assessment of risks or the information offered to prospective participants was ultimately deemed inadequate, resulting in volunteers' deaths and serious disabilities (e.g., Begley, 2001; Lemonick & Goldstein, 2002).

Arriving at a risk/benefit ratio is a necessary, important, but often-elusive judgment call. In general, the level of acceptable risk can be greater if the project is judged to be significant and important work, especially if the participants themselves might profit from some form of intervention or feedback available only in the research context.

The two extremes—known low risk and high potential benefit and known high risk and low potential benefit—create little debate when it comes to deciding whether to conduct a study. Whenever risks are known to be low and considerable benefit may result, the research will likely gain approval. When known risks are high and the likelihood of benefits are low or unknown, the research will not likely receive approval, except perhaps when individuals are in irreversible states and no other prospects to help them are available. As one gets closer to the middle, moderate risk and moderate potential for benefit, the decision becomes more complex, and the requirement for consent forms that participants understand becomes more critical.

Assessing Benefits

The potential benefits accruing from research participation are often impossible to estimate accurately. By definition, an experimental procedure is conducted to provide answers to heretofore-unanswered questions. So, if a procedure were already known to afford benefit, there would be no need to study it further.

In social and behavioral research, benefit may often exist primarily in the eye of the beholder. A researcher may study ways to enhance children's assertiveness, figuring that early training will provide young people with

coping skills that will serve them well, increase independence, decrease vulnerability to manipulation, and elevate self-efficacy. A critic might argue that assertive children would be perceived by adults as bratty, selfish, demanding, and disrespectful. Therefore, some may say that to encourage youngsters to be assertive, given traditional expectations for appropriate child behavior, would actually put them at risk in their homes and in traditional school systems.

The benefit test has also been debated regarding who or what benefits. Some argued that the test should be applied strictly to the research participants themselves, especially if a service project is exploratory and the participants are vulnerable in some way (Mosavel & Simon, 2013). That is, as a result of people's participation, some benefit might reasonably be expected to accrue to them directly. Others said that it is not necessary to expect that benefits be experienced by the participants of a given investigation, but some reasonable likelihood exists that the results will be useful in directing future research that may eventually benefit them or others. Indeed, science is a continuous and evolving process, and important findings can often be traced to the end of a chain of studies, with some tributaries leading to dead ends. Finally, still others believed that the benefit test is inappropriate altogether because the process of solid knowledge accumulation is in itself valuable, regardless of whether anyone benefits directly or indirectly.

Assessing Risks

Risk assessment is defined as the probability that unwanted harms will occur as a result of participating in a given study. Risks are evaluated according to what those harms could be and to whom, how serious they might be, and whether they could be reversed should they materialize. The designated six types of potential risks in research with human participants are physical, psychological, social, economic, legal, and dignitary (Koocher, 2002; National Research Council, 2003). We see most of these risks portrayed in the first 2 minutes of the now-classic comedy film *Ghostbusters*, in which

a researcher, portrayed by actor Bill Murray, behaves very badly. He brutally coerces and mistreats his participants, uses electric shock dangerously, and attempts to coax a pretty female participant into a sexual liaison.

In reality, and thankfully, potential risks in social and behavioral research are often nonexistent or trivial. It is unfortunate that many researchers have been unnecessarily burdened when they are reviewed using standards for high-risk research. Minor risks include boredom, inconvenience, performance anxiety, a perception that one's time was wasted, transitory annoyance, and confusion regarding how to interpret the experimenters' directions.

More serious risks that could materialize in social and behavioral research include invasion of privacy, breach of confidentiality, lingering stress and discomfort, lowering of self-esteem, upset reactions to being deceived or debriefed, embarrassment, negative effects from assignment to a no-treatment control group, and collective risks by which potential social consequences exist directly for the participants or for the class of individuals represented in the research.

A complicating problem relative to risk assessment is that many contemplated techniques or study approaches have not been previously studied. Pretesting with animals or less vulnerable participants (i.e., competent adults) may not be feasible. Thus, the degree of risk may simply be unknown. So, whereas risk minimization should always be contemplated from the onset, prediction of risks is often difficult because of the seemingly infinite variety of ways people respond to psychological stimuli and phenomena. What one may find frightening or stressful—such as being asked to touch a spider, view pornography, or answer very personal questions—another may experience as exciting, fun, or pleasurable novel.

Case 16–34: Privy Bod, an undergraduate student complained to the university research ethics committee that a psychology professor administered a survey asking questions about sexual practices. Ms. Bod was particularly upset because the desks were so close together that others could see her answers.

The complaint could have been easily avoided had the research assistant asked the participants to sit in alternating seats. Many risks in social and behavioral sciences can be minimized with a little empathy and forethought. However, there will always be people who are sensitive or biased in ways that cannot be foretold.

Occasionally, there may be a risk in *not* taking a risk. For example, is it acceptable to share information without consent when it appears that participants are in danger to themselves or others? If the researcher senses that a participant is extremely upset, is it right to simply ignore concerns because such intrusion is not part of the research protocol? What if a research participant discloses that she sells drugs to schoolchildren, intends to commit suicide, or wants to kill a family member, even when the content of such disclosures is not an integral feature of the studies at hand? Many researchers have no mental health or counseling training and may feel insecure about how to respond. As a result, some may lack familiarity with state laws that mandate reporting of abuse of children and other dependent persons (e.g., the elderly and disabled) or that require certain protective actions in response to revelation of planned harmful acts. Whereas ethical concerns about self-report research tend to center around the degree of allowable intrusiveness, perhaps such questions should be considered more often when researching topics such as abuse history, given that the costs of missed opportunities to intervene are so high (Beeker-Blease & Freyd, 2006). As is discussed in Chapter 6, it is difficult enough to decide what to do when such situations arise in therapy settings. The obligations of researchers are even more complex (Allen, 2009; Jeffery, Snaith, & Voss, 2005). Immediate consultation with a trusted expert and possibly an attorney are in order.

Research Conducted Outside Traditional Settings

Most discussions in this chapter apply to research conducted inside the walls of academic institutions, hospitals, community

agencies, or other facilities where participants come to the researchers. However, data of significant interest to mental health professionals are sometimes collected in schools, public places where “subjects of interest” gather, and even private homes. In these instances, some ethical requirements in structured settings do not translate well to these venues, and new ethical dilemmas present themselves.

Participants in field research may not always be aware that they are being observed, thus precluding any advance voluntary and informed consent contract. Sometimes, the participants are simply observed in naturalistic settings (e.g., a concert or rave) without any experimental manipulation. Sometimes, the context is contrived (e.g., observing people’s reactions to an unusual object placed on the sidewalk). At other times, the participants are deceived, and their reactions are observed (e.g., a confederate of the experimenter poses as an obnoxious store customer or a sick person on the sidewalk, while another confederate records observer’s reaction). If possible, the ethical investigator will inform and reassure the unknowing participants afterward, especially if people were made to feel uncomfortable or distraught. Clearly, debriefing is more difficult to carry out than in laboratory settings unless it is possible to do it on the spot. But, for those who are unaware of being observed, are no longer accessible, or are unwilling or unable to attend a follow-up session, debriefing may be impossible or even harmful if the study involved, say, overheard conversations or behavior later viewed as embarrassing (Kimmel, 2012).

Confidentiality and privacy concerns are minimized if unobtrusive (no manipulation), naturalistic observations of public behavior are made in such a way that identifying information cannot be linked to those being observed (APA: 8.05). However, technological advances that allow visual or audio recordings of people’s behavior using portable and easily concealed equipment complicate the ethical issue because a permanent record is created, heightening the potential for recognition of unwitting participants (APA: 8.03). In such cases, it is

necessary to disguise or remove the possibility of recognition.

When the participants perceive themselves to be in a private or confidential setting, additional ethical issues pertain whenever experimenters intrude themselves surreptitiously. The next case was adapted from a classic study by Middlemist, Knowles, and Matter (1976).

Case 16–35: Unsuspecting male students attempting to urinate in a university lavatory urinal were either crowded or not crowded by a confederate. A researcher with a periscope and stopwatch sitting in one of the stalls recorded the latency and duration of students’ micturition (i.e., urination) to test the hypothesis that crowding delayed starting and slowed finishing.

As Koocher’s (1977) criticisms of this study pointed out, everyone who comes into a bathroom (public or not) has an expectation of total privacy and assumes that their bodily eliminations are not being monitored.

Another classic, Humphreys’s (1970) “tearoom trade” account of the author’s observations while volunteering as a “watchqueen” (the individual ready to issue a warning if anyone might interrupt the acts of homosexual contacts in public restrooms) was also controversial (Sieber, 1982b; Warwick, 1973). The “ubiquitous Watergate” study (West, Gunn, & Chernicky, 1975) in which an attempt was made to induce participants to agree to commit burglary also faced negative commentary (Cook, 1975). Because it is usually impossible to assess whether harm befell any of the participants who disappear after being observed and whose actual identities may not be discernible, the ethical acceptability of such controversial techniques, even when useful information may be forthcoming, will continue to be debated.

Primary prevention/intervention research designed to minimize the onset of risks to the well-being of targeted populations is often conducted outside traditional research settings. The value of early treatment to forestall or prevent altogether future problems is held by mental health and medical professions and has

even been described as a professional obligation (Klosterkötter & Schultze-Lutter, 2010). Such research is usually regarded as cost-effective and humanistic because it attempts to discover ways to minimize human suffering by intervening prior to evolution of full-scale maladjustment or damage. (Interventions designed to enrich rather than prevent risks from materializing are less susceptible to ethical concerns.)

Benefit to the participants in the “treatment” group is always the intent, and many well-designed primary prevention projects have proven effective as model programs (APA, 2014). Usually, individuals judged as susceptible to developing potential maladjustment are recruited to participate in a program designed to reduce their risk level so that the maladjustment will not ultimately manifest itself. Examples of at-risk populations include the children of schizophrenic parents, those recently discharged from mental health facilities or other institutions, preschoolers from disadvantaged homes, parents who fit patterns indicating a susceptibility to abusing their children, recently divorced people, the fragile elderly, and people functioning under high stress. Educational, psychotherapeutic, and coping strategies and skill-building training are among the frequently employed interventions.

However, profound ethical issues lurk just below the surface. As Trickett (1992) so succinctly put it: “Primary prevention activities involve a value-driven, premeditated intrusion into the lives and settings of individuals and groups” (p. 94).

Case 16–36: A grant-funded study attempted to identify male children aged 3 and 4 who evidenced feminine interests, such as playing with baby dolls and other female gender-typed activities, while displaying averseness to male gender-typed activities. An intervention used behavioral techniques to strengthen an interest in activities that little boys typically prefer. In an attempt to “masculinize” them, punishment was administered when the boys acted like little girls. The rationale was that boys who display feminine characteristics as youngsters are at high risk for ridicule and rejection.

The researchers were denounced as homophobic and intolerant of individual differences. Their response was that the unfortunate outcome for these children was already known from case histories, and that they were not responsible for society’s cruel prejudices. However, they might be able to help some boys avoid a sad life, being rejected by other boys and often by girls. Regardless of your opinion on this matter, this study well illustrates how attitudes and values play a major role in the targets and goals of prevention research; this is especially true for primary prevention projects that raise multicultural concerns such as affirmative issues and variable selection from the perspective of the target population (McIntosh, Jason, Robinson, & Brzezinski, 2004). It would be unthinkable by today’s views of multicultural research to proceed without heavily involving members of the population of interest, if not as investigators at least as constant partner/consultants.

Because participants in prevention research have not, by definition, presented diagnosable symptomatology relative to the purpose of the intervention, four additional potential ethical problems arise: faulty risk predictions, labeling, privacy invasion, and abandonment. First, risk-level assignment is an imprecise art, and the potential for harm is present whenever risk decisions are made inappropriately. For example, using the preceding case, a little boy might be interested in feminine activities because he has older sisters who will play with him only if he fulfills certain roles. The boy may not harbor any intrinsic interest in female gender-stereotyped activities but feels in desperate need of his sister’s approval.

Following directly from risk-level assignment is the process of labeling participants as “at risk” for something not yet manifested. That label (such as “predelinquent” or “potential school dropout”) may carry a stigma or other consequences that could limit participants’ access to opportunity and growth (Horstkötter, Berghmans, de Ruiter, Krumeich, & de Wert, 2012). Furthermore, as Horstkötter and her colleagues suggested,

interventions may aim at equalizing people by removing capacities and orientations that others disapprove of but that the target population itself values.

Others who know of the risk label may treat the individual differently compared to if they had not known, possibly resulting in a self-fulfilling prophecy. For example, if parents or teachers know their teenagers have been judged by professionals as potential dropouts or delinquents, they may respond to them in ways that will increase the manifestation of the risks.

And, finally, primary prevention and intervention programming research is more likely than most other types of research to create dependencies. Researchers must be careful not to dump the participants for whom they were providing some possibly valuable service as soon as data are collected, leaving them resourceless (or even more exposed) than before. For example, if counseling is part of the intervention, terminating participants when the study concludes without regard for where they are in the counseling process is ethically problematic, especially if the participants remain in crisis and do not have the financial resources or options to continue counseling services elsewhere. These dilemmas must be considered and minimized to the greatest extent possible during the design phase of prevention research. The consent procedure of any intervention treatment must be especially clear with regard to what is and what is not included as a result of participation in the experimental program (APA: 8.02.b; NASW: 5.02).

Research and Multiple-Role Relationships

When research participants are also current or previous clients, even more ethical obligations arise. Is truly voluntary consent possible? That is, will the client feel coerced, and can participation be refused without feeling guilty? Most clients would go out of their way to avoid displeasing their therapists. However, their participation could jeopardize the therapeutic services being rendered.

Case 16–37: Jack Limp had difficulties satisfying his wife sexually and sought the services of Will Doubledip, M.D., a psychiatrist. Dr. Doubledip invited Mr. Limp to participate in a drug trial for erectile dysfunction. Limp was wary of any drugs and rarely took as much as an aspirin. However, he felt like he could not decline or else his psychiatrist would be put off just at the point where therapy alone was beginning to help. Unbeknown to Limp, his psychiatrist received compensation for referring potential participants to the study.

Whether Mr. Limp could be helped by participating in the study is not at issue here. In the situation on which this true story was based, the client felt so torn that he quit therapy as well as the drug trials. The therapeutic alliance had been broken by what the client perceived as an unwelcome intrusion into his protected therapeutic space. In addition, the notion of compensating physicians for identifying and referring patients who might benefit from a particular treatment creates a conflict of interest.

Conducting research on those with whom a fiduciary relationship has already been established for another purpose, and that includes students and supervisees as well as clients, constitutes a dual-role relationship. We recommend against conscripting current and previous clients into research unless needed benefits are likely and not otherwise available. Even here, care should be taken to present a sincere opportunity to decline. Special safeguards, such as a participant advocate, should be introduced when the power differential between the researcher and potential participants is especially large (see APA: 8.04a; AAMFT: 5.4; ACA: G.2.a, G.2.c, G3; NASW: 5.02.e, 5.02.h, 5.02.o).

Privacy and Confidentiality Issues in Research

Unless otherwise specified and agreed to by the research participants, data collected on human participants should be treated as confidential (APA: 8.02; AAMFT: 5.5; ACA: G1b, G2a7, G2d, G4d; NASW: 5.02.l, 5.02.m). Ensuring confidentiality also benefits the researchers

because participants are more likely to be open and honest. When research involves revealing an individual's health information, normally protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA; see Chapter 6), a specific authorization by the participant (or legal guardian) is usually required as part of the consent procedure (see DHHS, n.d.).

Research participants would not normally discover a confidentiality breach. Someone other than a research participant is the usual complainant, as the next case illustrates.

Case 16–38: Tab Cross, Ph.D., worked at a university counseling center and teaches two classes in the educational psychology department. He administered a large number of personality inventories to educational psychology students. Their names were required, but Dr. Cross promised that identities would be held in the strictest confidence and would be destroyed as soon as data were coded. Cross published an article on personality differences between students who had sought counseling and those who had not. However, a counseling center staffer contacted an ethics committee to express concern that Dr. Cross accessed the center's files. The colleague argued that Cross used confidential files for a purpose unrelated to the center's legitimate business, that students were not sufficiently informed of the study's purpose, that their consent was not obtained to access counseling center files, and that these breeches were not properly disclosed to the IRB.

Despite the fact that individual identities were not reported to anyone else, Dr. Cross committed an ethical violation by not obtaining consent from the students regarding his intent to access confidential counseling center records for the purpose of grouping his participants.

Protecting the privacy and maintaining the confidentiality of data are usually routine procedures in social and behavioral research. In most cases, the task of researchers is far simpler than that of mental health practitioners because keeping actual identities on file is usually unnecessary. The interest is often on how groups perform or differ from each other. Even

when data are not anonymous, the researcher can usually take simple precautions to ensure that no one has access to identifying information, often by assigning code numbers and keeping identifying information safe and separate.

Nevertheless, complex problems with regard to confidentiality can arise. For example, a mental health professional may conduct a qualitative study on a very few individuals who share a common but unusual diagnosis. This approaches the same ethical issues as discussed regarding case studies. To the extent that information is shared about their personal lives and habits, care must be taken to ensure that readers cannot discern identities. Or, if conducting research on abused persons, the dilemma of mandatory reporting can arise unless special arrangements are made, such as obtaining a federal confidentiality certificate (Haggerty & Hawkins, 2001). (See NIH, n.d.)

Researchers may promise confidentiality without a full understanding of disclosures that could possibly occur later. For example, lists of research participants can sometimes be accessed by others, and unauthorized follow-up studies or analyses for purposes other than the original one consented to by the participants could be performed. Any known or potential limits to confidentiality should be made known to the participants in advance. (See also Chapter 6.)

The Internet is an increasingly popular research tool because, after the cost of up-front programming, the size of the research population can be very large and diverse, and data can be automatically stored and made ready for almost-instant analysis (Gosling & Johnson, 2010). Participants need not be from the researcher's own community, and research assistants are not needed to be present while data are being collected (Jennings, 2014). Mail surveys, on the other hand, must often limit the number to be sent because of the cost of postage and data transfer. However, for most surveys, especially if the requested information is sensitive, special care must be taken to ensure that any promise of anonymity is in fact ensured (Keller & Lee, 2003; Kraut et al., 2004; Mathy, Kerr, & Haydin, 2003). The participants must also *perceive* that anonymity is ensured, or the

response rate will suffer. A web-based survey (as opposed to an e-mail survey that allows respondents to be more easily traced) reduces the possibility of tracking identities and is reassuring to respondents because no one can verify exactly who responded (Simsek & Veiga, 2001).

Social media are also utilized to attract research participants, especially populations that may be more difficult to reach otherwise, such as those with HIV/AIDS. However, issues of meaningful consent, maintaining confidentiality and privacy given that actual names are often known along with other personal information, managing data and security, and feedback provide special challenges, as described by Curtis (2014). Research accessing social media data also creates difficulties for IRBs, given the lack of clear guidelines (Moreno, Goniu, Moreno, & Dickens, 2013), complicated by the challenges of distinguishing between public and private behavior (Pittenger, 2003). Facebook endured a storm of protest when it attempted, in conjunction with researchers from two high-profile universities, to manipulate people's emotions by what they called "emotional contagion." Over 600,000 users had messages filtered to reflect positive or negative emotions. Outrage ensued over privacy violation and the possibility of using the technique for more nefarious reasons (Booth, 2014). Whereas attempts at blatant manipulation are expected from advertisements and other forms of commerce, social science researchers are held to higher standards (Ross, 2014).

Computers and electronic transfer systems allow inexpensive, instant data sharing that was never envisioned a few decades ago. Data sharing among scientists holds the potential for hastening the evolution of a line of inquiry, helps to ensure validity and error corrections, encourages collaborative ventures, and is generally encouraged when done responsibly (APA: 8.14). Even research participants receive an advantage in the sense that their contributions are maximized. Yet, concerns about privacy invasion have drastically increased as technological advances allow sophisticated surveillance as well as links and access among computer storage banks. Researchers should resist opportunities

to contribute information to databanks if confidentiality cannot be safeguarded.

WHAT TO DO

- Assign publication credit only for substantial contributions to the project.
- Despite any pressures to publish, uphold the integrity of science and the public trust by gathering and reporting data accurately.
- Maintain research competencies and seek consultation whenever needed expertise is in order.
- Fully familiarize yourself with the laws, ethics codes, and institutional policies that govern research activity.
- Ensure that consent from participants is voluntary and informed. In those cases for which participants cannot give meaningful or legal consent, take special safeguards.
- Ensure or disclose any limits of confidentiality, including for research conducted online.
- When participants remain unaware of being observed, gather and disseminate data in a manner that maintains anonymity.

WHAT TO WATCH FOR

- Whenever risks or harms to participants are possible, special obligations to search for alternative study methods are required.
- Conduct early discussions of authorship credit expectations and assignments for collaborative research teams to reduce the possibility of later conflict.
- Pay special attention to the risk of cultural or value biases that may adversely affect the participants' welfare, the meaningfulness of the data, and the interpretation of results.
- Remember to explain that the freedom to withdraw from the research project at any time is an important feature of ethical research.

WHAT NOT TO DO

- Avoid conflicts of interest and dual-role relationships in the conduct of research.

- Do not proceed with projects involving culturally or ethnically different populations without representatives or consultants.
- Deception should not be used just because it is convenient.

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17

Making Ethical Decisions and Taking Action

All that is necessary for evil to triumph is for good men to do nothing.

Edmund Burke

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The way we make decisions has attracted considerable attention in recent years. Such interest focuses largely on the preponderance of questionable decisions and why people who should know better make them. Specious and foolish decision making is even the subject of popular books, such as *Predictably Irrational* (Ariely, 2008), *Lies We Tell Ourselves* (Warren, 2014), and *Blind Spots* (Bazerman & Tenbrunsel, 2011).

The primary purpose of this chapter is to identify sources of reaching unwise conclusions that may put clients and you at risk of harm. If you are already a mental health or counseling professional and have worked at it for a while, you have almost certainly come in contact with at least one ethical dilemma that either involved you directly or involved a colleague you know personally. If you are still in training,

we guarantee that you will confront multiple ethical dilemmas in the course of your professional career and probably at least one before you complete your internship. You may not have created the problem, but you may have no choice but to respond in some way. How you react could have significant implications for your reputation and your career.

When colleagues, supervisees, or students have (or are about to) engage in a questionable act that could cause harm or lower public trust, mental health professionals have a proactive role to play. Turning away because intervening might prove stressful is understandable. Therefore, in the last section we detail the decision-making and action steps to consider on learning of unethical behavior committed by someone else.

The relevance of cultural variables to ethical decision making has also received increased attention in recent years. Therapists working with diverse clients whose values conflict with those in Western civilizations require specialized knowledge. Knapp and VandeCreek (2007) proposed a “soft universalistic” approach whereby it is recognized that most cultures share the same basic values, but they may not be expressed in the same way. Therapists need to assess this wider perspective by focusing on principle ethics (e.g., respect and compassion) rather than specific actions. Hanson and Kerkhoff (2007) encouraged therapists not only to become more proficient culturally but also to make the effort to reflect on the impact of their own beliefs and practices when dealing with culturally diverse clients. For example, a big challenge for North American therapists involves working with immigrants from countries who do not place a high value on personal autonomy.

Compact descriptions of fundamental values of a selection of socio-religious-cultural orientations were provided by Houser, Wilczenski, and Ham (2006). These orientations include, as examples, feminist, Native American, Confucian, Buddhist, Jewish, Islamic, Hispanic, and Pan-African orientations. Knowing, understanding, and creating sensitivity to worldviews different from one’s own is a critical step toward

making sound decisions about therapy directions. While cultivating an overview of different orientations, one should not also make assumptions that an individual client is going to reflect the same worldview. Unwarranted and possibly poor decisions could follow from believing everyone identified as from a certain culture is pretty much alike.

SELF-DECEPTION

If making ethical decisions were only a matter of gathering some data with a clearheaded consideration of options free from extraneous variables influencing our judgments, the number of ethical mishaps would dwindle considerably. However, social scientists have marveled at the exceptional ability of human beings to deceive ourselves (Ariely, 2012; McLaughlin & Rorty, 1988), and mental health professionals are not exempt.

Self-deception, according to Burton (2012), is common, universal, and responsible for the vast majority of human tragedies and earthly destruction. We often see what we want to see even when an impartial assessment would reveal a radically different conclusion (Mele, 2001). When self-interest is superimposed, it often functions in an unconscious manner (Moore, 2004) while minimizing guilt by believing that we have acted morally (Epley & Caruso, 2004; Kieffer & Sloan, 2009; Tenbrunsel & Messick, 2004). The delusion processes operating while contemplating an action go under a variety of names: rationalization, moral dissonance, moral fading, moral credentialing, moral hypocrisy, denial, repression, perceptual distortion, intellectualization, neutralization, confirmation bias, and egocentric ethics (Bandura, 1999; Batson & Collins, 2011; R. P. Brown et al., 2011; Detert, Trevino, & Sweitzer, 2008; Lowell, 2012; Mele, 2001; Monin & Miller 2001).

Some newer research findings fly in the face of what we thought was common sense, namely, that those who do good deeds are the ethical people we do not have to be concerned about. Instead, the work of Merritt,

Effron, and Monin (2010) revealed that people can engage in what they call “moral self-licensing.” Past good deeds can liberate us to commit acts that are immoral, unethical, or otherwise problematic, behaviors we would otherwise avoid for fear of feeling or appearing to be immoral. It is rather like saying, perhaps without full awareness: “I am such a good person that this little misdeed will not tarnish who I am.” Things may not turn out as badly as in the next case, but the chance of later regret is always there.

Case 17–1: Goodie Twoshoes, L.M.H.C., volunteered two mornings a week at a local women’s shelter. She also visited her elderly mother in a nursing home 50 miles away every Saturday. When a new client claiming to be in the “high-end electronics business” offered to give her a computer and all the accessories, she graciously accepted while telling herself, “I deserve this.” The client turned out to be a deeply troubled thief. When apprehended several weeks later, the client claimed that he had a partner and, as proof, reported that one of the stolen items was in her office.

Unfortunately, that single tiny wrongheaded decision can be the one to wreak havoc on a career. Ms. Twoshoes endured negative media attention, a police investigation, and inquiries from the state board about accepting such a valuable gift, which, of course, had been confiscated as stolen property in the meantime. By now, the computer also contained confidential information about this and other clients.

Organizational research on dishonesty in the workplace has long focused on angry, disgruntled employees as the ones to watch for. However, the work of Vincent, Emich, and Goncalo (2013) discovered that positive affect can promote dishonest behavior by providing the cognitive flexibility necessary to reframe and to rationalize dishonest acts. This phenomenon, which they labeled “moral disengagement,” suggests that positive affect paves the way for the commission of dishonest acts by altering how individuals evaluate the moral implications of their own behavior. Bottom

line: You do not have to be angry, disgruntled, or frustrated to engage in dishonest or unethical behavior.

Another intriguing finding with decision-making ramifications is how the time of day influences moral judgments. Kouchaki and Smith (2013) reported that study participants engaged in less cheating and lying on a series of tasks in the morning than on the same tasks in the afternoon. Strangely and counter-intuitively, those who are *less* likely to morally disengage are *more* affected by depletion of self-regulatory resources, probably because they were less prone to deactivate moral self-regulatory processes in the first place. This research suggested that as the day wears on, self-control can be reduced from lack of rest and having already made many decisions. In short, it may be wiser to make ethical decisions in the morning when we are at our moral peak.

Finally, our resolute belief that no one knows us as well as we know ourselves is not likely accurate. We wonder how others can be so deluded but do not entertain the possibility that the same may apply to us. Vazire and Carlson (2011) found that we have blind spots about ourselves that others can see, leading to the conclusion that listening to feedback from others may be more useful than we ever imagined. We promote consultation with trusted others throughout this book as an indispensable tool.

RED FLAGS

This more recent focus on the decider rather than solely on the decision itself helps explain a phenomenon we observed repeatedly while serving on ethics committees. Although some psychologists who came before the committee clearly deserved to be severely sanctioned, many others seemed to be unlikely ethics violators. Often, however, warning signs went unheeded due to rationalizations, high stress, incompetence in a given situation, or carelessness. So, if we are processing critical information without full awareness, we are prone to act according to influences we do not fully perceive (Goleman, 1985).

Not every warning sign is in itself an ethical violation, nor does their existence automatically lead to poor decisions with regrettable results. Many items in Box 17–1 (adapted from Keith-Spiegel,

2014) seem like common sense. But, once a matter signaling potential risk becomes apparent, careful consideration and any necessary accommodations in the next step are imperative.

Box 17–1 Red Flags: Proceed With Caution

A Desire for a Different Relationship From Client/Therapist

- Disclosing considerable, irrelevant details about your own life to a client.
- Thinking often about a client outside of sessions.
- Attempting to influence a client's hobbies, political or religious views, outside relationships, or other personal choices that have no direct therapeutic relevance.
- Instigating communications with a client between sessions for reasons you contrive or that are unrelated to treatment issues.
- Daydreaming that a client is not a client but, instead, in some other type of relationship with you (e.g., your friend or business partner).
- Noticing that your interactions with a client are becoming unrelated to the therapeutic goals.
- Actively seeking opportunities to spend time with a client outside of a professional setting.
- Anticipating, with excitement, a certain client's appointment.
- Finding yourself paying more attention to grooming and dress on a certain client's appointment day.
- Flirting with a client.
- Feeling sexually attracted to or aroused by a client.
- Wanting to touch a client.
- Daydreaming about having a sexual relationship with a client.
- Moving a client's hour to accommodate a personal agenda (e.g., the last client of the day so that a personal two-way conversation or other activity could take place uninterrupted afterward).

Rationalizing the Acceptability of a Contemplated Boundary Crossing or Deviations From Standard Practice

- Hearing yourself thinking, "This time it's different," "Everyone does it," "No one will get hurt," "No one will care," "I can still be objective," "It's such a minor thing," "Nobody else will care," or "Just this one time."
- Allowing clients to run up a bill that will be difficult for them to pay.
- Taking on an individual as a psychotherapy client with whom you had a preestablished close relationship (e.g., close family member, close friend, or ex-lover).
- Seeing clients outside of a professional setting that has no relevance to the client's therapeutic needs.
- Adding additional roles to the therapeutic relationship (e.g., employing a client).

Concerns About Personal Ambition and Financial Gain

- Viewing a certain client as being in a position to advance your own career or fulfill one of your extraneous needs.

Box 17-1 Continued

- Being exceedingly ambitious to “make it big” as a psychotherapist.
- Bartering with clients for services or tangible objects in lieu of collecting fees.
- Accepting clients while aware that your training and experience are likely insufficient to provide competent treatment.
- Failing to refer clients when it becomes clear that they are not benefitting from your treatment.
- Contemplating asking a client for a favor or a loan.

Needs to Enhance One’s Own Self-Esteem

- “Showing off” to clients beyond revealing the usual dissemination of credentials and achievements relevant to the services you render.
- Relying on a client’s presence or praise to elevate how you feel about yourself.
- Believing that you are the only therapist who can help a particular client.
- Indulging in rescue fantasies.
- Bragging about high-profile clients to others (even without identifying them).
- Feeling entitled to *all* of the credit when a client improves, especially if a marked achievement is attained while under your care.
- Promising a client that you will be his or her savior.

Expecting the Client to Fulfill Your Personal or Social Needs

- Anticipating that a client will offer favors or his or her services (e.g., use of a beach house, getting you a better deal from his or her furniture store or mortgage company).
- Viewing one or more clients as among the central people in your life.
- Feeling jealous or envious of a client’s other close relationships or life circumstances.

Fear of Being Rejected or Client Terminating Therapy for Financial or Other Reasons

- Giving in to a client’s requests and perspectives on issues based on fear that he or she would otherwise quit therapy.
- Encouraging a client’s dependence on you (discouraging autonomy).
- Experiencing a feeling of dread on sensing that a client may decide to quit therapy.
- Resisting the process of terminating a client despite clinical indicators that termination is appropriate.
- Frequently allowing therapy sessions to go over the allotted time.

Negative Feelings Toward a Client

- Resenting a noncompliant client.
- Feeling upset if a client is uncomplimentary toward you.
- Realizing a client’s values, politics, and opinions deviate markedly from your own.
- Resenting what you experience as unreasonable demands placed on you by a client.
- Feeling put-off by a client for strongly resembling someone else you detest or fear.

(continued)

Box 17–1 Continued

- Disliking a client.
- Dreading a certain client's appointment.

Signs That the Client Is the More Powerful Individual in the Relationship

- Allowing a client to take undue advantage without confronting him or her (e.g., allowing the client many missed appointments without calling to cancel).
- Failing to confront a client when doing so would be therapeutically appropriate and justified.
- Accepting a gift that is exorbitant or inappropriate or, even if it is modest, beyond the client's ability to afford.
- Giving a client gifts or offering to do favors unrelated to the client's therapeutic needs.

Personal Life Contamination of Professional Performance

- Failing to monitor how what is going on in your private life (e.g., marital difficulties, crises at home) could negatively affect your professional life.
- Having trouble paying attention during therapy sessions.
- Taking your own personal frustrations out on a client.
- Being so stressed or feeling burned out that your attention is diverted from professional responsibilities.
- Suffering from an emotional disorder (e.g., depression) that interferes with delivering competent services.
- Suffering from a physical ailment that causes you to frequently cancel scheduled appointments or cut sessions short.
- Failing to seek professional help with a serious medical or psychological problem that affects the quality of your services.

General Red Flags

- Allowing a problematic relationship with a colleague to fester and accelerate.
- Feeling uncomfortable discussing looming "red flags" that pertain to you with a trusted colleague for fear of being negatively judged.
- Being ignorant or misinformed with regard to the ethical expectations and standards of your profession or resources in your community in case of an emergency.
- Believing the issues raised in this book would never apply to you.

We have argued that not all boundary crossings are problematic, and some may be beneficial with some clients under certain circumstances. The next section offers additional considerations regarding boundary-crossing decisions.

MAKING ROLE-BLENDING DECISIONS

It is our strong impression that role blending accounts for a large proportion of the most inappropriate or mindless decisions that therapists

make. Boundaries become thin in the presence of self-serving circumstances and, if not perceived and reversed in time, cross a line.

Kitchener (1988) proposed that roles conflict when expectations in one role involve actions or behavior incompatible with another role. She suggested using three guidelines to assess the amount of damage created by role blending. First, as the expectations of professionals and those they serve become more incompatible, the potential for harm increases. Second, as obligations associated with the roles become divergent, the risks of loss of objectivity and divided loyalties rise. Third, when the power and prestige of the therapist exceeds that of the client, the possibility for exploitation is heightened.

Gottlieb's oft-cited (1993) model for avoiding exploitative multiple relations tracks the level of the therapist's power with the duration (or expected duration) of the professional relationship and the clarity of termination. Thus, if after 2 years of intense therapy and a tenuous termination, meaning the client may need to return at any time, no additional roles should be contemplated. However, after a Saturday afternoon "growth workshop" resulting in an agreeable one-time experience, the risk if the therapist enters into another role with an attendee seems minimal, and the success (or failure) of this new role relationship would be about what the parties do as individuals as opposed to the professional experience.

L. S. Brown (1994) added two additional factors that, if present, heighten risks of harm. First, objectification can occur when the therapist uses the client as an "it" for the purpose of providing entertainment or convenience. Second, boundary violations arising from impulse rather than from careful, reasoned consideration of any therapeutic indications place the relationship at higher risk. Thus, hugging a client is not unethical per se, but an assessment of any negative indicators should precede such an act.

Table 17-1 is designed to help assess whether blending roles should even be considered. We adapted from the work of Anderson and Kitchener (1996), Barnett (2007), L. S. Brown (1994), Ebert (2006), Gottlieb (1993), Kitchener

(1988), Reamer (2012), Vasquez (2007), and Younggren and Gottlieb (2004) as well as our own observations and research. Most risks can be evaluated along a continuum as opposed to the dichotomous scheme we present here, and each situation has its own idiosyncrasies requiring assessment before acting. However, if a clearheaded reflection tends toward the "more risky" column, we advise *considerable* caution before crossing a boundary. As L. S. Brown (1994) wisely stated:

The goal of an ethical decision is not to avoid any and all violations of boundaries, for this is impossible. Instead, the goal is to remain on the more innocuous end of the continuum, in the position where the abuse and exploitation of the power of the therapist are minimized. (p. 279)

This scheme allows for individualized decisions for each case. We agree with the argument put forth by Knapp, Handelman, Gottlieb, and VanderCreek (2013) in their important article, "The Dark Side of Professional Ethics," that refusing to consider exceptions to the rules may place barriers between clients and therapists in ways that result in lost opportunities for improving the therapist-client relationship and for facilitating positive outcomes. And yet, a final reminder: Most people can be adept at not seeing what they do not want to see under a tempting set of circumstances. The client can even be blamed for untoward consequences. A senior psychologist was sued in a highly publicized case when her personal life and that of a client became completely intertwined. She told an ethics committee, "Look what happened to me. I went out of my way to help him and he paid me back by destroying my career. I should have known. Once a snake, always a snake."

MAKING DECISIONS WHEN THERE IS LEAD TIME

Some authors purported that snap, intuitive, or unconsciously driven decisions about complex matters are superior to those carefully thought through. Examples of such works include *Blink*

TABLE 17.1 Evaluating Additional Roles with Clients

Basic Considerations Regarding Added Role Dimensions	More Risky	Less Risky
Relevant therapeutic issues or sociocultural factors (e.g., diagnosis, client's religion and traditions, family situation and dynamics)	Unclear whether an added role would be wise	Clear indications favoring an added role
Therapist/client power differential	High	Low
Therapist and client expectations	Incongruent	Congruent
Current level of client's dependency needs	High	Low
Blending is necessary or indicated	No	Yes
Likelihood of beneficial outcome	Low or unknown	High
Likelihood of client confusion	High	Very low
Potential for conflict of interest	High	Absent
Therapist and client obligations in the contemplated relationship	Disparate	Similar
Estimated duration of therapy	Longer term	Short term
Termination (or expected termination)	Conflicted/no time specifiable	Mutual/satisfactory
Prospects that client requires follow-up sessions	Very likely	Unlikely
Extent to which therapist's personal needs would be gratified more than those of the client	Considerable	Very small; negligible
Impulsivity of the therapist	High	Low
Degree of client pathology or past abuse	High	Low
Firmness of client's personal boundaries	Loose	Solid
Degree of client's autonomy	Low/needly	High/self-confident
Duration of therapist's professional experience	Beginning practitioner	At least 1 year of active, independent practice
Extent to which confidentiality can be indefinitely maintained	Not likely	Very likely
Therapist's access to collegial interaction and support	Little/isolated	Considerable
Extent of client's understanding of, and ability to consent to, the contemplated added relationship	Minimal	Full
The worst-case outcome scenario of the contemplated relationship still relatively benign	No	Yes
A consultation with a colleague about a contemplated added relationship has taken or will take place before going forward.	No	Yes

(Gladwell, 2007) and an article published in the prestigious journal *Science*, “On Making the Right Choice: The Deliberation-Without-Attention Effect” (Dijksterhuis, Bos, Nordgren, & van Baaren, 2006). However, other research confirmed that complex, difficult decisions deserve active planning, whereas the “trust-your-gut” approach is not only ill advised but possibly even

dangerous (Newell, Lagnado, & Shanks, 2007). When making decisions based on a complex array of variables, erroneously relying on a bad predictor (e.g., an emotional or gut reaction) is usually much riskier than excluding a solid predictor (Faust, 2013). We agree that choosing a car color or pair of shoes on the spot may remain satisfying in the long run, but when it comes to

making ethical decisions with potential consequences, snap decisions could destroy a career. Time allows for generating alternate perspectives, paying more attention to the total picture, and assessing one's own motivations, actions the therapist in the next case failed to take.

Case 17–2: Brusk Gonow, Ph.D., came to dislike a client he found arrogant and controlling. During the 10th and what would be the client's last session after the client criticized the office décor as cheap looking, Gonow blurted out, "I just realized that don't want to see you anymore. Good-bye."

The angry client pressed ethics charges. A committee found Dr. Gonow guilty of disrespecting a client, abandonment, and improper termination. Whereas a relationship that is not working requires a decision on the part of the therapist, how to proceed deserves careful consideration and consultation as opposed to a spontaneous outburst.

When ethical conflicts arise and a response must be made, the best possible decision becomes far more likely if several other conditions pertain. These include the following (adapted from Babad and Salomon, 1978):

- sufficient time available for the systematic collection of all pertinent information necessary to consider strategies, consultation, intervention, and follow-up;
- proper identification of the person or entity to whom one owes primary allegiance;
- an opportunity to involve all relevant parties;
- operating under low stress and a mindset that maximizes objectivity; and
- the maintenance of an ongoing evaluation that allows for midcourse corrections or other changes to satisfactorily resolve the dilemma.

Fortunately, most of the time on-the-spot decisions are not required. Either nothing will happen until the conditions stated can be satisfied or the problematic act has already occurred but incremental damage seems unlikely in the immediate future.

Thorough knowledge of relevant codes accompanied by a sincere motivation to follow them does not completely insulate therapists

from questionable conduct. This is because professional ethics codes consist primarily of general, prescriptive guideposts with inherent gaps when it comes to deciding what *context-specific action* to take (Bersoff, 1994; Keith-Spiegel & Whitley, 1994; Kitchener, 1984). Indeed, ethics codes were never intended to cover every conceivable act under every possible circumstance. Furthermore, it seems unlikely that the creation of a comprehensive guideline is even possible, leaving it to ethics boards to determine the appropriateness of a given action in a specific context. Therefore, all mental health professionals should internalize a *decision-making strategy* to assist in coping with every ethical matter as it arises. We expect that such a process will maximize the chances of an ethically sound result, although we also readily acknowledge that this does not always happen. Some outcomes will remain problematic no matter how hard one tries to resolve them. Rationalizations and other forms of self-delusion as noted previously in this chapter can be difficult to override, even in the most ethically scrupulous of practitioners. However, those who can document a sustained, reasoned effort to deal with the dilemma will have a distinct advantage should their decisions and actions ever be challenged.

We must stress at the outset that the application of ethical decision-making strategies does not actually *make* a decision. However, a systematic examination of the situation will likely have a powerful influence on a final decision.

A Suggested Decision-Making Strategy

According to Rest (1982), "executing and implementing a plan of action involves figuring out the sequence of concrete actions, working around impediments and unexpected difficulties, overcoming fatigue and frustration, resisting distractions and other allurements, and keeping sight of the eventual goal" (p. 34). Whereas one should undertake decision making deliberately, the actual process can range from a minute to days or weeks. Some may only take seconds because the situation and corresponding ethical responsibility are unambiguous. Others can be complex due to the number of individuals involved, ambiguous issues, a

need to clarify loyalties and confidentiality requirements, and so on. (We discuss necessity to make swift decisions under emergency or other urgent conditions in the next section.)

We do agree with Rogerson, Gottlieb, Handelman, Knapp, and Younggren (2011), who argued that the popular “recipe approach” to making ethical decisions ignores the many nonrational factors, some of which are automatic, intuitive, and affective processes that lead to biases and departures from normative theories of rationality. Yet, at some point, after reflection and perhaps consultation, a procedure leading to a decision can benefit from an action strategy.

1. Determine whether the matter truly involves ethics. First, the situation must involve an ethical issue. The distinction between the merely unorthodox or poor professional etiquette and unethical behavior may become clouded, especially if one feels emotionally involved or under attack. Sometimes, a claim of, “That’s unethical!” more accurately translates as, “I’m so upset by you that it must violate some rule.”

A helpful starting point focuses on identifying the general moral or ethical principle applicable to the situation at hand. As we have already noted, overarching ethical principles such as respect for autonomy, nonmaleficence (doing no harm), justice, and according dignity and caring toward others rank among those often cited as crucial for the evaluation of ethical concerns. Readers will find elements of these principles reflected in ethics codes, although sometimes one will take precedence over another. For example, autonomy ranks below responsibility if a client threatens to harm another party or talks seriously about suicide. Fortunately, the ethical matter in question can often link to a specific element of a relevant ethics code, policy, or law, which makes this phase easier to complete.

2. Consult guidelines already available that might apply as a possible mechanism for resolution. Be prepared to do some homework by locating the resources representing the moral responsibilities of mental health providers. Ethics codes and policy statements from relevant professional associations; federal law or

local and state laws (including those regulating the profession); research evidence (including case studies that may apply to the particular situation); and general ethics writings are among the materials that one might consult. As examples, *Decoding the Ethics Code* (Fisher, 2013) and *APA Ethics Code Commentary and Case Illustrations* (Campbell, Vasquez, Behnke, & Kinscherff, 2010) provide illustrations and interpretation for members of the American Psychological Association (APA). The American Association for Marriage and Family Therapy’s (AAMFT’s) *User’s Guide to the AAMFT Code of Ethics* (2013) provides the same kind of assistance for its members that remains mostly relevant, despite the issuance of a revised code in 2015. Most mental health professional associations post valuable ethics-related information on their websites.

The solution does not necessarily become clear at this point, and contradictions may crop up that cause more confusion than before this process started. Nevertheless, collecting relevant information constitutes a critical step to take conscientiously. A disregard for extant policy or relevant ethical obligations may result in unwanted consequences.

Early in the process, you should also collect information from all parties involved, if relevant and appropriate. Sometimes, this step reveals that a client’s misunderstanding led to an improper interpretation, or the new data may reveal the matter as more grave than first suspected. Confidentiality rights must be assessed and, if relevant, protected throughout the process. In some cases, confidentiality issues may preclude you from taking any further steps at this time.

3. Pause to consider, as best as possible, all factors that might influence the decision you will make. Assess the situational factors that will have an impact on your decision. These might include the seriousness of the alleged transgression, whether others know about it, and who may be harmed.

As we have already noted, an extremely common reason for poor ethical decisions arises from the inability to see the situation objectively because of prejudices, biases, lack

of competencies, or personal needs that distort the perception of the dilemma. We recommend pausing again at this point to introspect and gain an awareness of any rigid mindsets that could be affecting your judgment. Avoid undue influence by irrelevant variables, such as an individual's personal appearance, political affiliation, or social status. We also recommend searching out any financial ramifications (or other factors that work to your personal advantage), seeking to ensure that these are not blurring anyone's vision, including your own.

Stress and anxiety in one's personal life are important to factor in whenever making almost any decision. Kouchaki and Desai (2015) found that anxiety can lead to self-interested unethical behavior. These researchers suggested that anxiety increases threat behavior, which in turn allows people to perceive their unethical decisions as defensive rather than problematic. The APA Board of Professional Affairs Advisory Committee on Colleague Assistance (2014) offered a progression that we have witnessed all too often among ethics violators: (a) Stress leads to distress; (b) distress can lead to impairment; and (c) impairment greatly elevates the chances of behaving improperly.

Except in those instances when the issues appear clear cut, salient, and specifically defined by established guidelines, mental health professionals may well have differing opinions regarding the *best* decision. Personality styles and primary guiding moral or religious principles can significantly influence the ethical decision-making process. Other personal characteristics that influence decisions include criteria used to assign innocence, blame, and responsibility; personal goals (including level of emotional involvement); a need to avoid censure; a need to control or to have power; and the level of risk one is willing to undertake to become involved. Divergent decisions could also be reflected in judgments about the reprehensibility of a particular act. For example, no bright line demarcates the appropriate level of nonsexual personal involvement with a client, as we illustrated many times. Indeed, we have observed marked discrepancies about the seriousness of an alleged violation during actual

ethics committee deliberations. Such lively debates have included differences in the perceived degree of harm or potential for harm, the presumed motivations of the accused therapist, and estimates of the likelihood that the act will reoccur.

Consideration of any culturally relevant variables becomes important at this point (APA, 1993; Hansen & Goldberg, 1999). Diverse individuals working together may hold differing perceptions of what is and is not acceptable behavior (King, 2000). If such factors as the degree of expected confidentiality, the value placed on autonomy, gift-giving traditions, bartering practices, geographic locale, placement of professional boundaries, gender, age, ethnicity, or culturally based expressive behaviors exhibited during therapy sessions play a part in an ethical matter, an inappropriate decision might result if culturally based variables were not considered in the mix. Many proscribed acts are unethical no matter what the culturally relevant variables, but other instances can be influenced one way or the other depending on the cultural context.

4. Consult with a trusted colleague. Because ethical decision making involves a complicated process influenced by our own perceptions and values, we can usually benefit from seeking input from others. We suggest choosing consultants known in advance to have a strong commitment to the profession and a keen sensitivity to ethical matters. Choose a confidant with a forthright manner, not an individual over whom you have advantaged status; otherwise, you may hear only what he or she thinks you want to hear. A good consultant can stimulate thinking and generate new ideas as well as evaluate your own plan, help you become more aware of any personal factors that could be coloring your perspective, and make you feel supported and confident (Bowers & Pipes, 2000).

We have heard of confidants who gave flawed advice, even causing the person seeking it to commit an ethical infraction. One therapist asked a colleague whether he should agree to treat a rape victim, given that he had no relevant experience or training related to victims

of sexual violence. The colleague allegedly replied: "Sure, how else are you going to learn?" In another incident, a poorly selected consultant advised a newly licensed counselor to simply "trust his gut to know what's OK" when it came to intermingling with clients outside the office. His barely begun career suffered when he attended a client's wild and noisy bachelor party. The police were called, drugs were found, and the woman dancing naked was underage. Attendees were all arrested, and an article naming names appeared in the local paper. As a bottom line, if you doubt a confidant's advice, seek a second opinion.

5. Evaluate the rights, responsibilities, and vulnerabilities of all affected parties. All too frequently a flawed decision results from failing to take into account a stakeholder's right to confidentiality, informed consent, or evaluative feedback.

6. Generate alternative decisions. This process should take place without focusing on the feasibility of each option and may even include alternatives otherwise considered too risky, too expensive, or even inappropriate. The alternative of not making a decision at this time and the decision to do nothing at all should also be considered. Establishing an array of options allows for the occasional finding that an alternative initially considered less attractive may be the best and most feasible choice after all.

7. Enumerate the consequences of making each decision. Whenever relevant, attempt to identify the potential consequences of a decision. These include psychological and social costs; short-term, ongoing, and long-term effects; the time and effort necessary to implement the decision; any resource limitations; any other risks, including the violation of individual rights; and any benefits. Consider any evidence that the various consequences or benefits resulting from each decision will actually occur. The ability to document this phase may also prove useful should others later question the rationale for your final decision and corresponding action.

8. Make the decision. Rachels (1980) has observed that the right action is the one backed by the best reasons. If the previous phases have

been completed conscientiously, perhaps with the ongoing support of a consultant, a full informational display should now be available. Happily, a decision that also feels like the right thing to do may well become obvious at this point. Even so, many moral and just decisions do not always protect every involved person from some form of injury, including yourself. Therefore, if anyone could suffer harm, pause to consider any steps that could minimize the damage. For example, if a therapist suspects that an out-of-control adult client might harm his child, the therapist may have to file a report with the state's child protection agency. Sometimes, a more positive outcome can occur with parental engagement rather than alienation, as could happen in the next case.

Case 17-3: Robyn Resque, M.S.W., had treated Tillie Tipsy, an alcoholic single mother of two, for 18 months. Tipsy had remained sober for more than a year and had made sincere efforts to attend effectively to her children, now ages 6 and 8. One day, she appeared for a therapy session intoxicated. She had just learned that she faced a layoff from her job at a local business that had filed for bankruptcy. She felt embarrassed and depressed that she had broken her sobriety and mentioned that she had lost her temper and beaten the children with a belt before coming to therapy.

In most states, Ms. Resque would be obligated to breach Ms. Tipsy's confidentiality by filing a report of suspected child abuse with appropriate authorities. Doing so would protect the children, conform to state law, and constitute ethically acceptable behavior. Ms. Resque could, however, also go a step further by attempting to engage Ms. Tipsy in collaborating with jointly filing the report and by attempting to engage the authorities in assisting the family while Ms. Tipsy strives to restore her sobriety and find alternative employment. The first course of action addresses ethical necessity. The second alternative not only involves considerably more effort and advocacy but also could yield a better outcome all around.

Ideally, information about the decision should be shared with all affected parties or

at least with some subset of representatives if a larger population is involved. Sometimes, these parties cannot be contacted, are unable to participate, or cannot give consent due either to age or to physical, mental, or other limitations. In such cases, additional responsibilities to protect their welfare apply. Special advocates or other safeguards may become necessary in complex situations.

Some potential decision options can be quickly dismissed because they involve flagrant violations of respectable governing policies or someone's rights or because the risks far outweigh the potential benefits. Sometimes, several decisions appear equally feasible or correct. Alternatively, the best decision may not be feasible due to various factors, such as resource limitations, requiring a consideration of a less preferable option.

The intriguing analyses in Cathcart's (2013) *The Trolley Problem or Would You Throw the Fat Guy Off the Bridge?* and Edmonds's (2014) *Would You Kill the Fat Man?* struggle with the most challenging and troubling decisions. This occurs when one or more individuals must suffer or lose so that others can be saved, no matter what decision is made. A version of such a problem for mental health professionals may present like this:

A counselor who is also your brother and single father of three young children is doing hard drugs. One day, your brother tells you he is also sharing cocaine with some of his clients because "snorting blow is way better than talking about your problems." You try to intervene, but he angrily refuses. You ask your parents to talk to him, but your brother tells them to mind their own business. You warn him that you may have to take some formal action if he does not get help, and he threatens with, "You will be sorry!" Basically, you have two choices: (a) say and do nothing and allow probable harm to befall your brother's clients as well as himself and children or (b) turn him in to the authorities or licensing board, resulting in a likely loss of his freedom and license to practice, leaving his young children's welfare and situation uncertain.

The choice is excruciating, and doing nothing is a decision. Whereas most choice options are not as agonizing as the one in our example, loyalty pitted against the welfare of others does often arise (Felton, 2011).

Sometimes, your role in decision making will extend only to presenting the assembled information because those affected have the right to decide for themselves. When this happens, professionals can experience a personal dilemma. Whereas we are morally obligated to make decisions in the best interests of those with whom we work, clients and colleagues may choose to make decisions we would not have made on their behalf.

9. *Implement the decision.* Now comes the hardest part. Mental health professions will remain strong and respected only to the extent that their members willingly take appropriate actions in response to ethical dilemmas. This often demands moral backbone and courage. It is at this point that the decision-making process comes to fruition, and the decision maker must actually *do* something. This becomes the most difficult step, even when the decision and course of action seem perfectly clear (See Gentile, 2009).

The ideal resolution results when a decision can be made *prior* to the commission of an ethical infraction that could otherwise have untoward consequences. Sometimes, the appropriate action involves simply ceasing and desisting from a practice that, after a careful decision-making analysis, seems ethically risky even if no harm has yet occurred. Sometimes, the best course of action is the recognition that one lacks certain competencies, requiring continuing education or additional supervision. Often, the implementation will involve the need to do something differently from now on and an attempt to ameliorate any potential damage. Remediation attempts can range from making an apology to an additional intervention or the provision of services or resources to those who were wronged. Sometimes, the implementation will involve proactively contacting an ethics committee or a licensing board to determine the appropriate resolution.

Unfortunately, the implementation phase also becomes a point at which this entire

process can derail. Research tells us that most therapists can formulate what they *should* do. However, they will more likely respond to their own values and practicalities when determining what they would *actually do*, which is *less* than they know they should do (Bernard & Jara, 1986; Bernard, Murphy, & Little, 1987; Wilkins, McGuire, Abbott, & Blau 1990). Tenbrunsel and Messick (2004) used the term *ethical fading* to describe the tendency to move the ethical or moral implications of implementing a decision into the background. Ethical fading is enabled by such factors as language euphemisms (assigning a label to an act that is less serious or benign) and errors in perceptual causation (letting yourself or another offender off the hook, perhaps by blaming the victim).

We must also note that the organizational culture in which one works plays a significant role when ethical decisions must be followed by an action. Conflicts are unlikely to arise when the integrity of the employer parallels more general ethical guidelines and employees feel confident that their decisions will be supported up the line. Dilemmas can prove problematic, however, when an employer's policy does not support or seems contradictory to general moral principles, professional ethics codes, and one's own moral commitments.

Case 17–4: A counselor in a community agency complained to the agency manager that Lucy Lips, Ph.D., often talked in intimate detail about her clients, using their real names, in the coffee lounge. The manager replied, “Don’t be so critical. We all work here, and these people don’t really care if we talk about them among ourselves.”

The “bad barrels” argument holds that characteristics of an organization’s culture can inhibit ethical behavior, even among individuals with otherwise high moral standards (Trevino & Youngblood, 1990). Such characteristics include support for and encouragement of unethical behavior by management, widespread and unchecked unethical actions by colleagues, unjust organizational policies, and intense pressure to perform. Such

characteristics cause painful conflicts for ethical mental health professionals.

What should be done when an employer’s actions or policies are contrary to the professional’s ethical guidelines? Members of all four professional associations are mandated to attempt to intervene and resolve conflicts between the ethics code and their employers (APA: 1.03; AAMFT: Preamble; American Counseling Association [ACA]: D.1.g, D.1.h; National Association of Social Workers [NASW]: 3.09.c, 3.09.d, 3.10.b). We do know of colleagues who have voluntarily terminated their employment rather than remain associated with dishonorable employing institutions. Unfortunately, this solution is not always practical for mental health professionals without other options.

When ethics code principles clash with laws, regulations, or other governing legal authorities and reasonable attempts to resolve the matter fail and, if unsuccessful, one may then follow the law (APA: 1.02; AAMFT: Preamble; ACA: 1.1c), although APA specifies that psychologists may not use an unsuccessful attempt to justify abuse of human rights. (See Chapter 11 for a discussion of whistle-blowing and decision implications.) Social workers should become actively involved in promoting social justice and engage in political action that supports human rights (NASW: 6.04).

ETHICAL DECISION MAKING UNDER BEHAVIORAL EMERGENCIES AND CRISIS CONDITIONS

Frantic phone calls from clients or their families, clients’ threats to harm themselves or someone else, unexpected client behavior or demands, and alarming revelations during a therapy session are not rare occurrences. As a result, ethical dilemmas demanding an immediate response can and do unexpectedly arise. With no time to prepare a carefully reasoned decision using a procedure such as the one we have just presented, therapists may rightly feel anxious and become prone to react less than

satisfactorily. It is even possible that the anxiety may encourage decisions that are self-serving, protective, or even unethical (Kouchaki & Desai, 2015).

Callahan (2009) noted that *behavioral emergencies* and *crises* are often described as interchangeable, and yet distinguishing the two may have relevance for how decisions are made. A *behavioral emergency* requires an immediate response and intervention to avoid possible harm. Behavioral emergencies include suicidal or violent behavior or interpersonal victimization. The client's status must first be evaluated, followed by an intervention to reduce the risk of harm. Interventions can range from the simple, such as nonjudgmental listening, to ordering inpatient hospitalization. Finally, a plan must be created for what should be done next. Notice that Callahan's definition of behavioral emergencies essentially requires three decisions. *Crises*, on the other hand should be reserved for an external event that causes a loss of psychological equilibrium, leading to an individual's difficulty with coping. These may be more commonplace events causing anxiety or stress, such as the response to a spouse unexpectedly asking for a divorce or the loss of a job, to the trauma resulting from a life-or-death situation. In these types of crisis, the individual may reach out for, or at least welcome, assistance.

Mental health providers rank high among those in professions vulnerable to ethical and legal requirements when making decisions and acting under emergency or crisis conditions (Hanson, Kerkhoff, & Bush, 2005). These conditions pertain when therapists are concerned about a client's condition (especially if information is incomplete), when the best course of action is unclear, when the situation is emotionally charged or time is of the essence, or when stakes are high should a negative outcome result (Kleespies, 2014). Both coping and decision-making skills must be brought to bear (Sweeny, 2008) (see Chapter 13).

We can even find ourselves called on when not directly involved in the cause of the emergency itself. Rubin (1975) vividly described an instance in which he was summoned by the administrators of his university to manage a threatening and armed student. Time was of

the essence. Even the determination of "client" could not be carefully decided. Was it the violent student, the people he was menacing, the university, the public, or all of these? This psychologist could hardly maintain a disinterested objective stance because his own life was put in danger. Although this was an extreme case, most therapists will face at some point a serious situation requiring a decision and taking action during less-than-optimal conditions.

The next case grouping involves instances when something terrible is, or appears to be, in progress.

Case 17–5: Huff Bitter expressed considerable anger toward a boss who had recently threatened to fire him. During a psychological assessment, the client described his boss to the therapist as "an exploiter of the working class who deserved to be exterminated." Bitter detailed a clear plan to perform the "execution" himself with a hunting knife he kept in the trunk of his car.

Case 17–6: Irma Anguish brought her 10-year-old daughter to therapy because she was becoming unusually reserved and withdrawn. Mrs. Anguish could offer no explanation for this abrupt change in her daughter's demeanor. When the mother excused herself to go to the restroom, the child revealed that for the past 3 months her stepfather had entered her room after everyone else went to sleep. He touched her body and requested that she fondle his genitals. The stepfather had warned the girl not to tell her mother or brothers because, if she did, the police would break up the family and it would be her fault.

Case 17–7: Halfway through a therapy session, an angry husband pulled a gun from his jacket and shot at his wife, who promptly pulled a gun from her purse and shot back.

Involving the appropriate authorities would be acceptable in all of these cases, despite the fact that reporting might violate a confidence in the process (see Chapter 6). The client's boss appeared to be in danger of bodily harm or even death, and a child may be experiencing ongoing harm. In the last case—and we swear this incident actually occurred—the warring spouses

survived. Nevertheless, the therapist found himself in a potentially perilous situation in the presence of two clients who were enraged, wounded, and armed.

Sometimes, situations may not involve immediate danger, but they do necessitate immediate action.

Case 17–8: Sanford Spot, L.M.F.T., took a call from the 13-year-old daughter of a couple he was seeing for marital counseling. The girl sobbed, “I just called to say goodbye because I am running away from home,” and hung up.

Because the child is a minor, Mr. Spot should inform the parents immediately, and the authorities might become involved if the child proves difficult to locate.

Despite many warning signs, whether an emergency clearly exists may not be clear. The next cases illustrate ambiguous situations. The therapists’ suspicions could prove unfounded, and yet ignoring them could lead to disastrous consequences. How would you react to the next three situations?

Case 17–9: A client who had expressed suicidal ideation in the past showed uncommonly flat affect during a therapy session. Wilbur Worry, Psy.D., knew the client had experienced stressors recently and became concerned that his apathy and apparent peacefulness might indicate a resolve to end his life rather than a sign of improvement. The client vehemently denied any intent regarding self-harm. Fifteen minutes before the scheduled end of the session, the client stood up and calmly stated that he had to be somewhere else.

Case 17–10: Gray Guardian, M.S.W., knew of the tensions in the home of his fragile client, who lived with her son and his wife, but became particularly concerned because the client had been rapidly losing weight. He asked the client about a large bruise circling her arm. After fumbling with her words, the client swore she fell in the shower. Guardian doubted the bruise could have occurred in that way, but the client claimed her living arrangement had improved and promised to see a physician about her weight loss.

Case 17–11: Shelly Startle, L.M.F.T., was awakened in her home at midnight by a loud pounding on her front door and someone yelling her name. Startle recognized the voice of one of her clients, who was upset during the last couples session, saying, at one point, “No one cares about me, so I don’t care about anyone else.”

As each of these three cases illustrates, a situation requiring some decision that is bound to have ethical implications occurs most often when an element of ongoing harm or immediate danger appears to be possible. As seasoned clinicians know, uncommonly flat affect in clients at risk for suicide could indicate that the client has made a decision to resolve personal pain by exercising the “ultimate solution.” Elder abuse is not rare, and the vulnerable victims may be too intimidated to report it. Mrs. Startle may be the victim of stalking. Clients who stalk their therapists are not uncommon, and estimates of the risk of such stalkers becoming aggressive are as high as 25% (Kaplan, 2006). The incidence of stalking of mental health professionals is somewhat higher than that among the general public (Miller, 2014). According to a survey conducted by Purcell, Powell, and Mullen (2005), about one fifth of the stalking clients were believed to be acting from infatuation, and almost half were regarded as resentful. Most of the victims were women. Such incidents pose difficult ethical issues in that the therapists must decide whether to violate confidentiality by reporting their own clients in the absence (usually) of any direct threat of bodily harm. Yet, none of the three cases is clear cut.

Regardless of the nature of the actual or impending emergency, therapists are in the unenviable position of having to make a number of delicate decisions at a time they, themselves, may feel anxious or stressed. Do both ethical and legal perspectives require maintaining confidentiality? If a disclosure appears warranted or mandated, who should be drawn into the matter? A client’s family? A state agency or emergency response team? The police? What details can be appropriately disclosed? What is an acceptable alteration in the degree of acceptable involvement with a client during a crisis?

We have argued consistently throughout this book that therapists almost always serve the consumers of their services best when they hold to appropriate professional roles, and we offer many examples of boundary violations that caused substantial harm. However, crises may call for temporary exceptions to our usual advice. The most ethical response under conditions of possible calamity—especially those involving matters of life and death—might conceivably involve ministering to distraught family members, breaking a confidence that would have remained secure under usual circumstances, showing more patience or engaging in more than the usual nonerotic touching, or even actively searching for the whereabouts of clients or their significant others. For example, Case 17–8 presents one of those rare occasions when the therapist might consider jumping in his car and driving to the family home in hopes of finding that the minor child has not yet run.

Because of their general nature, ethics codes will often offer little help in such crises. For example, codes allow divulging information shared in confidence only as mandated or permitted by law or proper authorization has been obtained from the involved parties (APA: 4.05.b; AAMFT: 2.2, 2.3, 2.7; ACA: Blc, B7; NASW: 1.08.b, 1.07.p). Statutes, regulations, or case law in many states allow disclosure when a client or others require protection from harm. Yet, if a client says, “I get so mad at my mother that I feel like wringing her neck,” has the remark crossed a sufficient threat threshold? Prediction of the actual level of immediate danger is not an exact science, but mental health professionals can be held accountable for their inaction and misjudgments. (See Chapter 6 for a more detailed discussion of disclosure obligations.)

Mental health professionals are, on occasion, themselves the target of a potential crisis. Fortunately, it is rare for a therapist to be harmed or killed by a client, but it does happen.

In one actual instance, an entire ethics committee appeared to be targeted for “elimination” by one of its own.

Case 17–12: Wyde Awake, Ph.D., was referred to a licensing board committee by an insurance carrier. The company’s audit revealed that Dr. Awake billed for 100 hours of psychotherapy during a 5-day period, for an average of 20 hours a day according to insurance company records. Although Dr. Awake’s clients failed to substantiate that these sessions actually took place, Awake insisted that his clients’ recollections were in error and that he did not require much sleep. When Awake was asked by an ethics committee to better explain his hours, he threatened to hire the Mafia to kill all of its members unless the charges against him were immediately dropped. The psychologist’s adult son also issued belligerent communications ordering the committee to “back off,” which only added to the members’ distress.

Dr. Awake proved to be mentally ill, and the death threats proved hollow. (For a discussion of impaired practitioners, see Chapter 2.)

Clients at Special Risk for Behavioral Emergencies and Crises

Some clients wait until their situation reaches urgent proportions before consulting a mental health professional. In such instances, therapists may have to make critical judgments with potentially significant consequences about people with whom they have not yet formed a professional relationship or gathered sufficient information. The next case illustrates this predicament.

Case 17–13: During the first 5 minutes of the initial therapy session, a highly agitated man claimed that his 26-year-old daughter was being abused by a neighbor by forcing her into slavery, and he wanted to know what to do about it. He alleged bizarre and potentially dangerous sex acts that the neighbor regularly perpetrated on his daughter. He restated several times his conviction that the neighbor posed an immediate threat to his daughter’s life.

Does the father’s story seem credible? After all, the therapist does not yet know this person. Does his agitation arise from actual events or

perhaps from a misunderstanding of consenting adults' particular sexual proclivities? Could the father's concerns reflect a delusional state of mind? Why has he not brought his daughter with him? Had he called the police and, if so, what was their response? Without answers to these questions, an optimal course is difficult to discern. The careful therapist can obviously listen with an empathic diagnostic ear but cannot rush to judgment.

Assessing and responding to a client who may pose a risk of suicide carries a heavy and stress-provoking responsibility. Becoming well versed in the clues should be an essential part of all psychotherapists' training. These include a verbal statement of intent, suicidal ideation, a history of past attempts, a precipitating event, deterioration in social or vocational functioning, a plan of action, intense affect, and expressed feelings of hopelessness and despair (Barnett & Johnson, 2010; Bongar & Sullivan, 2013; Hendin, Maltsberger, Haas, Szanto, & Rabinowicz, 2004; Hendin, Maltsberger, Lipschitz, & Kyle, 2001; Kleespies, 2009; Pope & Vasquez, 2005). Depending on the situation, some therapists may struggle with the ethics of suicide itself, as when a client has a terminal illness and experiences constant and severe pain (Curry, Schwartz, Gruman, & Blank, 2000; Peruzzi, Canapary, & Bongar, 1996; Werth, 1999a, 1999b).

According to several surveys, one quarter to one half of therapists sampled lost a client through suicide (e.g., H. N. Brown, 1987; Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989; Chemtob, Hamada, Bauer, Torigoe, & Kinney 1988). Legal analyses of actions by suicide patients' families revealed no agreed-on, clear-cut course of action when clients threaten to harm themselves (Berman & Cohen-Sandler, 1983; Fine & Sansone, 1990; Litman, 1991; Slawson, Flinn, & Schwartz, 1974). An important step therapists should take in such cases involves carefully documenting concerns and decisions when working with potentially suicidal clients. Such records will prove critical to a later defense should a therapist be sued, and the quality of such documentation may determine whether a defense attorney

will take the case (Simpson & Stacey, 2004). Lawsuits against mental health professionals remain fairly rare (although on the rise), yet client suicide accounts for a significant proportion of them. The wise therapists will become well versed in the legal aspects of suicide in advance of being forced to learn them under pressure (see Baerger, 2001; Feldman, Moritz, Benjamin, & Andrew, 2004; Gross, 2005; Gutheil, 2004; Packman, Pennuto, Bongar, & Orthwein, 2004; Remley, 2004; VandeCreek & Knapp, 2000; Weiner, 2005).

Clients with certain diagnoses, such as borderline personality disorder, seem exceptionally prone to crises (Shinefield & Kalafat, 1996) because of emotional lability, impulsivity, and tenuous relationship histories. The high incidence of child abuse in our society suggests that most therapists will also have to deal with challenging family crises and the associated legal reporting mandates. Preparing for what to expect and what to do in such circumstances alleviates the tension to some extent and maximizes the chances for the best outcome (Committee on Professional Practice and Standards, 1995; Kalichman, 1999; Zellman & Fair, 2002). (Chapters 1 and 5 also address high-risk clients.)

Preparing in Advance

Although behavioral and crisis management techniques are well beyond the scope of this book, we conclude this section by offering suggestions to prepare for making difficult decisions under tight time constraints.

1. *Know the emergency resources available in your community.* Keep the names, numbers, and descriptions of community services in an easy-to-access location. The prudent therapist will also check the quality of the resources. This list should be updated at least once every year because some resources lose their funding and disband, new ones are established, and others undergo reorganizations that improve or downgrade their service. If such emergency resources are utilized during a

- crisis, follow up on the quality of their performance and carefully monitor the client's progress.
2. *Form or join an alliance of colleagues in your community with each person agreeing to be available for consultation when emergencies arise.* Ideally, a mental health professional with experience in emergency care should be included. Keep these names and numbers in an easy-access resource file.
 3. *Know the laws and policies in your state or locale relating to matters that are likely to accompany crisis events.* These include mandated reporting statutes (specifying the conditions under which information obtained in confidence must be reported to authorities) and commitment procedures. Seek clarification on any sections of the law or policies that seem unclear before applying them becomes necessary. Frantic searches through files or frenetic phone calls to colleagues or attorneys are poor substitutes for preexisting knowledge.
 4. *Locate an attorney in your community who is knowledgeable about matters that have legal implications relevant to your practice.* Keep that phone number in your easy-access resource file. Decisions in difficult situations that result in a negative outcome, such as a client causing harm to another, may result in involving you in legal action (Kleespies, 2014).
 5. *Actively seek learning experiences to sharpen your knowledge about the kinds of crises that may arise in your practice.* Take a continuing education class in crisis counseling if your formal training was deficient. Courses in first aid and cardiopulmonary resuscitation are also good ideas, just in case.
 6. *Conscientiously define your own areas of competence, then practice only within these confines.* Although competence is an ethical issue in and of itself (see Chapter 2), practicing within your competence bounds provides an additional advantage during emergencies. The ability to function admirably during crises is often related to the level of expertise and experience with a particular clientele population or diagnostic group. Early on, refer clients who exceed your training and expertise to appropriate practitioners.
 7. *Carefully monitor the relationship between yourself and those with whom a close and trusting alliance has been built.* Therapeutic miscalculations can result in intense client–therapist dynamics that lead to unanticipated outcomes. The mishandling of transference by therapists has been traced as the cause of client crises, including completed suicides (Skodol, Kass, & Charles, 1979; Stone, 1971). Gaining information about clients' spiritual beliefs early on is also advised. Those undergoing a severe loss or other difficult life situation may also experience a spiritual crisis, and the therapist who understands a deeper meaning of a client's despair is in a position to respond effectively (Cunningham, 2000).
 8. *Never rely solely on your memory.* Conscientiously document any emergency or crisis event, including the decisions you made and your rationale for making them. Careful records will greatly assist you, and possibly others, should the event later require a formal review.

Crises in the Therapist's Life

Therapists can experience calamities with little time to make modifications for their clients and other professional commitments. The therapist who, for example, falls acutely ill must deal with revised session scheduling, how much to disclose to clients, and how the therapist should refer clients if it becomes necessary to interrupt services (Kahn, 2003). Juggling these unwelcome but necessary adjustments becomes even more difficult because of the reason for making them.

Case 17–14: The client felt increasingly irritated as her counselor, Di Verted, L.M.H.C., became unresponsive and distracted during the session.

The client finally snorted, "I feel like you are not paying any attention to what I am trying to tell you, and it upsets me because my husband forgot my birthday again, and you don't seem to care." Ms. Diverted apologized and haltingly disclosed that her 3-year-old granddaughter had drowned in the family swimming pool a few days earlier. The stunned client expressed sympathy, got up, and left.

The counselor did not handle her understandable personal grief as it affects her clients well. A client felt ignored and then was forced to deal with mixed feelings about being embarrassed about complaining about what was, by contrast, a trivial matter. The client was also perhaps more drawn into her therapist's personal life than felt comfortable. Ms. Verted needed more time before commencing her practice. She might have considered canceling appointments or referring urgent cases to a backup therapist, explaining to her clients that she needed time to deal with "a pressing family matter." In the situation described, Ms. Verted might consider sending the client a note apologizing for not recognizing her own need for more personal time and for any discomfort the situation caused.

DEALING WITH OTHERS' UNETHICAL BEHAVIOR

An alarmingly high percentage of scientists and advanced students confide that they know of scientific misconduct committed by their peers, but most do nothing about it. Relatively few cases of scientific misconduct ultimately are reported to the appropriate agencies (Eastwood, Derish, Leash, & Ordway, 1996; Glick, 1989; Steneck, 1999; Swazey, Anderson, & Lewis, 1993; Tagney, 1987; Zweibel & Goldstein, 2001). Dracy and Yutrzenka's (1997) sample of paraprofessional mental health workers said they would confront or report serious violations to their supervisors but were less likely to report less serious violations. Good (1995) found a general disinclination among his sample of counseling psychologists to confront peers believed

to have alcohol or substance abuse problems. Other surveys have revealed, discouragingly, that respondents most often reported a willingness to implement less direct and less restrictive decisions that are less consistent with ethical guidelines, often acting instead from expedience and opportunism (Smith, McGuire, Abbott, & Blau, 1991). A large national survey of government-funded researchers produced a more positive picture (Koocher & Keith-Spiegel, 2010). The majority of those who observed or learned of behaviors that would corrupt the scientific record attempted to intervene.

We understand that confronting another person for an uncomfortable reason unleashes a range of emotions: anxiety, fear of an unknown response and outcome, concerns about retaliation and longer-term consequences, loss of an established relationship, and so on. In their "risk-as-feelings" hypothesis, Lowenstein and his colleagues proposed that emotional reactions to risky situations can overpower cognitive assessments and drive the ultimate decision (Loewenstein, Weber, Hsee, & Welch, 2001). Unfortunately, that decision may be to do nothing or very little as a way of avoiding the overwhelming negative emotions associated with taking more responsible action.

This book is primarily about the ethical obligations of mental health professionals in their own work with clients, supervisees, and students. However, we also have responsibility to watch out for each other (APA: 1.04, 1.05; AAMFT: 1.6; ACA: I; NASW: 2.09, 1.11). We are in an advantageous position to observe or hear about unethical behaviors. Unethical activity often persists, totally unchecked, unless someone takes notice and intervenes.

To engage in unethical behavior rests on three factors, according to our adaptation of Whitley's proximate causes of academic dishonesty (Whitley, 1998; Whitley & Keith-Spiegel, 2002): (a) The individual's own moral assessment of committing an unethical act; (b) the benefits that the individual expects from acting unethically; and (c) the individual's perceived risk of getting caught.

Thus, any thought of acting unethically is quickly reversed if the individual realizes

that his or her own values and commitment to professional standards preclude going forward. Even if an individual talks him- or herself into the acceptability of a questionable act, the perceived benefits may rank lower than the perceived risks of exposure. However, when an individual rationalizes a need to commit an unethical act, anticipates sufficient benefit from doing so, and perceives a negligible risk of getting caught, the factors align to form a strong intent to carry through. At that point, using Whitley's model, there remains only one source of intervention, a *situational constraint*. Colleagues at the site or with inside knowledge may constitute the *only* source of situational constraint. That may be you.

What about acts committed without awareness or due to ignorance or emotional distress that clouds judgment? The impact can prove just as harmful as purposefully committed unethical acts. Again, peer colleagues stand in the best position to intervene, to attempt to minimize any harms, and to help ensure that the act will not likely recur. It is also easier to confront someone who you believed acted without awareness because the feeling going in will be more about educating than accusing (Keith-Spiegel, Sieber, & Koocher, 2010). When a colleague has already willfully committed a questionable act, intervention becomes more demanding, uncomfortable, and worrisome.

So, what should you do when you observe an ethical violation or hear about an alleged unethical act committed by a colleague? Should you infer that it is a one-time-only mistake and forget about it? Believe that others will take care of it, letting you off the hook? Trust that what goes around comes around? Assume that somehow the matter will take care of itself? Convince yourself that no one will be harmed, even if this pattern of behavior continues? Oddly, how to respond to the unethical behavior of others is rarely thoroughly discussed in the professional literature. However, we believe this matter to be extremely important and deserving of thorough airing.

Ironically, colleagues frequently divulge their ethical infractions to one of their peers, sometimes without an awareness of doing so.

Case 17-15: During a casual conversation with a colleague following a seminar on unconventional therapy techniques at a professional meeting, Slappy Noclue, Ph.D., described an adult female client who he would take across his knee and spank gently on her buttocks. He believed the technique to be extremely useful in "facilitating transference resolution in histrionic women" and, in an apparent gesture of helpfulness, encouraged the colleague to try it.

The stunned listener quickly disengaged from the conversation without commenting on Dr. Noclue's paddling technique, but the conversation lingered in the colleague's mind as he struggled with what, if anything, to do about it. He did not know Dr. Noclue well, they lived a thousand miles apart, and the client apparently did not make a complaint. In the actual incident, the colleague believed he did the best he could when, after making a telephone call resulting in a long conversation, Noclue agreed that his technique was not appropriate because "it might get him into trouble."

More commonly, colleagues come for advice before a contemplated action occurs. Sometimes, the motivation for soliciting confidants is to gain approval before they act. In such situations, you have been presented with an exceptional opportunity to be a part of upholding the integrity of the profession by setting a colleague straight.

Case 17-16: Spot Lite, Psy.D., treated a client who murdered his mother prior to the client's arrest and conviction. Details about the gruesome crime ran as the lead story on local TV news almost every night. Lite asked a colleague if she thought it would be OK to contact the TV station with interesting tidbits about the murderer's childhood and other revelations made during counseling but never revealed by the media. Dr. Lite defended his plan as an opportunity to educate the public, especially if their children were abusing or killing animals. He also figured it was a way to get his name and face out to the community, and it could not cause a convicted murderer any further harm. The colleague quickly advised Lite that this would be unethical and why.

Mr. Lite hoped that his colleague would validate his self-serving brainchild. But, Lite probably knew better himself at some level, making the task of assisting in the prevention of a contemplated confidentiality violation easier.

Sources of Resistance to Becoming Involved

Most of us grew up trying to avoid being called a “tattletale.” Even as adults, coworkers perceived of as “highly ethical” may simultaneously be rated as less likable (Trevino & Bart, 1992). Thus, the urge to flee from taking responsibility to address the unethical behavior of others is, sadly, understandable. In group practice, treatment centers, or research settings, one might feel reluctant to appear disloyal to the institution by complaining about a colleague. Conflicting feelings between a perceived duty to take action and wanting to maintain a protective stance toward a colleague comprise a common source of reticence to engage. It is also tempting to rationalize that someone else will deal with it (“bystander apathy”) or that the matter is not serious enough for concern. It is all too easy to procrastinate until the matter no longer seems relevant, especially if the evidence seems ambiguous, as it often is. Furthermore, becoming involved may involve a significant commitment to a time-consuming process (Behnke, 2006).

Fear of retaliation may cause resistance, especially if the individual already seems menacing or is of higher professional status. Knowledge of the often-publicized fate of whistle-blowers ending up as targeted themselves may explain why an observer chooses to remain silent (e.g., Rothchild & Meithe, 1999; Sprague, 1993, 1998). (See Chapter 11 for a discussion of whistle-blowing.)

Your Relationship to the Possible Ethics Violator

Those who observe or hear about the possible unethical actions by other mental health professionals often know the alleged offenders

personally. How you get along with a suspected colleague will affect both your interpretation of the situation and the approach taken. The colleague could be a good friend or an intensely disliked adversary. He or she could be a subordinate or a supervisor. Taking direct action usually proves easier with a subordinate (not so threatening) or when one dislikes the suspected colleague.

If the colleague is a friend or acquaintance with whom no previous problematic interactions have occurred, a confrontation can go well. You can express to your friend that your interest and involvement arise out of caring and concern for his or her professional standing. The danger, of course, lies in risking disruption of an established, positive relationship. If you can effectively educate your friend, however, you probably protected this individual from embarrassment or more public forms of censure. Discomfort, to the extent that it ensues, may prove temporary.

Case 17-17: Bill Wrong, Ph.D., mentioned to his office mate, Kelly Right, D.S.W., that he was going to start charging insurance companies for sessions even when the clients cancelled or failed to show. This was happening far too often, and he reasoned that he set time aside for them that should be compensated. Dr. Right shared both her sympathy and her concerns that his plan was actually a form of fraud. Dr. Wrong quickly reversed his plan.

When the act is discovered after the fact, a successful outcome may not be guaranteed, but one may feel compelled to act anyway.

Case 17-18: Nellie Notice, Ph.D., and Hank Panky, L.M.F.T., shared an office suite and were good friends, frequently socializing along with their family members. One evening, Notice entered a restaurant in the next town just as Mr. Panky was leaving with his arm around a young redhead woman. Notice had seen the young woman in their reception area every Tuesday at 4 p.m. Notice remained unobserved as she watched the two hug and kiss while waiting for Panky’s car. Notice overheard Panky say, “We only have 3 hours, so let’s get over to your place.”

Dr. Notice was hurt, disappointed, and angry and pondered what to do. She tried to imagine that what she saw was innocent, but could contrive only ridiculous stories, such as “The redhead woman is actually his daughter from a previous relationship who he had not revealed, and they meet weekly at the office just to talk.” She also worried that should the client ever make a formal complaint, she will be tainted by her association with Mr. Panky. Dr. Notice realized she needed to act because she was unable to overlook what she saw. She confronted an embarrassed Panky, who said he “just got caught up in something,” and he would “take care of it.” Although Dr. Notice did apparently end the affair, things could still go wrong. The client’s option to complain remains a possibility, or Mr. Panky could reoffend.

If you do not know the colleague personally, the confrontation will feel, by definition, more reserved. An expression of concern and a willingness to work through the problem cooperatively may still prove effective.

If you dislike a colleague or feel upset by this person’s behavior, courage to act may come more from the thrill of revenge than from genuine bravery and conviction. Anger is a powerful motivator to become involved, but introduces an exceptionally negative influence on adaptive ethical decision making (Thiel, Connelly, & Griffith, 2011). One should never attempt such an intervention, however, when one’s strong emotions would get in the way. Proceed more cautiously in such instances. If others know the same information (or if it can be appropriately shared with others), you might consider asking someone who has a better relationship with the individual to intercede or to accompany you. If that proves infeasible, and a careful assessment of your own motivations reveals that the possible misconduct clearly requires intervention on its own merits, then you should take some form of action. It may still prove possible to approach this individual yourself, and if you maintain a professional attitude, it may work. We know of one therapist who approached his long-standing nemesis with concern about her conduct. The two eventually became friends as a result of

working through the matter together, each gaining newfound respect for the other.

Similarly, should someone ever approach you with a concern about your own conduct, treat this as a professional gift and carefully consider any opinion and advice offered. If one person dares to speak with you about the matter, others might already be aware of a possible problem as well.

Before Taking Action

Table 17-2, adapted from *Responding to Research Wrongdoing* (Keith-Spiegel et al., 2010), summarizes issues to consider when action should be considered but you have yet to decide whether it should be informal between you and the suspected violator or reported to a supervisor or an ethics committee, licensing board, or another appropriate forum.

Hints for Engaging in Informal Confrontation

One attractive feature of informal peer monitoring is that when it works out well, two goals can be met simultaneously: A problem is solved, and a colleague may be saved from scrutiny by a more formal (and onerous) correctional forum. The process for engaging in formal reporting of unethical behavior is covered in the next chapter. However, if you decide to go ahead with an informal approach, we offer some hints.

Preconfrontation Preparation

1. *Identify the relevant ethical principle or law that applies to the suspected breach of professional ethics.* If no violation of law, relevant policy, or ethics code has occurred, then the matter may lie outside the domain of ethics. Perhaps the colleague has an offensive personal style that feels unpleasant but does not rise to the level of ethical misconduct. Perhaps the colleague holds personal views that seem generally unpopular or widely divergent from your own. In such instances, you

TABLE 17.2 Considerations in Deciding Between an Informal or Formal Intervention

Characteristic	Informal Intervention	Formal Intervention
Overall advantages	Informal intervention is not bound by strict investigative rules. There is a solid potential for a collegial problem-solving meeting, as opposed to an adversarial process. A problem may be prevented or fixed without the issue being elevated to a formal inquiry.	Formal intervention is more appropriate for some kinds of issues, particularly those that are more serious or involve significant incompetence.
Overall disadvantages	You are on your own (maybe with the support of a colleague). The suspected individual does not have to cooperate. If things go badly, adverse actions could follow (e.g., the individual may be more likely to retaliate or gossip about or attempt to blame you). Note: You can decide to take more formal action later if the case warrants it and you are dissatisfied with the informal attempt.	Formal intervention will take more of your time and will likely feel more stressful. The suspected individual may attempt to turn the tables and try to blame you. You may risk some of the consequences of blowing the whistle (e.g., social marginalization). The individual may be exonerated if evidence is not sufficiently strong, which in turn may put you in an awkward position.
<i>The Suspected Individual's Personal Characteristics</i>		
Rational and fair	One never knows for sure when another person feels stressed or attacked, but if you have judged this person correctly, an intervention may go well.	Personal characteristics are irrelevant if the act is serious and the evidence is strong and an informal intervention is attempted but failed.
Difficult (e.g., abrasive, arrogant, abusive)	An informal intervention may prove difficult, but could work if you are respected by the suspected individual, you are the individual's superior, or if you are perceived as trying to help rather than harm.	The suspected individual is now exposed and could be more likely to put up a vigorous defense or attempt to retaliate unless the evidence is very strong.
Ambitious and competitive	Move with caution as such individuals would feel they have a lot to lose. However, they may fear a formal inquiry even more.	If other factors align (e.g., serious offense and evidence is strong), a formal approach is indicated.
Extremely stressed, mentally disturbed or addicted to alcohol or drugs	Consider the nature of your standing relationship. If it is not strong and of long standing, an informal intervention is probably not indicated. Also consider that they may not follow through with what they promise.	This is a safer route, but expect blowback if the individual's problem is characterized by acting out.
<i>The Quality of Your Evidence</i>		
Strong	Strong evidence is important, but other factors must be taken into account also (e.g., your position relative to the individual).	The evidence should be strong and documented.

(continued)

TABLE 17.2 Continued

Characteristic	Informal Intervention	Formal Intervention
Weak or circumstantial	If evidence is weak (too weak for a formal approach) and you remain concerned, consider an informal meeting that seeks clarification but makes no accusations. The person may even be appreciative.	Formal reporting is risky and unlikely to convince others. Can you obtain stronger evidence?
Others possess the same information/evidence	This strengthened position will likely be helpful, especially if you intervene together.	Additional witnesses will strengthen your formal report.
<i>Your Relationship and Status With Regard to the Suspected Individual</i>		
The individual is your friend.	You do friends a favor by gently trying to help them avoid what could be a serious problem for them and your institution or organization.	Realistically, this would be a difficult step to take. But if the act is very serious, damage (or potential damage) is severe, and an informal approach could not solve the matter, you must consider formal action.
Your status is the same or higher than the individual of concern.	This is less risky. Informal resolution is a reasonable approach and should be considered mandatory if the individual is your student or supervisee.	This is less risky, although disturbed individuals with lower status than you can always make things difficult.
The individual is an adversary or disliked.	An informal resolution is unlikely to go well. You may be too emotionally involved or your motives will be seen as suspect. If the matter warrants an intervention, you might pass the evidence to someone else (if appropriate) if an informal approach still seems the best way to go at this point.	If your concerns meet other criteria for formal intervention (e.g., strong evidence), then involving objective third parties (i.e., your institution's procedure for handling wrongdoing) makes sense. Be prepared for the suspected individual to say you are acting out of spite.
You see yourself as a victim or are very angry or heavily emotionally involved	An informal intervention will likely go poorly, and we recommend against doing so unless or until you feel calm and controlled.	Cool off, consult with trusted others, make sure you have a strong case, and consider making a report. Keep in mind that the accused may continue to make you angry, especially if he or she retaliates.
Your status is lower than the individual of concern.	Move with considerable caution unless you have support from others or very strong evidence.	Move with considerable caution. Strong evidence and support from others are essential.
This is not someone you know or work closely with.	Assess with other factors. (Our respondents were more likely to get involved with such individuals.)	This is indicated if evidence is very strong.
<i>About Your Institution</i>		
The level of administrative support is high.	You may still want to intervene informally if other indicators suggest that this approach would create a better outcome, especially if your evidence is not compelling.	If administrative support for scientific integrity is high and wrongdoing is condemned, risks to you are greatly minimized.

(continued)

TABLE 17.2 Continued

Characteristic	Informal Intervention	Formal Intervention
The level of administrative support is not known to be strong or efficient (e.g., little experience with such matters, procedures not well organized).	If the suspected individual is your supervisee, other support is not normally necessary because you can exercise your supervisory responsibility and authority. If support is not strong, you need to accept that you may be on your own. However, our research revealed what may seem to be counterintuitive. Those who felt unsure of the level of their institution's support were <i>more</i> likely to become involved informally and had a high satisfaction rating.	This is more risky. If the offense is serious and your evidence is strong, you may want to make a formal complaint.
The administration is known to ignore (or even reward) deviant behavior.	You may still be able to accomplish something on your own if other risks are not evident.	Formal reporting is risky. The organization may retaliate against you.
The level of administrative support is unclear to you.	Obtain more information; ask your superior what he or she knows about how concerns about unethical behavior are handled.	It is important to obtain more information before acting so you know what you will be dealing with. It is not necessary or desirable to divulge why you are seeking information at this point.
<i>Apparent Nature of the Act in Question</i>		
The act appears to be a first-time offense or mistake (not that you would know for sure).	An informal approach is indicated if the suspected individual is a student or supervisee and is possibly indicated otherwise.	A formal approach is indicated if the assumed first-time error is serious, evidence is strong, and an informal intervention fails.
The act may be a pattern of long standing.	Unless the act represents one that is unintentional and can be overcome with training or insight, informal intervention is probably not indicated.	If you can document a pattern, and especially if the act is serious and appears to be intentional and will have repercussions for your institution, formal reporting is strongly indicated.
The act appears to you to be committed unintentionally or from carelessness.	This is often an excellent opportunity for an informal solution or consultation, especially if no harm has yet been done.	This is indicated if serious harm has been done and if informal intervention fails.
Gross incompetence is involved.	It is unlikely that an informal intervention can be useful unless the area of incompetence is restricted to a single technique or other teachable matter.	This is indicated for overall gross incompetence in the conduct of research. Evidence should be compelling.
Confidentiality issues pertain (e.g., an informant has shared evidence only on the condition that you keep it confidential).	If you are unable to deal with the matter without violating a confidence, there may be nothing you can do. Remain vigilant for new confirming information.	Unless some other way exists to make a strong case besides violating a confidence, there may be nothing else to do. Remain vigilant for confirming information from another source. Note: There may be times when it is ethical to break confidentiality, such as when someone is in immediate danger.

(continued)

TABLE 17.2 Continued

Characteristic	Informal Intervention	Formal Intervention
The act appears imminent but has not yet occurred (e.g., an individual divulges a flawed or unethical plan).	Preventing or correcting wrongdoing before it occurs may be the best use of informal interventions.	Unless potentially catastrophic, formal reporting is unlikely to be the correct format as nothing has yet happened. Existing investigatory systems do not address prevention. The suspected person can deny any future intentions.
The act is of an extremely serious nature (or has serious consequences for clients, students, research participants, the institution, the public or you).	An informal approach is not indicated. But, if the matter is something dangerous that you can correct quickly, informal intervention on the spot is best. This may be followed by a formal inquiry.	Unless it is an emergency situation, formal reporting is indicated.
<i>Your Personal Sources of Support</i>		
Strong support from family or friends	Support from those close to you will provide emotional strength but is not likely useful in making the decision.	Support from those close to you will provide emotional strength but not likely be useful in making the decision.
Strong support from your collegial confidants	The fact that others support your perspective enhances the validity of your concerns. Social support can be emotionally sustaining even if an intervention does not go well.	Knowing that you will have support from others is emotionally sustaining.
Little or no support from colleagues and others	If others with whom you have confided are not supportive, why not? Review the matter again to ensure that your motives and evidence are valid.	This is not a good sign. You will not likely obtain support from the recipients, who will formally review the matter, if you have not been able to garner agreement from trusted colleagues that you are making a wise decision.
Consideration of your own time and emotional resources	Informal interventions usually take far less time and can be less stressful because no formal mechanism is involved. If the interaction should go very badly, then things have the potential to become more complicated.	Prepare to devote some time to this process (even though you do not have control over it), and some level of stress can be anticipated. Courageousness and a commitment to integrity are sustaining.
<i>Your Own Welfare</i>		
Your degree of control of the process	Informal intervention allows for considerable control of the plan and how the suspected individual will be approached. How the individual will respond, however, cannot be predicted.	The committee or board will take over the entire procedure. You may be asked for more information. The accused will be offered due process, have his or her own witnesses, and may hire a lawyer.
Expected level of stress	Stress can range from mild to severe, taking other characteristics into consideration. But, overall, this is likely to be less anxiety-producing than formal reporting.	Stress is likely to be moderate to high, especially if the matter takes unexpected turns.

have the right, of course, to express your feelings to your colleague, but you should not construe doing so as engaging in a professional duty.

We must note that any concerns about research wrongdoing can be tricky because the formal definition of *scientific misconduct* includes only falsification, fabrication, and plagiarism. Other purposeful or unintentional acts can sully the scientific record—such as applying incorrect statistical analyses, being careless with data collection, or manipulating the sample selection to maximize desired results—and may have to be approached as matters of responsibility or competency rather than violating a formal policy.

2. *Reflect thoughtfully on your own motivations to engage in (or to avoid) a confrontation with a colleague.* Make sure strictly personal issues are not clouding your judgment. If you are (or perceive yourself to be) directly victimized by the conduct of a colleague, you will probably feel more disposed to becoming involved. In addition to any fears, anger, biases, or other emotional reactions, do you perceive that the colleague's alleged conduct—either as it stands or if it continues—could undermine the integrity of the profession or harm one or more of the consumers served by the colleague? If your answer is affirmative, then some form of proactive stance is warranted. However, if your emotional involvement or vulnerability (e.g., the colleague is your supervisor) creates an extreme hazard that will likely preclude a satisfactory outcome, you may wish to consider passing the intervention task to another party. In such cases, first settle any confidentiality issues.
3. *It is also wise to consider any cultural issues* that may help to better understand the situation.
4. *Assess the strength of the evidence.* Ethical infractions, particularly the most serious ones, seldom involve acts committed openly before a host of dispassionate

witnesses. With few exceptions, such as plagiarism or durable material such as letters or e-mails, no tangible exhibits corroborate that an unethical event ever occurred. A starting point involves categorizing the source of your information into one of five categories:

- a. Direct observation of a colleague engaging in unethical behavior.
- b. Knowing or unknowing direct disclosure by a colleague that he or she has committed (or is about to commit) an ethical violation.
- c. Direct observation of a colleague's suspicious but not clearly interpretable behavior.
- d. Receipt of a credible secondhand report of unethical conduct.
- e. Casual gossip about a colleague's unethical behavior.

If you observed ethical behavior, have durable and convincing evidence, or the colleague disclosed an unethical act, you have a professional responsibility to proceed in some way. Having a suspicion of unethical behavior without clear-cut evidence, however, will probably occur more often. Proceeding may take more tact and feel more precarious, but if you have good communication with the colleague, we suggest carefully moving forward.

If your information was not gained directly, ask yourself about the credibility of the source. Reports by clients about previous treatment relationships can be difficult to evaluate, requiring clinical skills to assess the likelihood of accuracy based on factors such as the degree of psychopathology (Overstreet, 2001). If the information came by casual gossip, proceed with considerable caution. It is often impossible to know the beginning and endpoint, and the information may be twisted by the time it gets to you (Michelson, van Iterson, & Waddington, 2010). The motivations of those passing on the story, coupled with the exaggeration and distortion that always hang heavy on "grapevines," could cause a colleague unfair damage. If no way exists to obtain any substantial, verifiable facts, you may choose to ignore the information

or, as a professional courtesy, inform your colleague of the scuttlebutt. If the colleague is guilty of what the idle hearsay suggests, you may have a salutary effect. However, we recognize that this constitutes risky business and may prove effective only if you feel reasonably confident that you can anticipate the colleague's reactions.

If you find yourself approached by a credible person who claims firsthand knowledge and seeks assistance to pursue the matter, we suggest providing as much help as you can. Because we will often advise you to consult with colleagues before taking any action, it seems only fitting that you should react receptively when others approach you, if that seems appropriate. You may be able to assist the person with a plan of action that will not include your direct involvement. Gottlieb (2006) offered questions to ask yourself when accepting a role as an ethics consultant. Are you qualified to address this specific issue? Can you remain objective? Are there any conflicts of interest? Do you have the time and needed resources to become involved? You might offer a referral if you feel that you cannot comment confidently. If you do agree to become actively engaged, make certain you obtain proper permission to reveal any relevant identities and that your information is as complete as possible.

5. *We strongly recommend you consult at this point with a trusted colleague who has demonstrated sensitivity to ethical issues, even if only to assure yourself that you are headed in the right direction.* Your professional associations may also provide consultation. "Fresh eyes" have a way of clarifying ambiguities and ensuring coverage of all of the bases.

6. *Avoid the easy outs.*

You may well find yourself tempted to engage in one of two covert acts as alternatives to confronting a colleague directly. The first involves casually passing the information along to others in an effort to warn them. Although informing others may provide a sense that duty has been fulfilled, this step will more likely serve to diffuse responsibility. Idle talk certainly cannot guarantee that an offending colleague

will shape up or that improved public protection will follow.

The second temptation involves engaging in more direct, but anonymous, action, such as sending an unsigned note or relevant document (e.g., a copy of an ethics code with one or more sections circled in red). This approach also does not guarantee constructive results. The reaction to an anonymous charge may prove counterproductive, only assisting an offender in perfecting nondetection. A certain amount of paranoia may result, adding suspiciousness to the colleague's character.

Another problem with both of these surreptitious approaches is that you might have gotten it wrong. The presumed violator may have been misjudged. To gossip or become a "mystery accuser" that an innocent individual cannot identify imposes considerable distress and unfair harm. Such tactics, if unwarranted, would constitute a moral failure on your part.

The Confrontation

1. *If you decide to go ahead with a direct meeting, schedule it in advance, although not in a menacing manner.* For example, do not say, "A matter has come to my attention about you that causes me grave concern. What are you doing a week from next Thursday?" Rather, indicate to your colleague that you would like to speak privately and schedule a face-to-face meeting at your colleague's earliest convenience. An office setting would normally be more appropriate than a home or restaurant, even if the colleague is a friend. We do not recommend attempting to handle such matters on the phone unless geographical barriers preclude a direct meeting. Letters create a record but do not allow for back-and-forth interaction and observation of body language and contemporaneous emotion, which we believe conducive to a constructive exchange in matters of this sort. We do not recommend e-mail or texting for the same reasons, as well as the

additional concern that electronic communications may allow for unauthorized others to gain access.

2. *Set the tone for a constructive and educative session.* Do not take on the role of accuser, judge, jury, and penance dispenser. The session will probably progress best if you view yourself as having an alliance with the colleague. Such a partnership would not proceed in the usual sense of consensus and loyalty, but rather as a collaborative effort between colleagues attempting to solve a problem together.
3. *When entering the confrontation phase, remain calm and self-confident.* The colleague may display considerable emotion. Remain as nonthreatening as possible. Even though it may feel like a safe shield, avoid a rigidly moralistic demeanor. Most people find righteous indignation obnoxious. We suggest soothing language, such as expressing confusion and seeking clarification. It might go something like this: "I met a young woman who, on learning that I was a therapist, told me that she was your client, and that the two of you were going to start dating. I thought we should talk about it." Things are not always as they seem. Social comparison research has shown that people tend to view others as less ethical than themselves and as less ethical than they actually are (Halbesleben, Buckley, & Sauer, 2004). It will always prove wise at the onset to allow an explanation rather than provoking anxiety. For example, you may learn that the young woman was a client of your colleague, but only briefly and several years earlier. The discussion would likely proceed far differently than had you stormed into the meeting with accusations.
4. *Describe your ethical obligation, noting the relevant moral principle or ethics code standard prompting your intervention.* Do not play detective by attempting to trap your colleague through leading questions or withholding any relevant information that

you are authorized to share. Such tactics lead only to defensiveness and resentment, thus diminishing the possibility of a favorable outcome.

5. *Allow the colleague ample time to explain and defend his or her position in as much detail as required.* The colleague may become flustered, embarrassed, defensive, and repetitive. Be patient.
6. *If you are intervening on behalf of another, you will first have to disclose why you are there and offer any caveats.* You might say something like, "I, myself, have no direct knowledge of what I want to discuss with you, but I have agreed to speak with you on behalf of two of your supervisees." Your role in such instances may involve arranging another meeting with all of the parties present and possibly serving as mediator during such a meeting.
7. *If the colleague becomes abusive or threatening, attempt to steer the person to a more constructive state.* Although many people need a chance to vent feelings, they may settle down if the confronting person remains steady and refrains from responding in kind. If a negative reaction continues, it may be appropriate to say something calming, such as, "I see you are very upset right now. I would like you to think about what I have presented and, if you would reconsider talking more about it, please contact me within a week." If a return call does not follow, consider other forms of action. This could involve including another appropriate person or pressing formal charges. It would probably prove wise to have another consultation with a trusted colleague at this point. You should inform the suspected offender, in person or in a formal note, of your next step if you plan to take more formal action.

The High Price of Turning Away

Intervention is not always appropriate, as we have detailed. However, others who had solid knowledge of ethical violations, especially

when the breaches could harm vulnerable clients, but courage to intervene could not be mustered, may well pay a price anyway. "Moral distress" can result when one knows better but does nothing (Austin, Rankel, Kagan, Bergum, & Lemermeyer, 2005). Furthermore, the misconduct of others, left unabated, can become *your* problem. An unethical office mate or collaborator may blemish your own work and reputation. An organization discovered to have shamelessly treated its clients or research participants pollutes your association with it.

Perceptions of oneself as shirking a duty and as a result feeling somehow complicit in unethical actions of another do not sit well over time. Forty percent of government-funded National Institutes of Health (NIH) scientists in a large survey (Keith-Spiegel et al., 2010) who did not become involved even though they had evidence of wrongdoing committed by others still felt misgivings, sometimes years later. Most in this group did not act because they were not sure what they should have done, suggesting that this professional responsibility deserves more attention in training curricula.

Failure to become involved can also dampen professional self-esteem and perhaps even how we judge ourselves as human beings. Austin and her colleagues (2005) offered a literary example from Camus's novel, *The Fall*. The narrator, Clamence, recounts seeing a young woman on a bridge over the Seine one late night, followed by a splashing sound and pitiful cries. An "irresistible weakness" swept over him, and he did not act. For many years thereafter, Clamence was haunted by the desire to go back in time so he could try to save her and, by doing so, save himself.

Case 17-19: A colleague confided to us that a therapist who once worked in her office complex had become sexually involved with several female clients on a regular basis. She could even hear the sounds from her own office. "You knew something was going on," she told us, but she never said a word to anyone. The offending therapist is long since deceased, yet she still berates herself for not doing something back then. She still feels like a collaborator in unknown harms.

Case 17-20: Another colleague told us about his discovery of a student who fabricated supervisory hours and cheated on exams. Because of the attraction he felt toward the student, he did nothing. This colleague now censures himself for letting down his life-chosen profession as well as himself. When he learned that the woman, now a practicing counselor, was being sued for harming a client due to incompetence and exploitation, he also felt responsible.

Finally, ignoring unethical behavior reinforces violators' perception that they got away with something and, in an organizational setting, may even encourage others to misbehave. As Jane Addams, the first American woman to win the Nobel Peace Prize said, "Action indeed is the sole medium of expression in ethics."

When an Informal Resolution May Not Be Appropriate

Partially because of reported incidents of harassment and intimidation, ethics codes allow members the option of deciding the appropriateness of dealing with the matter directly. However, if an informal solution seems unlikely and substantial harm has already occurred (or is likely to occur), formal action should be taken—such as contacting a licensing board or ethics committee—as long as any client confidentiality rights or other conflicts do not preclude reporting (APA: 1.04, 1.05; ACA: II.2.a, I.2.b; NASW: 2.10, 2.11).

Here, we expand some additional comments noted in Table 17-2. We know of very rare instances of threatened physical harm, retaliation, or legal action for harassment and slander against therapists who attempted to deal directly with the ethical misconduct of their colleagues. The next case illustrates this difficult outcome.

Case 17-21: My Tee Goodtry, Psy.D., received complaints from several clients and other therapists about the "whiskey breath" of Groggy Sot, M.S.W., one of the practitioners in her group office practice. She approached him with her concerns. Mr. Sot yelled at Dr. Goodtry, accused her of being jealous of his wife, and threatened to sue

her if she repeated these “vicious allegations” to anyone else. Dr. Goodtry felt helpless and afraid. However, she had also detected a strong stench of liquor on Mr. Sot’s breath.

We would advise Dr. Goodtry to request a formal investigation. Fortunately, she knows others who may join with her in doing so. Whereas Mr. Sot proved a poor candidate for informal collegial intervention, some impaired therapists with more temperate and likable personalities may respond well to a supportive colleague’s honesty and concern.

Ethical violations often involve colleagues whose conduct and professional judgment are affected by addiction, physical or (more often) emotional problems, and marital discord (Katsavdakis, Gabbard, & Athey, 2004). According to a survey undertaken by the APA Task Force on Distressed Psychologists, almost 70% of the sample personally knew of therapists experiencing serious emotional difficulties. However, only about a third were believed to have made substantive attempts to help themselves (reported in VandenBos & Duthie, 1986). We estimate, from our own experiences sitting on ethics committees, that about half of the therapists with sustained complaints appeared to have some personal turmoil or emotional condition that very likely contributed to the commission of an ethical violation.

If a colleague seems generally incompetent because of insufficient training or emotional impairment, informal intervention will not resolve the problem. Such individuals rarely have insight into their shortcomings and could cause considerable harm to clients. However, if the incompetence seems restricted to a single technique or application that could benefit from either remediation or discontinuation, informal intervention remains a viable option.

When the alleged unethical behaviors are extremely serious, possibly putting yet others in harm’s way, and when the fearful but otherwise credible individuals making the charges adamantly insist on remaining anonymous, therapists may not feel comfortable ignoring the situation altogether. However, there may be nothing else that can be done. Sometimes,

the option to do nothing may not exist, as with adherence to a state’s mandatory reporting laws. However, for other reporting situations not required by law, ethics codes leave no options if confidentiality issues cannot be resolved.

Case 17–22: A new client told Ima Current, Ph.D., that he had adverse experiences with his previous therapist that left him feeling abandoned and unlikable. He claimed that Dr. Weary Brusque would sit for most of the session saying nothing or texting on his iPhone while the client spoke. When Brusque did respond, the client claimed he simply barked quick orders, such as, “Just cut off that relationship” and “Tell your boss how you feel.” Dr. Current was acquainted with Dr. Brusque and thought him odd. Nevertheless, she was willing to discuss the matter with Dr. Brusque. When she offered to intervene, the client became frantic and remained resolute in his refusal to be identified.

Dr. Current is stuck. She cannot completely discount the remote possibility that Dr. Brusque had attempted to apply some strategic or paradoxical principles with this particular client or that the client is exaggerating. She can, however, certainly educate the client about behavior expected of professionals and possibly help him follow through later with a complaint should the client change his mind.

Finally, mental health professionals may be requested by another colleague or a client to assist in confronting an alleged violator, but the requester also insists on concealing his or her identity. Often, such people fear reprisal or feel inadequate to defend themselves. Occasionally, a third person critical to pursuing the matter is unavailable or unwilling to become involved or to be identified. These situations pose extremely frustrating predicaments. Approaching colleagues with charges issued by unseen accusers violates the essence of due process. Furthermore, alleged violators often know (or think they know) their accusers’ identities anyway.

In conclusion, we favor collegial intervention when the signs suggest an informal approach may solve a problem and set a colleague back on track. The final chapter of our

book discusses ethics codes and the formal mechanisms for managing and deciding the outcomes of complaints.

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18

Ethics Codes, Regulations, and Enforcements

One cool judgment is worth a thousand hasty councils.

Thomas Woodrow Wilson

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ETHICS CODES OF PROFESSIONAL ORGANIZATIONS

If a profession is to thrive, the public must have faith in those who practice within it. That trust is ultimately determined by its members' collective commitment to uphold professional and ethical standards. Unfortunately, self- and

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informal peer monitoring have not proven sufficient to fully protect consumers.

Formalized rules and adjudication venues have been put in place to educate both therapists and the public about ethical practice, to investigate complaints, and to impose sanctions. We believe that a thorough understanding of the role of ethics codes and mechanisms

for monitoring, processing, and dealing with complaints will help you avoid the inevitable entanglements that will pop up, often when you least expect them.

The Many Faces of Ethics Codes

Ethics codes are almost as old as recorded history. The first profession-generated code, the Hippocratic oath, was created in around 400 B.C.E. This fascinating guide for physicians in those times contains anachronistic directives, such as disallowing the removal of kidney stones and physician training must involve no charge to students. Yet, it also echoes themes present in today's professional ethics codes, such as upholding confidentiality and forbidding sexual relations with patients (specifying, interestingly, patients of both sexes, be they free or slaves).

Most professions can be characterized by a formal organization that speaks for its members, a systematic program of required training, a body of knowledge to teach, a means of regulating or influencing the members who provide the service, and an ethics code (Pryzwansky & Wendt, 1999). A code of ethical standards is one of the major features of a profession because it creates an implied social contract that purports to balance professional privilege with responsibility and a commitment to consumer welfare (Wynia, Kishore, & Belar, 2014).

Today's ethics codes for mental health professionals are similar in most ways. They promote acting in the best interests of consumers served; maintaining and practicing within the bounds of one's competence; striving to ensure that no harm comes to those with whom they work; protecting confidentiality and privacy; acting responsibly; avoiding exploitation; and upholding the integrity of the profession through exemplary conduct.

Besides serving as a pledge to the public, ethics codes of mental health professional organizations attempt to take on many other functions, perhaps too many. At once, ethics codes

- are impressive public relations documents leading to the enhancement of public confidence in the profession;

- include a critical mission of the organization;
- spell out which principles morally responsible members are expected to follow;
- attempt to clarify the proper use and misuse of skills and expertise;
- provide general guides to decision making;
- assist in educating the next generation of professionals;
- define the rules for judging those whose actions have been called into question by ethics committees and other regulating agencies;
- Serve as tools for licensure boards, civil litigants, and other formal mechanisms of redress to cite in sanctioning and defending allegations of professional misconduct; and
- give consumers an additional layer of protection should licensing boards or other regulatory boards be unable or unsuited to consider a complaint.

Ethics codes serve to safeguard the profession itself. Because one original purpose was to forestall outside regulation by attempting to preclude the necessity for it, consumers may perceive ethics codes as protective only of the profession, perhaps by watering down or even ignoring some issues altogether. After all, ethics codes represent the collective experiences of those within the organization empowered to make decisions about ethical matters; thus, the codes invariably become the product of expertise and political compromise (Bersoff & Koeppl, 1993). Nevertheless, even a cursory review of the codes we feature in this book reveals consumer welfare as of primary importance.

The creators of ethics codes fully understood that mental health professionals cannot avoid or prevent every possible harm or ethics-related incident. Nor can practitioners be expected to come up with perfect solutions to every dilemma, even when they do everything expected of them. Also, codes cannot speak to every context in which an incident occurs. Thus, a degree of generality and flexible language (e.g., "attempts to," "takes reasonable precautions," and "whenever feasible") become unavoidable. The effect, unfortunately, could

also be to narrow liability by creating enough ambiguity and loopholes to wriggle out of charges of unethical conduct (Bersoff, 1994; Keith-Spiegel, 1994; Koocher, 1994). For example, the American Psychological Association (APA) code states, in part, “*Psychologists do not knowingly [emphasis added] engage in behavior that is harassing or demeaning to persons with whom they interact*” (APA: 3.03). Concerns that such loose language allows the uninformed and unaware to escape scrutiny have been echoed. What do you think about this next case?

Case 18-1: Wanto Stare, L.M.H.C., created a circular seating plan in his adolescent therapy group that purposely placed Minny Dresser directly across from his chair. He confided to a colleague that the seating scheme was to position himself to look at an “adorable chick that wears short skirts and doesn’t always pay attention to what her legs are doing.” When advised that such behavior was highly questionable, Stare countered that the colleague had no sense of humor.

Mr. Stare’s attitude is typical of self-serving individuals who rationalize their inappropriate behavior. He clearly lacks insight into how his notion of harmless gratification compromises the level of care and genuineness that should accompany his services, especially regarding the client he objectifies as an “adorable chick.” He also takes advantage of a client to whom he owes a professional responsibility, even though she may remain unaware of his game.

Fisher (2013) pointed out the necessity and value of modifiers in the ethics code. “When feasible,” for example, is not the same as “whenever you feel like it.” “As appropriate” allows for a variety of decisions that take context and other variables into account when making the best decision. Whether acts were “reasonable” and “relevant” allows for competent clinical judgment based on the nature and context of a given situation.

The question has more recently been asked, Are ethics codes too negative and rule-based? “Positive psychology” has exploded in recent years, with its roots in primary prevention objectives and the human potential movement. The

time seemed ripe to consider both “good” and “better” just as medicine embraced the concept of “wellness.” It has been argued that professional ethics should evolve in a similar way (e.g., Handelsman, Knapp, & Gottlieb, 2009). We agree that risk management can be taught and executed positively by encouraging taking pride in learning and practicing with the highest standards of care. But, would an all-positive approach to ethics codes work?

Actually, the APA Ethics Committee acted on the idea of a more positive code almost 40 years ago. In the late 1970s, it seemed like a progressive idea to revise the code by listing how ethical psychologists behave, not what they should avoid doing. The 1977 revision contained only a single negatively worded sentence: “Sexual intimacies with clients are unethical.” (That sentence, in itself, was a breakthrough.) We have a unique perspective on how this “positive code” played out because we were there, one of us as an author.

So, why did the APA go back to including more “shalt nots” in subsequent revisions? It turns out the positive approach was often unworkable for the adjudication function the ethics code must serve. Respondents complained that “the code did not specify that we could *not* do that,” and it was sometimes difficult to argue the point. Confusion ensued because when told what one *does* do does not necessarily mean you cannot do something else. Standards clarifying what to avoid or what is not acceptable are much easier to interpret and enforce.

An Overview of Selected Ethics Codes of Mental Health Professionals

We have cited the ethics code designations relative to specific topics of four mental health professional organizations throughout the book. The underlying themes, issues, and directives among these codes are far more similar than dissimilar, even though the topics are shuffled into different orders and headings and the lengths and amount of detail varies significantly. Also, emphases on individual topics vary from code to code,

usually based on the context and sometimes the primary populations with whom members of each profession work. Some codes are more specific and sometimes appear to be unique. For example, the National Association of Social Workers (NASW) expects its members to avoid derogatory language in their written or verbal communications to or about clients (NASW 1.12). Whereas no other code is as specific, the emphasis on respect for clients presumes that one must not degrade them. Truly unique differences among the codes are less common.

The following material provides a brief description of each of the four codes and how to find more information online.

American Psychological Association's Ethical Principles of Psychologists and Code of Conduct

The most recent major revision of the APA code was adopted in 2002 and amended slightly in 2010. The "Preamble" and "General Principles" lay out aspirations toward which all psychologists should strive. These include respecting people's rights and dignity, doing no harm, acting responsibly and maintaining the trust of those with whom we work, acting with integrity, and being just and fair.

The bulk of the 2010 APA code consists of 10 standards intended to be specific enough to use as compelling rules to govern most decisions that could result in ethics violations should they be ignored.

1. "Resolving Ethical Issues" covers conflicts among ethics and the law and other organizational demands and how to deal with and report ethics violations.
2. "Competence" mandates maintaining skills and practicing within the boundaries of one's developed skills, exceptions for providing services in an emergency situation, responsibilities when delegating work to others, and dealing with one's personal problems.
3. "Human Relations" covers unfair discrimination, sexual and other forms

of harassment, multiple-role relationships and other exploitation, third-party requests for services and services delivered on or through organizations, informed consent, cooperation with other professionals, interruption of psychological services, and avoidance of harm.

4. "Privacy and Confidentiality" includes maintaining and disclosing the limits of confidentiality, recordings, privacy intrusion, disclosures, consultation, and the use of confidential information for didactic purposes.
5. "Advertising and Other Public Statements" presents what to avoid in self-promotions, descriptions of workshops and nondegree educational programs, media presentations, testimonials, and in-person client solicitation.
6. "Recordkeeping and Fees" outlines steps regarding the documentation, maintenance, accuracy, dissemination, withholding of, and disposal of confidential material. It also covers bartering and making referrals.
7. "Education and Training" covers the design of educational and training programs and how to describe them, accuracy in teaching, dealing with student disclosures, assessing students, mandating therapy as a course or program requirement, and admonishments against sexual relationships with current students and supervisees.
8. "Research and Publication" specifies requirements for gaining informed consent to participate in research and conditions for allowing exceptions, reporting results, plagiarism, publication credit, sharing data, and maintaining confidence when evaluating materials submitted for review. Also covered are the use of deception, debriefing, and the humane care and use of animals in experimentation.
9. "Assessment" covers bases, uses, consent, scoring, and interpretation (including by testing services) of assessment techniques, as well as test construction, use

by unqualified persons, test security, and obsolete and outdated tests.

10. "Therapy" standards deal with informed consent, couple and family therapy, group therapy, providing therapy to those served by others, interruption of therapy, and termination. Also covered are admonitions against sexual intimacies, former lovers, relatives and significant others of current therapy clients, and the ground rules for engaging in sexual relationships with former therapy clients.

The APA code contains considerable detail about the conduct of research, including the humane care of animals. Many APA members are educators or social and behavioral scientists who may or may not maintain a clinical practice. Testing and assessment are also given heavy consideration, given that many psychologists develop or use psychometric tools in their practices.

The current ethics code of the APA can be accessed online (<http://www.apa.org/ethics/code/index.aspx>). The APA ethics code is not the sole publication related to ethical matters within the APA, although it is the only enforceable document. A number of guidelines for practitioners provide additional assistance in maintaining high standards of care. Examples include *Guidelines for Prevention Psychology*; *Guidelines for the Practice of Telepsychology*; *Specialty Guidelines for Forensic Psychology*; *Record Keeping Guidelines*; *Guidelines for Psychological Practice With Older Adults*; *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*; and *Guidelines for Psychological Practice With Lesbian, Gay, and Bisexual Clients*. Guidelines are created and updated as deemed necessary, and all are available online (<http://www.apa.org/practice/guidelines/>).

The APA Ethics Office website (<http://www.apa.org/ethics/index.aspx>) offers user-friendly information to guide consumers through the process of filing a complaint, the committee's rules and procedures, and how to receive additional assistance.

American Association for Marriage and Family Therapy Code of Ethics

The American Association for Marriage and Family Therapy (AAMFT) code of 2015 offers a preamble and nine major principles. The preamble reminds members that the ethics code is binding and calls on them to honor the public trust, commit to service and advocacy, follow the highest standards in their practice, and seek consultation as needed. It also lists aspirational core values such as integrity, acceptance of a diverse membership, and the embrace of innovation.

1. "Responsibility to Clients" includes information on nondiscrimination, informed consent to therapy, exploitation, multiple-role relationships, abandonment, reporting the unethical conduct of others, referrals, and responsibility when conducting therapy other than face to face.
2. "Confidentiality" covers disclosure limitations, gaining written authorization before divulging information to others, client access to records, protecting records, and preparing for practice changes.
3. "Professional Competence and Integrity" requires members to maintain competency and develop new skills, to remain aware of regulatory standards, to seek assistance with personal problems, to avoid conflicts of interest and other forms of exploitation, and to exercise care in public statements and reporting of their work. A list of conditions under which members can be sanctioned is provided.
4. "Responsibility to Students and Supervisees" admonishes members to avoid sexual intimacies with students and to maintain students' trust by not exploiting them, to oversee their work and professionalism, and to maintain confidentiality.
5. "Research and Publication" includes the requirement for institutional approval, respecting and protecting research participants, gaining informed consent, allowing the right to decline or withdraw, maintaining confidentiality, seeking expert

professional advice, and publication issues (authorship of students' work, plagiarism, and accuracy).

6. "Technology-Assisted Professional Services" covers competence to deliver services through any electronic means, consent to treat or supervise, confidentiality, documentation, and technology training and use.
7. "Professional Evaluations" covers performance of forensic services, testimony in legal proceedings, competence, avoiding conflicts, and the separation of custody evaluation from therapy.
8. "Financial Arrangements" mandates members to ensure that financial arrangements are disclosed and understood by clients and supervisees and conform to accepted professional practice; to provide truthful representation of services, forbidding offers or acceptance of kickbacks or withholding of records for nonpayment; and to take special care when using payment recovery procedures and when bartering services.
9. "Advertising" of services requires self-promotion that informs the public and accurately represents a member's qualifications and services, seeks to correct any misrepresentation, and warns against advertising a specialization without appropriate training or supervised experience.

The code notes that marriage and family therapists often have an especially daunting task because the client may be more than one person, each with his or her own rights to confidentiality. The AAMFT code is the only one not specifically stating a duty to warn should clients threaten themselves or others. However, most states do have mandatory reporting laws, and the AAMFT code does advise disclosure when mandated by law.

The ethics code of the AAMFT can be accessed online (http://www.aamft.org/iMIS15/AAMFT/Content/legal_ethics/code_of_ethics.aspx). At the bottom of the web page is information on how to press a complaint.

American Counseling Association's Code of Ethics

The American Counseling Association's (ACA's) (2014) code is exceptionally detailed and, like the others, spells out overarching values to guide counselors. These include a dedication to enhancing human development throughout the life span and embracing a cross-cultural approach in support of the dignity and uniqueness of all people. The ACA code is divided into nine sections:

1. "The Counseling Relationship" includes client welfare, records and dissemination, informed consent, avoiding harms, prohibited noncounseling relationships, maintaining boundaries (including in virtual relationships), advocacy, group work, fees and business practices, therapy termination, and referrals.
2. "Confidentiality and Privacy" covers respect for privacy, multicultural and diversity considerations, exceptions and limitations, information shared with others, third-party payers, group work, clients lacking capacity to give informed consent, records and documentation, storage and disposal, and case consultations.
3. "Professional Responsibility" calls for dedication to improving the lives of those with whom counselors work; knowledge of standards, competence and continuing education; self-monitoring for effectiveness; impairment; advertising and public statements; honesty; treatment modalities; and responsibilities to other professionals.
4. "Relationships With Other Professionals" covers relationships with coworkers, interdisciplinary teamwork, employer policies, negative employment conditions, and consultation competency.
5. "Evaluation, Assessment, and Interpretation" includes competency to use assessments, informed consent, data release, diagnoses, multicultural issues, instrument selection and scoring, interpretation, security, and conditions of

- administration. Also included are obsolete data and assessment construction.
6. "Supervision, Training, and Teaching" covers supervisor and counselor-educator competence, supervisory relationships and responsibilities, student and supervisee responsibilities, field placements, multicultural infusion, and evaluations. Student welfare issues include what programs administrators should disclose to prospective students, career advising, multicultural competence, addressing personal concerns, evaluating students, roles and relationships between counseling educators and students, and student/educator boundaries.
 7. "Research and Publication" outlines the rights of research participants, vulnerable populations, record maintenance, boundaries, reporting of results (including the obligation to report unfavorable results), publications and presentations, use of case examples, plagiarism, and authorship credit.
 8. "Distance Counseling, Technology, and Social Media" covers knowledge and legal considerations, informed consent and security, confidentiality, distance professional relationships, records, and web maintenance.
 9. "Resolving Ethical Issues" covers knowing the standards and the law, decision making, suspected violations, consultation, reporting, unwarranted complaints, and conflicts between ethics and the law or organizations.

This lengthy code includes a number of specific topics not detailed in other codes. For example, end-of-life decisions, contagious life-threatening diseases, deceased clients, supervisor emergencies and absences, career counseling, replication studies, and the call to teach ethics are among the ACA principles. Also, as the newest code, the coverage of technology issues is the most comprehensive of the four codes to date.

The ethics code of the ACA can be accessed online (<http://www.counseling.org/docs/ethics/>

[2014-aca-code-of-ethics.pdf?sfvrsn=4](http://www.counseling.org/docs/default-source/ethics/policies-and-procedures-revisions.pdf?sfvrsn=4)). The policies and procedures for processing complaints can also be accessed online (<http://www.counseling.org/docs/default-source/ethics/policies-and-procedures-revisions.pdf?sfvrsn=0>). E-mail can be used to move forward with a complaint (ethics@counseling.org).

National Association of Social Workers Code of Ethics

The NASW (2008) code preamble promotes the enhancement of human well-being. It also offers several broad ethical principles to which social workers should aspire. These include service, social justice, dignity and the worth of persons, the importance of human relationships, integrity, and competence.

The NASW code consists of expectations of social workers in the following six areas:

1. "Ethical Responsibilities to Clients" details commitments to clients (including their rights to self-determination and informed consent), competence (including cultural competence), conflicts of interest, privacy and confidentiality, access to records, sexual relationships and other physical contact, payment for services, and interruption and termination of services.
2. "Ethical Responsibilities to Colleagues" covers respect, interdisciplinary collaboration, consultation, collegial disputes, referrals, sexual relationships with students in training and colleagues, harassment, and dealing with incompetent and unethical colleagues.
3. "Ethical Responsibilities in Practice Settings" details supervision and consultation, education and training, performance evaluation, client records and transfer, billing, continuing education, commitments to employers, and labor-management disputes.
4. "Ethical Responsibilities as Professionals" includes competence, discrimination, private conduct, dishonesty and deception, impairment, misrepresentation, client solicitation, and assigning credit to others.

5. “Ethical Responsibilities to the Social Work Profession” involves promoting integrity and ethical issues in evaluation research.
6. “Ethical Responsibilities to the Broader Society” expects members to be involved with activities that improve social conditions, uphold human rights, and promote social justice.

The NASW code emphasizes social activism and social justice. It offers more detailed proscriptions regarding privacy and confidentiality and collegial relationships compared to the other codes.

The NASW ethics code as well as the complaint process and the rules and procedures for processing complaints can be accessed online (<http://www.socialworkers.org/pubs/code/default.asp>).

ENFORCEMENT OPTIONS

Although this chapter focuses on the ethics codes and committees of professional associations empowered to investigate and adjudicate complaints, other formal mechanisms have been established by law to protect the public from unlawful, incompetent, and unethical actions perpetrated by mental health providers. These include the following:

1. Criminal law applicable to all citizens, including members of any profession.
2. Profession-specific legal controls that emanate from state laws via licensing boards.
3. Civil litigation to process claims of malpractice or other professional liability.
4. Federal and state laws and regulations, such as policies issued on the protection of human participants in social and behavioral science research, confidentiality of records, civil rights violations, or prescribing medication.
5. Professional review committees to handle misunderstandings or complaints involving third-party payers, institutions, or employers. Professional review

committees are rarely used now. (See Chapter 13 for detailed information about malpractice claims, responses, and prevention.)

The existence of several venues set up to protect the public from unethical practitioners has both advantages and drawbacks. The primary asset is that each has its own mission and focus, which in the best case scenario allows an incident to have the most-fitting forum for a hearing and resolution. For example, if a therapist extorts money from a client, adjudication by criminal law would probably result in the most appropriate outcome. When a therapist poses a hazard to the public, licensing boards may constitute the most suitable contact because they have the power to revoke a license to practice.

Despite these other resources, it is fairly easy to generate a list of reprehensible, objectionable, and blatantly unethical acts that are neither illegal nor in violation of any policy *except* the ethics codes of professional organizations. In such cases, ethics committees may be the sole source of consumer redress, assuming that the alleged violator is a member of the organization. (Membership in these organizations is voluntary, and as we expand on, professional organizations have no jurisdiction over nonmembers.)

Sometimes, more than one enforcement option may apply to any given incident. For example, an ethics committee of a professional association would likely take action following a criminal conviction. In fact, it is theoretically possible for a single case to ultimately play out in every venue noted. Herein lies a significant drawback associated with the existence of many avenues of consumer redress. Efforts may be duplicated, resulting in unnecessary expense and confusion. None of these arenas is known for its swiftness in responding to, investigating, and deciding cases. It can take several months to years to resolve complaints, much to the consternation of *complainants* (the individuals making the complaint) as well as the *respondents* (those against whom the compliant is lodged).

Finally, enforcement operations can become an expensive line item in an organization's budget. The APA maintains a full-time ethics director and associate director (both of whom hold Ph.D. and J.D. degrees), and a small support staff. The office consults regularly with legal counsel, creates educational materials, offers workshops, manages considerable correspondence and other paperwork, and works with the ethics committee and various consultants during deliberations and appeals. Despite the conduct of as much business as possible by mail, in 2014 the APA spent around \$850,000 (not counting staff fringe benefits) to administer its adjudication, education, and consultation programs.

The Relationship Between Law and Ethics

General criminal and civil law do not adequately protect consumers from unethical acts by mental health professionals. Some aspects of moral behavior are external to law despite the apparent overlap. Morals and laws usually have similar purposes, which is to specify conduct that facilitates harmonious living and respect for each other's rights, property, and physical safety and to preclude anarchy. But, some laws have been criticized and even overturned because they were deemed immoral and unjust. We do not have to look far back in history to laws during the Spanish inquisition allowing for the torture and killing of those with dissident religious beliefs; the Nuremberg laws in Nazi Germany requiring Jews to give themselves over to concentration camps and likely deaths; the internment laws in the United States during World War II requiring persons of Japanese descent to give up their property and be confined to camps for the duration of the war; and segregationist laws forcing blacks to use different facilities (Pollock, 2004). Some of the same themes play out today, such as rationalizing a lawful purpose for "enhanced interrogations."

Some conduct specified as unethical in professional ethics codes can also qualify as civilly or criminally actionable. Mental health

professionals can also lose their license to practice and face expulsion from their professional associations as a result of being found guilty of a felony. However, a great many matters of morality and ethics cannot be enforced by laws. We cannot, for example, legally force people to be thoughtful and kind to each other. The result is that the correspondence between "legal" and "ethical" as well as between "illegal" and "unethical" can be complicated and sometimes incongruent.

Conviction on a misdemeanor will not usually be handled in the same manner by ethics committees unless the offense also involved the violation of an ethical principle while acting in a professional role. Thus, a therapist fined for unpaid parking tickets, nude sunbathing, or trespassing at an antiwar demonstration would likely not be deemed professionally unethical even though the behavior carries legal sanctions. Differences among state legal statutes allow discrepancies in these cases.

The more striking disparity between ethics and the law can be found in the many instances of fully legal behavior (or, perhaps stated more correctly, conduct that ordinarily would not be in violation of any criminal or civil law) that are unethical according to the profession's ethics code. Consider this case:

Case 18-2: Sadie Smile, Ph.D., struggled with her own downturns in life. She and her only surviving parent were estranged, a recent divorce left her bitter, and she was drinking too much at night. She became short-tempered with her clients and often mixed up their case narratives from one week to the next.

Dr. Smile is not breaking any law; she also demonstrates a lack of competence for expected standards of care. We may sympathize with her personal troubles, but ethical standards cannot ignore mistreating clients. Should one of them complain, an ethics committee may show some lenience if she has caused no lasting harm, has no previous violations, and can prove she is committed to taking concrete steps to solve her problems. Many types of poor professional

judgments falling short of seriously harming clients would fall into this category.

Finally, mental health professionals may occasionally find themselves placed in a most challenging dilemma. They might believe it is in a client's best interest to resist responding to a legal reporting mandate or to openly defy some law they view as irrelevant or harmful to a client's particular situation. For example, a therapist may choose not to report child or elder abuse in the sincere belief that continued psychotherapy will better serve the family than would engaging legal authorities or public agencies. Reporting information about clients as required by state or government institutional regulations may be viewed by some therapists as violating their clients' rights to privacy. Legislators and other policy makers often react to social problems by mandating the engagement of clinicians in ways that sometimes require impossible skills, such as accuracy in predicting suicide or violence against others. It is not surprising that the behavior of scrupulously ethical psychologists is not always consistent with the law.

Defying the law can also be a matter of personal conscience. This dilemma is illustrated in the next case.

Case 18–3: After many attempts at negotiation, a group of therapists agreed to participate in a sit-in in the administrative offices of Bozo Managed Care, Incorporated. The therapists contended that the company misled patients and encouraged incompetent treatment. The management at Bozo allegedly told the therapists earlier that if they continued criticizing the organization they would all face termination as providers. Those who participated in the sit-in felt so strongly about their concerns that they were willing to lose their provider status despite the fact that Bozo threatened to call the police and have them all arrested for trespassing. The therapists stayed put, and the police came. The therapists were arrested when they refused to leave.

We are neither encouraging nor dissuading colleagues from acting according to their conscience or engaging in nonviolent civil

disobedience. This takes courage, commitment, and an understanding and acceptance of possible consequences. (See discussion in Chapter 11 for “whistle-blowing” and considerations for decision making whenever these soul-searching matters arise).

Licensing Boards

State licensing laws establish practitioners' scope of practice and the regulations detailing licensing board enforcement procedures. As presented in Chapter 2, licensing boards evaluate the entry-level qualifications required to offer professional services to the public under protected titles, such as “psychologist,” “physician/psychiatrist,” or “marriage and family therapist.” The relevance to the ethical principles of a professional organization is that well-functioning licensing boards stand in a position to help ensure competence through the setting of regulatory standards. State licensing boards are also charged with monitoring the conduct of the professionals they have already licensed. In general, state boards adopt some or all provisions of the profession's ethics code. This means that the same misconduct may qualify for sanctioning at both the statutory state and professional organizational levels, although reasons specified for denial, revocation, or suspension of licensure can vary significantly among the states.

Most state licensing boards are comprised of licensed members of the profession and public members appointed by the governor or other executive branch official. In some states, each profession has its own board, while in others many professions may be clustered under an omnibus-style board.

Licensing regulation is not always effective. Inconsistencies across jurisdictions cause confusion (DeMers & Schaffer, 2012; Johnson, Porter, Campbell, & Kupko, 2005). Some boards have come under attack for abuse of power, failure to provide due process for the accused, unfair or improper investigative procedures, and presuming guilt (Coale, 1998; Peterson, 2001; Shapiro, Walker, Manosevitz,

Peterson, & Williams, 2008; Williams, 2001). Complaints about state licensing boards can sometimes be little more than self-righteous whining, but cases of well-documented abuses are on record. Consider the following examples:

Case 18–4: A licensing board of Largely Rural State relied on a system that involved deputizing local psychologists to conduct investigations of cases far from the board's headquarters. In one situation, the ex-wife of a client treated by Ima Sucker, Psy.D., complained that the individual psychotherapy her former husband had received led to their divorce. The woman was never Dr. Sucker's client, and her ex-husband never signed a release of information to the licensing board. Nonetheless, the board asked a local psychologist to investigate. Not knowing any better, the local psychologist contacted Dr. Sucker. In an effort to cooperate fully, Dr. Sucker gave information without asking for a release from the former husband.

Case 18–5: Mary Tripped-Up, Ph.D., was asked to undertake a child sexual abuse evaluation by a woman who was seeking a divorce because of domestic violence. Dr. Tripped-Up evaluated the child and found no signs of abuse. Nonetheless, she was subpoenaed to court by both parties in the divorce. In an informal meeting with both parties and their lawyers outside court, she was asked for "informal advice" on a child custody settlement. She made a variety of properly qualified recommendations, which were readily accepted by all concerned, and a court hearing was avoided. Months later, however, the settlement agreement broke down, and the father filed a licensing board complaint. The board, in a hurry to resolve cases, did not do a careful investigation and offered Dr. Tripped-Up a consent decree by which, if she admitted giving improper advice, they would simply issue a reprimand. Tripped-Up's lawyer, who was unfamiliar with the issues and potential consequences, urged her to take the offer without seeking any expert advice. She accepted and was promptly sued by the father, who cited the consent agreement as evidence.

Dr. Sucker's case soon became a major embarrassment for the licensing board when it realized that it had unintentionally led Dr. Sucker to breach the man's confidence. Dr. Tripped-Up was dropped from two managed care panels because of disciplinary sanctions by the board. Ironically, she had done nothing wrong except to obtain and accept poor legal advice.

The quality of licensing exams and statutes have also been called into question (e.g., Herbsled, Sales, & Overcast, 1985; Koocher, 1979, 1989). It is unreasonable to expect that licensing boards will credential *only* those who are competent and morally fit. The boards are established primarily to vet candidates against the minimum acceptable threshold of competence and to address complaints. The rules for minimum qualifications are often defined in legislation that boards must follow, and not every incompetent or unsavory practitioner is reported or is the subject of complaints. Because state licensing credentials vary in educational and experiential requirements across profession and state lines, mobility across state lines for psychologists, social workers, and counselors can prove difficult or unrealistic. Herman and Sharer (2013) provided a history of attempts to create national standards for psychologists, but attempts to date have not proven successful. Medicine and nursing have fared better as professions in promoting interstate mobility, and federal policy makers have stated that enhancing practice mobility is a priority. As was discussed in Chapter 4, this will become increasingly important as access to mental health services via telemetry becomes more prevalent.

Unlike ethics committees, licensing boards can prevent an unscrupulous and harmful individual from operating with a protected title in the state in which the individual is licensed. Some also levy fines. This is tremendous power when one realizes that even successful criminal or civil litigation may not prevent a mental health professional from continuing to practice. In balance, the public is well served when a licensing body functions effectively and focuses on its primary role of

protecting the public from unqualified and unethical practitioners.

For U.S. and Canadian psychologists, the most frequent causes among the 4,397 disciplinary actions during 1983–2009 were (in descending order of frequency) sexual misconduct, unprofessional conduct, nonsexual dual relationships, negligence, conviction of a crime, failure to maintain adequate or accurate records, and inadequate or improper supervision or delegation (Pope & Vasquez, 2011). It has been estimated that as many as 11% of psychologists will have to respond to a licensing board complaint during the course of their careers (Schoenfeld, Hatch, & Gonzales, 2001), and licensing board complaints have become far more frequent than civil lawsuits. However, a good number of complaints, perhaps as high as 50%, are found to be groundless (Van Horn, 2004).

Ethics Committees

Ethics committees consist primarily of members of the profession—typically experienced and well regarded for their sensitivity to ethical matters—elected or appointed by the governing body of the professional association. Some committees include public members. Committee members serve without pay and, at the state and local levels, often without reimbursement for expenses. Serving on an ethics committee is not an easy duty. The dilemmas committee members face are often extremely difficult because the issues are intricate, the parties to the action are distressed, and the facts of the case are not always clear. The time commitment can be extensive, and the experience itself is often both intense and exhausting.

Ethics committees are able to investigate violations at all levels of seriousness, whereas state regulatory boards rarely have sufficient resources or even the inclination to investigate behaviors that may be offensive to professional sensibilities and clearly cross the line but are not likely harmful to the public. For example, a dispute over a publication credit will not likely trigger the interest of an overburdened licensing board staff. It is in such contexts that the

ethics committees of professional associations can play a critical role in filling that gap.

Many organizations subscribing to an ethics code—especially smaller organizations and state-level chapters—no longer adjudicate complaints. Instead, these organizations perform primarily educative and consulting functions and refer aggrieved consumers to the national associations or state licensing boards. Some may view ethics codes with no mechanism to back them up as mere window dressing, toothless, or possibly even misleading. However, they do set aspirations and expectations for members, establishing a standard of care for proper conduct. Some state and smaller associations offer consultation and hotlines when a member is facing a dilemma. Some screen applicants for evidence of unethical behavior prior to acceptance.

There are understandable reasons why most state professional associations no longer investigate and adjudicate complaints. Objectivity requires lack of familiarity with respondents and complainants; this was difficult to ensure at the state level, requiring committee members to often recuse themselves (Grenier & Golub, 2009). As complaints became more diverse and complex and as the potential for easy public access to guilty findings increased dramatically, the conclusions reached by ethics committees were more frequently appealed or challenged. Whereas ethics committees were originally intended to serve as the hallmark of a profession—namely, fulfilling an autonomous, monitoring function—accused mental health professionals today more often view the process as adversarial rather than collegial. Legal assistance, outside consultants, liability risk, and associated clerical and duplicating services quickly drain the already-modest budgets of most state and smaller organizations.

Some professional associations drop members who have been adjudicated for serious infractions by another legitimate authority. For example, the APA notifies other professional associations, licensing boards, and its members when it expels a member or when one resigns while under ethical scrutiny. If a complaint is received about a member who has been convicted of a felony (or

equivalent criminal act) or found by a court of competent authority to have committed malpractice, has lost a license, and a few other findings of ethical failings as adjudicated by another body, committees may accept such information as *prima facie* evidence and take action. Thus, the burden of ethics monitoring currently falls largely on national professional organizations, licensing boards, and the courts.

Although ethics committees of professional associations seem uniquely able to pick up some of the slack that other levels of control may be unwilling or unable to handle, whether they always exert a constructive and efficient means of peer control and public protection has also been called into question. Specific criticisms include bias among committee members; lack of training and experience of members to function adequately in a quasi-judicial capacity; conflicts of interest; excessive time taken to adjudicate cases, resulting in possible harm to the public in the interim; insufficient investigatory and other resources to do the job properly; failure to follow due process; timid procedures from fear of lawsuits; reactive rather than proactive procedures; and a bias favoring guild interests and due process rights of respondents over the welfare of the complainants or (conversely) the tendency to take the complainants' sides while depriving the respondents of due process and an unbiased tribunal.

Frustrated complainants can always contact lawyers or the media when sources of redress are inefficient or reach unwelcome conclusions.

Case 18–6: Antsy Grandee became impatient with the lengthy delay and interminable paperwork involved in submitting a complaint. She had suspicious notes handwritten by her therapist and took her evidence to the local newspaper. The paper carried a story that attracted the interest of the local television station. A camera crew showed up, unannounced, at the therapist's home. He yelled at them, charging harassment because he had not yet had an opportunity to defend himself. The story ran on the 6 o'clock news.

As a result of the media coverage, the therapist's practice and reputation diminished considerably, and the complainant, whose fragile private life was also exposed, felt humiliated. Two of the charges against this therapist—both involving poor judgment in treating this particular client—were eventually sustained, but we can only speculate whether both the therapist and the complainant would have been better served had the complaint been processed more expeditiously.

Despite the criticisms, we maintain a positive view of the status and importance of ethics committees. Having to respond to a complaint can have a salutary effect by encouraging the complainant to be more careful in the future. And, although respondents may not always appreciate it, there are advantages to well-functioning ethics committees that take care to protect the rights of the accused as well as the accuser. Should professional association ethics committees undergo significant downshifting or go out of business altogether, the onus of monitoring would fall entirely on licensing boards, malpractice litigation, and civil courts.

One might ask the question, Besides inconvenience and emotional distress, does a guilty finding by an ethics committee have any real impact on the violator? After all, as we describe further in the chapter, the penalties do not always involve expulsion or public exposure. Nevertheless, one's livelihood is jeopardized (Grenier & Golub, 2009). Malpractice insurance renewals, insurance provider panel applications, license renewal forms, and hospital staff membership applications all ask whether any disciplinary actions have been sustained against the applicant in the past. Thus, even a reprimand would have to be reported and explained, with an attendant risk of nonrenewal or exclusion. In addition, professional job applications may require disclosure of any discipline for professional misconduct, which means job offers may not be forthcoming, even when sustained infractions were minor. (See Chapter 13 for more about malpractice.)

COMPLAINTS TO ETHICS COMMITTEES

As psychologists who served for many years on ethics committees, we have arrived at some solid impressions about the characteristics of people who press complaints. A majority of complaints come from persons who are (or were) psychotherapy clients or family members of psychotherapy clients and who were unhappy with the conduct, therapy techniques, competence, or payment policies of their psychotherapists. Therapists' professional involvement in child custody cases or as participants in other litigation work is an especially high-risk area of practice. Most other complaints come from other psychologists or closely allied professionals concerned about a colleague's conduct, students, supervisees, coworkers, and other private citizens dissatisfied with nontherapeutic services, such as teaching methods and performance evaluations, supervision, business consultations, or research procedures. Every code spells out in different levels of detail of the professionals' responsibility when interacting with their ethics committee (APA: 1.05, 1.06, 1.08; AAMFT, 3.12: Preamble; ACA: I.2; NASW: I.11).

The majority of complainants have had direct, personal interactions with the psychologists against whom they are charging ethical misconduct. However, a minority of the cases are complaints about persons the complainants do not know personally. In such instances, the complainants are usually other mental health professionals. For example, therapists may mail in newspaper accounts of misconduct or lawbreaking by other therapists and suggest that the ethics committee undertake an investigation if they have not already done so. Most cases involving plagiarism are discovered by other academics or by students in the course of their literature searches. Sometimes, therapists will assist in pressing charges against a client's previous therapist, teacher, or employer.

People who complain to ethics committees appear to share several common characteristics. They tend to be knowledgeable about redress procedures, capable of describing the situation

as they see it, and sufficiently motivated to sustain themselves through the various, and sometimes arduous, stages of the ethics inquiry process. Ethics committees, then, tend to hear from complainants who are resourceful, articulate, and persevering. They may well comprise a highly selective group. Consumers who may have legitimate grievances against their therapists but who are frightened, debilitated by hurt, unassertive, unresourceful, inarticulate, overwhelmed, or lack knowledge about how to pursue a grievance may never come to the attention of ethics committees or any other redress mechanism unless a supportive individual is available to assist them.

We note, as an aside, that we know of instances when ethics complaints were considered but never pressed (or ultimately withdrawn) because the therapist apologized to the client. In some cases, that was always the only outcome the client wanted. Sometimes, a misunderstanding was uncovered and resolved. Apologies can avert lawsuits (Robbennolt, 2003). Of course, an apology is usually tantamount to an admission of responsibility, so we are not making a blanket recommendation. However, we have all experienced the healing power of the words "I'm really sorry" and the long-term, disturbing effects of an anticipated apology that never comes.

We are questioned about the prevalence of complaints from people who are deeply troubled or delusional, often assuming the rate to be quite high. After all, people who consult therapists typically have emotional issues. In fact, few complainants could be characterized, solely on the basis of their correspondence, as seriously impaired. When committees receive complaints such as the ones illustrated next, the most common recourse is to ask for more specific details and evidence or to contact the respondents for their impressions of what took place.

Case 18-7: A woman complained that her social worker had claimed the souls of her cat, two dogs, and the canary.

Case 18-8: A retired military officer charged two Veterans Affairs psychologists with attempting

to brainwash him into killing small boys, overthrowing the Saudi royal family, and bombing Los Angeles.

Case 18–9: An office worker wrote a long and rambling letter charging her therapist with following her everywhere she went, tapping into her home telephone, stealing small items from her apartment, and hiring someone to drive by her apartment on a noisy motorcycle at all hours of the day and night.

Ethics committees would not typically dismiss such complaints without further exploration. At the very least, an attempt is made to ensure that the therapists did their utmost to protect the welfare of these clients.

Ethics committees can take on cases *sua sponte*. That is, based on information in the public domain (e.g., newspaper articles, local television news stories, service advertisements, or court records), the committee may initiate the investigation on its own.

Case 18–10: A large envelope was sent to an ethics office with no identifying information about the sender. The contents consisted of a 1995 monograph describing the results of a survey on teenage runaways and a copy of a 2006 doctoral dissertation, authored by someone else, containing the same data and most of the text as it appeared in the earlier published paper.

Although ethics committees do not normally pursue anonymous complaints, this case became an exception because the evidence was publicly available. The committee sustained a plagiarism violation.

Case 18–11: Five students reported that a counselor at the local mental health center committed sexual misconduct, and the matter went to trial. The evening news carried a story about the guilty verdict. Another therapist who viewed the news report informed an ethics committee of the incident.

The viewer did not have to put herself in the position of being an identified complainant.

The story was in the public domain, allowing the ethics committee to make its own inquiry if it chose to do so.

The Perils of Being a Complainant

Taking the time and effort to bring legitimate complaints against mental health practitioners who have behaved unethically helps the mental health professions keep their houses clean. The Internet makes it easy to learn about an organization's ethics operations. However, there are requirements—many related to maintaining due process for the respondent—by which complainants must abide.

A few uncomfortable features accompany the pressing of complaints, aside from the alleged incident itself. Complainants must be willing to have their identities and the nature of their complaint shared with the accused. They must also sign a waiver allowing the respondent to share information relevant to the case. Given that this material was usually shared in confidence (i.e., therapy notes, diagnoses, or psychological assessment records), it will now be viewed by complete strangers (i.e., ethics committee members and maybe the associations' boards). Complainants may feel distressed because earlier disclosures to their therapists might now be used as a defense. Unfortunately, at this point some sincere complainants may decide that they are unwilling to endure the process. Those who persist have agreed to have their identities known to the respondent and relevant matters about themselves shared with the committee from the perspective of the respondent.

Case 18–12: On receiving an inquiry letter from an ethics committee, Sanford Assail, Ph.D., responded, "This woman is the poster child for bipolar disorder. You can't believe anything she says."

Ethics committee members will not dismiss a complaint simply because a respondent questions the complainant's credibility. They respect the vulnerability of complainants and will look further into the matter before making any decision. Dr. Assail also made an exceptionally poor

impression on the committee with his offhanded and disrespectful characterization of his client.

Sometimes, the respondent does not offer a defense and agrees that the ethical violation occurred as the complainant described it, making it straightforward for the committee to proceed. Occasionally, in an attempt to create a defense, the respondent will, unwittingly, offer additional incriminating data.

Case 18–13: Footin Mouth, Psy.D., told an ethics committee that the reason she sat in her client's lap and allowed him to stroke her hair during their therapy sessions was because the client insisted on it. She wrote, "I pride myself in responding to the needs of all of my clients, whatever those needs might be."

Complainants may be asked for additional information as the committee assembles relevant materials. Then, they wait. Cases can take months to adjudicate. This may be distressing to the complainant (and the respondent as well) because the act of pressing a charge, as well as being on the receiving end of one, sets up a persistent, uncomfortable anticipation while awaiting resolution. When the investigation is complete and the decision has been reached, the complainant will be informed. Feedback is likely to be scanty compared to the detail most complainants would like to know, but they should take some measure of satisfaction helping a profession help itself.

Do consumers ever issue fabricated or distorted complaints? Cases of disgruntled clients who found fault with the services received, became angry or vengeful for some reason unrelated to an ethics violation, or did not want to pay an outstanding bill do occasionally occur. Unraveling the veracity of a complaint may be impossible (Hedges, 2006). Many of these may be winnowed out by reviewing the therapists' notes, schedules, and other evidence; however, some groundless but credible-sounding complaints are more difficult to defend (Williams, 2001).

Countercharges

When the complainant is also a mental health professional, occasionally the respondent files a

countercomplaint. Sometimes, both appear to have legitimate grievances against each other. The APA Ethics Committee attempts to ascertain what led to the first complaint but will not normally act on the second complaint until the first one is resolved. However, with a two-thirds vote of the ethics committee, simultaneous charges can be reviewed.

Countercharges can also serve no purpose other than to harass the person making the original complaint, a ploy that ethics committees do not condone as they waste time and dishonor the purpose of their mission (APA: 1.07; ACA: I.2.e).

Case 18–14: Terry Pushy, Psy.D., complained to an ethics committee that Hunker Downe, Ph.D., had refused, after three requests, to supply information about an ex-client who Pushy was currently seeing. Downe issued a countercomplaint, insisting that that Dr. Pushy was rude and therefore "an unworthy recipient of a professional courtesy."

Dr. Downe should have released the information, as a matter of client welfare, shortly after receiving the initial request and release form signed by the client. Even if Dr. Pushy's manner was rude (which might be understandable after multiple requests for information), that does not absolve Dr. Downe from failing to fulfill a professional responsibility. Downe's countercomplaint appears to be an attempt to evade responsibility and shift blame on to Pushy.

The Perils of Being a Respondent and How to Respond If Charged

On receiving the letter from an ethics committee (or licensing board), some respondents express outrage that anyone would dare question their judgment or their method of practice. Anger toward the source of the complaints is common, especially when respondents feel their actions were misrepresented or unfair. Others see a charge as a game of wits and attempt to outmaneuver the committee, perhaps with the aid of an attorney.

Sometimes, respondents refuse to interact with the committee at all, although they may come around on learning that failure to respond is, in itself, an ethics violation (made explicit in APA: 1.06 and ACA: I.3). Many are able to retain a dignified approach to the charge but cannot escape underlying anxiety. Some respondents are so distressed and exhausted that they jeopardize their own health and well-being.

Mental health professionals who are charged with an ethical infraction must keep foremost in mind that “beating the system” is *not* the appropriate goal. Those who join professional mental health associations have agreed—voluntarily and with informed consent—to obligate themselves to formal peer monitoring. All of us, as well as the public, receive advantages from this system. Were all ethics committees to be discontinued, the professions would be at the mercy of outside controls, and clients would be put into the way of additional harm.

So, what should one do if someone issues a complaint that an ethics committee (or a licensing board) will pursue against you? First and foremost, avoid doing anything impulsive. Knee-jerk actions are far more likely than not to be counterproductive. The first steps you take are the most critical (Mascari & Webber, 2006). Judges confide that the demeanor and presentation of defendants in malpractice cases makes all the difference, and careful preparation and a cool head are the keys (Gallegos, 2014). It is important to minimize the impact on one’s defense through self-defeating behaviors (Thomas, 2005).

The state licensing board complaint review process is somewhat different across states and from ethics committees, and detail is beyond the scope of this book. For example, a complaint may have been pressed against you but found groundless by the board, and you may never know about it.

It is wise to review carefully available resources to guide you through the process (e.g., Bricklin, Bennett, & Carroll, 2003; Koocher & Keith-Spiegel, 2013; Shapiro et al., 2008; Woody, 2013; Zur, n.d.). Here are some

general tips. (See Chapter 13 for similar but not identical steps to take if you are sued.)

1. Know who you are dealing with and understand the nature of the complaint and the potential consequences before responding.
 - a. Are you dealing with a statutory licensing authority or a professional association?
 - b. Are you dealing with nonclinician investigators or professional colleagues?
 - c. Is the contact an informal inquiry or a formal charge? (Sometimes licensing boards and ethics committees approach less serious allegations by asking the therapist to respond before they decide to make formal charges. In such instances, however, “informal” does not mean the same as “casual.” Rather, such inquiries may be a sign that the panel has not yet concluded that the alleged conduct was serious enough to warrant drastic action or meets their definition for issuing a formal charge. The correct response should be thoughtful and cautious.)
 - d. Do you have a detailed and comprehensible rendition of the complaint made against you, including a list of the specific alleged infractions or sections of the code or law that were allegedly violated by you?
 - e. Have you been provided with copies of the rules, procedures, or policies under which the panel operates?
2. Do not contact the complainant directly or indirectly, even if you want to try to work it through or are considering making an apology. The matter is no longer subject to informal resolution. Any contact initiated by you may be viewed as coercion or harassment.
3. If appropriate, confide in a colleague who will be emotionally supportive through the process. We strongly advise, however, that you refrain from discussing

the charges against you with lots of other people as this can backfire if you are later sued and the colleague you spoke to is subpoenaed. Spreading your story, even spinning it in your own defense, will likely produce an adverse impact as more and more individuals become aware of your situation and indiscriminately pass the story on, perhaps embellishing it as it spreads. Additional problems regarding confidentiality may also be raised. In no instance should you identify the complainant to others, aside from the board making the inquiry.

4. If the complainant is a client, be sure that the authorities have obtained and provided you with a signed waiver authorizing you to disclose confidential information *before* responding to the charges. We know of instances of licensing boards asking recipients of complaints to obtain consent from their own clients. Such requests are inappropriate because they put mental health professionals in the uncomfortable and awkward double bind of asking complainants to surrender their confidentiality to serve the needs of those charged with misconduct.
5. Assess the credibility of the charge. Compile and organize your records and the relevant chronology of events. (This is when you will be grateful that you kept careful notes.) Respectfully respond fully to the committee's questions within the allotted time frame. Limit the scope of your response to the content areas and issues that directly relate to the complaint. It is not uncommon for a respondent to dig a deeper hole by including material that suggests culpability. If you need more time, ask for it. Be sure to retain copies of everything you send.
6. Do not take the position that the best defense is a thundering offense. This will polarize the proceedings and lower the chances for a collegial solution.
7. The professional staff of the organization may be available to answer questions about procedure.
8. If you believe you have been wrongly charged, state your case clearly and provide any appropriate documentation.
9. If the complaint accurately represents the events but does not correctly interpret them, provide your account with as much documentation as you can.
10. If you have committed the offense, document the events and start appropriate remediation actions immediately. Present any mitigating circumstances and any corrective steps you have already taken, such as seeking supervision to deal with areas of professional weakness or entering into a psychotherapy relationship to explore relevant issues.
11. Be patient. It is likely that you will have to wait for what will seem like a long while before the matter is resolved.
12. Take active, constructive steps to minimize your own anxiety and stress levels. If this matter is interfering with your ability to function professionally, you might benefit from a counseling relationship in a privileged context.
13. Consultation with a lawyer is advised if the matter involves an alleged legal offense, if the ethics committee is not following the rules and procedures you consented to follow by virtue of your membership in the organization, or if the action might lead to disciplinary action that will be made public. However, except for expulsion hearings or formal license revocation, respondents are typically expected to respond personally to the inquiry. A letter from an attorney is not sufficient and will probably also be regarded as inappropriate. If a charge is sustained and you are asked to accept disciplinary measures without a formal hearing, then you may want to consider reviewing the potential consequences of the measures with an attorney before making your decision.
14. If offered a settlement, "consent decree," or any resolution short of a full dismissal of the case against you, obtain additional legal or professional consultation.
15. Know your rights of appeal.

Being found guilty of an infraction can feel devastating. Isolation resulting from shame stunts the healing process. One is unsure about who to confide in, who will be supportive, and who will turn away. A case study by Warren and Douglas (2012) offered a glimpse into stigma attached to being found culpable. This painful passage is taken from a diary of the recipient of an adverse licensing board decision:

The day the letter came from the licensing board was not unlike the day I received the call of my father's death. Something permanently ended, the pain visceral, deep, unrelenting, and the regret of not doing things differently is unforgiving. Not only is the pain unending, the fears are immobilizing. What will others think of me? Will I lose my job? ... I wish there was a cave of solitude and safety I could escape to ... I do not want to be seen. (Warren & Douglas, p. 137)

We do strongly advise against attempting any mischief by manipulating records or people. The truth has a way of getting out, as illustrated by this somber case.

Case 18–15: Addiction researcher and psychologist William Fals-Stewart at the University of Buffalo hired three actors to falsely defend him against charges of fabricating data. On the basis of the witnesses' testimony, he was found not guilty of scientific misconduct. Fals-Stewart then sued the university for \$4 million for damaging his reputation. Subsequently, evidence came to light that the witness testimony was scripted by Fals-Stewart. He was charged with attempted grand larceny, perjury, and identity theft (Marshall, 2010).

Fals-Stewart was found dead in his home shortly after the second charge.

PROCEDURES, DISPOSITIONS, AND LEVELS OF SANCTIONS

Each association has its own methods of handling complaints and reviewing them, but their purposes are similar. They aspire to educate their members (including those who have been

charged with ethical misconduct), assessing the validity of complaints by attempting to uncover the nature of the events leading up to them, using their ethics code as the guide for deciding whether the complaints fall within their purview, and deciding whether the members were at fault and, if so, exacting appropriate corrections and penalties. We use the procedures of the APA to briefly illustrate how ethics committees work from the inside.

The ethics committee members of 30 or so years ago would likely be stunned by how detailed and legalistic the complaint and decision process has become. This complicated, extensive document requires careful scrutiny in its own right to fully appreciate the ethics committee procedures. (Access to the complete APA Rules and Procedures, October 2001, is available online.)

When a complaint of alleged unethical conduct is received by the APA, it is evaluated to determine its appropriateness before being handed over to the full committee. Some complaints are dismissed for reasons presented at the end of the chapter. APA membership can also be voided if it was obtained by false or fraudulent means. For example, if an individual listed an academic degree that was unearned, that individual will simply be dropped.

An alternative provision was instituted in 2001. The APA allows respondents to resign from the association before opening a case to investigate them, and as of 2014, about one in five choose to do so (APA Ethics Office, personal communication, October 17, 2014). Before 2001, the accused could not escape the ethics committee's review by resigning or by not paying association dues. The new provision, however, is not exactly a clean getaway. The formal record will read, "Resigned while under ethics investigation," and such information will be reported to the complainant, the full APA membership, and anyone else who requests the information. Such a designation becomes publicly available and is probably perceived by others—correctly or not—as admitting guilt, leaving the nature of the violation up to every individual's imagination. Otherwise, one would assume the accused psychologists would have

stuck out the process and defended themselves. Although this provision has substantially reduced the previously escalating cost of running the APA Ethics Office, complainants may not be at all happy on learning that the individual about whom they complained will not be held directly accountable.

If a case is opened, the respondent receives a charge letter, and a formal mechanism is set into motion. Here, we briefly describe and illustrate the various dispositions available to the APA Ethics Committee.

Dismissal of Charges: No Violation

When no evidence of wrongdoing is uncovered, the respondent and complainant are so informed, and the case is closed. In such instances, the complainant often misunderstood the psychologist's conduct or did not understand the psychologist's responsibilities in certain difficult situations. At other times, the psychologist's conduct (and often that of the complainant as well) could hardly be characterized as exemplary but was judged to be within the tolerable expression of emotion or behavior given the situational context. Three cases illustrate appropriate dismissal of charges.

Case 18–16: Mazy Pickle complained that she was tricked into committing herself to expensive psychotherapy through a bait-and-switch technique. She claimed that she was seeing a therapist at no charge because her company agreed to pay for her sessions. But, during the 10th session the therapist announced that the fee would now be \$50 per session. Mazy suspected that he was collecting from both the company and from her and contacted the ethics committee.

The therapist explained, and the company's personnel director corroborated, that he was part of an employee assistance referral network for the company that agreed to pay for the first 10 sessions. Afterward, if the client wished to continue, fees would be charged based on the employee's ability to pay. The company's benefits brochure fully described this arrangement, and according to the therapist, he discussed it

briefly during the initial session and included the information as part of his Health Insurance Portability and Accountability Act (HIPAA) notice given to all new employee assistance program clients. On further inquiry, the client did vaguely remember something about 10 sessions.

Case 18–17: Mia Frantic complained that her psychologist, Leslie Concerned, Ph.D., contacted the paramedics and the police and told them she was suicidal when she claimed she was, in fact, just a little agitated and only wanted to get her therapist's attention. Ms. Frantic claimed she suffered embarrassment and loss of her home after her landlord had her evicted because of the commotion. She also complained that the psychologist violated his duty to keep information shared between them confidential.

Dr. Concerned responded that Ms. Frantic texted him, claiming to have taken "lots of pills." Because Dr. Concerned feared for her safety and did not know what kind of pills or how many were ingested, he decided that other forms of assistance should also be marshaled. When he arrived at Ms. Frantic's apartment, the police (called by the paramedics) were already there, and the client was throwing books at them before being restrained. A hospital report indicated that the woman had not taken any pills. The psychologist's account of the incident and some of the other dynamics between the two persuaded the committee that he exercised appropriate professional judgment.

Case 18–18: Billy Blunt, an aid at a state mental facility, complained that a staff psychologist had called him "an inept boob" in front of patients and other staff, thus jeopardizing his employment status.

The psychologist admitted that she was extremely angry at the employee, but that his behavior deserved a sharp reaction. She was able to document that Mr. Blunt had just struck a severely regressed schizophrenic in the face because the man ignored his order to go to the dayroom. He was fired, but not because of the psychologist's outburst.

A Violation That Would Not Warrant Further Action

A complaint can be dismissed up front if the charge is true but only a minor or technical violation occurred, if the problem had already been adequately addressed in another way, or if an error is likely to be corrected.

Case 18–19: A therapist was distressed to see a splashy brochure on the supermarket public board sporting goofy-looking cartoons with text bubbles saying things like, “I’m nuts, but Dr. Cureall is better than any psychiatrist,” and “No one else in town can do what she does,” and “Look, Mom, I’m sane again!” The therapist pulled the brochure off the board and sent it to an ethics committee along with a copy to Dr. Cureall expressing disapproval.

The content of such ads no longer clearly qualify as ethics violations (see Chapter 11), but the committee decided to inform her of the criticism. Dr. Cureall responded that she had hired her cousin to create a promotional package, and he had proceeded to post the brochures before she reviewed the final version. She reported feeling chagrined and was actively attempting to reclaim and destroy the already-distributed brochures.

Insufficient Evidence

When it is decided that a complaint, if valid, would constitute a breach of ethics, the ethics committee may still be unable to open a formal case when sufficient evidence cannot be gathered during a preliminary investigation. So, unless additional credible witnesses or supporting documents can be produced, it usually becomes the complainant’s word against that of the respondent. Impressions of credibility do factor in but are not always persuasive one way or the other. Both the complainant and respondent may be informed that definitive evidence is lacking, and that any additional evidence or information that either may possess should be shared with the committee. But, alleged infractions often occur in private, and no evidence

beyond hearsay or opinion is available to either party or to the ethics committee.

Closing the matter without further action feels frustrating, both to an individual who made a valid complaint or to an innocent psychologist who was complained against. The complainant who was indeed wronged by the respondent no doubt experiences further stress when an ethics committee is unable to substantiate the charge. In these cases, complainants suffer an additional indignity when the profession seemingly lets offenders off the hook. This perception on the part of complainants is understandable, although not entirely accurate. The records are maintained for a long period, and should similar complaints be pressed, the initial complaints may be retrieved and reviewed. Even though lack of evidence may have allowed escape this time, sensitization to the issues and the noxious experience of undergoing an ethics inquiry may preclude a reoccurrence of such infractions.

As for the unjustly accused psychologist who could not prove his or her innocence, a lingering feeling of unrest may persist despite the fact that no violation was substantiated. It is unfortunate that an innocent therapist would undergo an inquiry by peers who close the case in doubt. Certainly, ethics committee members themselves are also disappointed when cases are shut due to insufficient evidence. They know that someone was not served well, but they could not determine who that someone was.

Educative Letters

Ethics committees take every opportunity to educate those who appear before them. Even when the charges are dismissed, the respondent may receive a letter designed to inform the respondent of why the act was inappropriate and, when appropriate, what to do instead. For example, Mazy Pickle’s therapist (Case 18–16) was found innocent of perpetrating bait-and-switch fee setting. However, the letter from the ethics office closing the matter offered the therapist some ideas for ensuring that no misunderstandings resurfaced in the future.

For minor violations, when it seems clear that they resulted in no real harm and when the psychologist seems amenable to understanding what needs to be done differently, an educative letter may be all that is issued.

Sustained Charges, Sanctions, and Directives

Four sanctions can be assigned (or referred to the APA Board of Directors) when the APA Ethics Committee issues a finding other than dropping the charges:

1. A *reprimand* is the appropriate sanction if there has been an ethics violation but the violation was not of a kind likely to cause harm to another person or to cause substantial harm to the profession and was not otherwise of sufficient gravity to warrant a more severe sanction.
2. A *censure* is the appropriate sanction if there has been an ethics violation and the violation was likely to cause harm to another person, but the violation was neither a kind likely to cause substantial harm to another person or to the profession nor of sufficient gravity to warrant a more severe sanction.
3. *Expulsion* from the organization is the appropriate sanction if there has been an ethics violation, and the violation was likely to cause substantial harm to another person or the profession or was otherwise of sufficient gravity to warrant such action.
4. A *stipulated resignation* may be offered after finding the respondent committed a violation of the ethics code or failed to show good cause why he or she should not be expelled, contingent on execution of an acceptable affidavit and approval by the board of directors.

In addition, *directives* in the form of required actions to satisfy part or all of the committee's decision include the following:

1. A *cease-and-desist order* requires the respondent to immediately terminate the specified unethical behavior(s).

2. *Other corrective actions* to remedy a violation, protect the interests of the association, or protect the public may be imposed. Such a directive may not include a requirement that the respondent make a monetary payment to the APA or persons injured by the conduct.
3. *Supervision* requires that the respondent have his or her work monitored by an appropriate practitioner. The cost of supervision is borne by the respondent.
4. The *education, training, or tutorial requirement* requires the respondent to engage in an appropriate learning experience.
5. *Evaluation and/or treatment* requires the respondent to be evaluated to determine the possible need for treatment or, if dysfunction has been established, obtain appropriate treatment.
6. *Probation* requires monitoring of the respondent by the committee to ensure compliance with the mandated directives while they are in force.

It is generally useful to consider the degree of seriousness of an infraction as a criterion for determination of any penalties. Other factors may mitigate or aggravate the determination of the penalty ultimately imposed. As is clear on even a cursory reading of the APA or any other professional ethics code, violating some principles could cause far more harm than violating others. A scheme to aid in understanding the seriousness of infractions is presented in Box 18-1, adapted from Koocher, Keith-Spiegel, and Klebanoff (1981), and remains in general agreement with rules and procedures used today. This scheme facilitates a consideration of the appropriateness of sanctions and other mediating factors.

Level I-A deals essentially with *malum prohibitum* offenses, that is, behavior that is wrong primarily because it is proscribed in a code of ethics, in contrast to behavior that is inherently immoral. No malicious intent can be ascribed to the therapist in question, and an ethics committee could respond by educating the individual or suggesting better ways of handling matters in the future.

Box 18–1 Levels of Ethical Violations and Possible Directives or Sanctions

Level I-A. A finding that a therapist's behavior or practice was not clearly unethical, but in poor taste or insufficiently cautious.

Level I-B. A finding that a minor infraction occurred, but the potential for harm was unlikely. The therapist may have been insufficiently cautious, though not necessarily intentionally.

Level II-A. A finding of clearly unethical misconduct although unlikely to harm the public or profession substantially.

Level II-B. Deliberate or persistent behavior that could potentially lead to substantial harm to the client or public, although little harm may have actually occurred.

Level III-A. Continuing or dramatic misconduct producing a genuine hazard to clients, the public, and the profession.

Level III-B. Individual clients or others with whom the therapist worked are substantially injured, and there are serious questions about the therapist's potential for rehabilitation.

Level I-B carries I-A a step further, addressing behavior that is unquestionably inappropriate and somewhat offensive. Still, the committee may have the sense that the violation is relatively minor, that the individual in question did not fully realize the nature of the problem, and that an educative stance rather than a punitive one would be most effective. An ethics committee may request that the therapist cease and desist from engaging in the activity or behavior, noting that a more serious finding could result if the practice continued.

Level II (and Level III) involves *malum in se* offenses, that is, behavior that is unethical in itself in the view of the professional/scientific community. This category is reached when an ethics committee finds that a substantive violation did indeed occur. For Level II offenses, the therapist clearly should have known better, although the action or inaction did not result in any harm beyond remedy.

Level III is reached when substantial harm accrues to others or to the profession as a result of the respondent's unethical behavior. The respondent may seem resistant to or ill-suited for rehabilitation and poses a threat to the public. Motivation to change or to demonstrate concern for the behavior is unclear. In some cases, resignations with stipulations are permitted, while in other cases ethics committees recommend expulsion from the organization, and

the relevant state licensing board is informed. Expulsion is, of course, the most severe sanction and represents banishment from one's profession and one's peer group. The process is an extended one, involving formal hearings and board of directors' approval, too detailed to be adequately described here. The next two cases illustrate expulsion offenses.

Case 18–20: Seymour Fraud, Ph.D., who was found guilty of cheating insurance companies out of thousands of dollars, was also being investigated by a state regulatory agency and an ethics committee. During the period when both investigations were actively open, an insurance company charged that Dr. Fraud had billed for over 50 additional client sessions that had never taken place.

Case 18–21: Harley Stud, Ph.D., was charged by several women with sexual exploitation. Dr. Stud admitted engaging in sexual relations with them but denied that it was exploitative. He claimed that they all needed special types of sexual activity to function as effective women. The only issue on which he would agree was that his form of therapy "did not work on these four women, but," he added, "it has worked beautifully on scores of others."

Both psychologists appeared to be unsuitable candidates for rehabilitation because neither revealed any insight into the problematic

nature of their serious transgression or gave any indication that their views and practices would change.

Stipulated resignations, a less formidable sanction, can be offered by the committee contingent on the approval of the board of directors. The agreement may include various provisions. This sanction is most likely to be offered when respondents admit to an ethical violation or the act that prompted a show cause action. The violator is offered an opportunity to resign from the association for a negotiated period of time. At the end of this period, the violator may reapply. The committee will reexamine the case to see if the psychologist can demonstrate that major steps, either those stipulated or those taken on their own initiative, ensure that the nature of the difficulties has been ameliorated and is unlikely to resurface. At its option, the committee can act to restore the psychologist to membership in good standing.

What if a member is unhappy with the decision reached by the ethics committee? There are additional possibilities for review before the ethics process is finalized. Failure of the ethics committee to follow their own rules would be grounds for reconsideration. Other options, such as a request for independent adjudication or a formal hearing, are also available for certain sanctions.

Licensing boards issue similar sanctions except they have the power to suspend or revoke licenses, which has an immediate impact on a therapist's livelihood. Other licensing board sanctions include a cautionary letter, censure, and license suspension until certain conditions have been met. Psychology licensing boards are required to report disciplinary sanctions to several data banks (see DeMers & Shaffer, 2012).

Mitigating Factors and Public Exposure

The system we described in Box 18-1 provides a helpful framework to assist in curbing capricious punishment or excessive leniency relative to the specific violation. It must be recognized, however, that violations that may appear identical can be decided differently for justifiable reasons. Common mitigating factors that might

lead to different sanctions or directives for similar violations include an assessment of the motivation or intent of the respondent, number of prior complaints, years of experience in the field, the willingness of the respondent to accept responsibility for his or her actions, and the respondent's demeanor and any self-initiated attempts at remediation. So, an ethics committees may show lenience (e.g., apply an educative approach) to a first offender who committed a relatively minor offense due to inexperience. If the same offense is committed by a recalcitrant, experienced psychologist, however, a more severe sanction would be considered. Actions judged to be willful and intentional as opposed to unintentional may require a more punitive response and be seen as more damaging, even if they were not (Ames & Fiske, 2013).

Sanctions have an immediate impact to the extent that the respondents have been educated, sensitized, embarrassed, or shamed into shaping up their practices. Other more tangible consequences may also accrue as noted. However, the APA cannot, on its own, pull a psychologist's license. It can, however, inform licensing and certification boards when an APA member is expelled. The board receiving the information may then take some action. At its discretion, the APA may also inform other parties if it is determined that additional sharing of information would be in the best interests of the public or the profession. The APA members learn the identity and the general nature of the standards violated as a part of the annual membership dues statement package. The APA Ethics Office may inform any person who inquires in writing that a former member lost APA membership because of a sustained ethics charge or show cause action if the process occurred after June 1, 1996, or if the individual resigned while under ethics investigation. (Stipulated resignations are excluded unless such disclosure was part of the stipulation.)

The APA has not yet proactively disclosed serious violators to the public at large through easily located venues. Some associations have more actively publicized information on disciplined mental health professionals. The bimonthly magazine of the California chapter of the association

representing marriage and family counselors, for example, has for years described sustained charges that led to licensure revocation or suspension of marriage and family counselors as well as psychologists and social workers. Identities and location of practice are disclosed. These descriptions are in such detail that we have been able to adapt a number of our cases from them.

Technological innovations have provided easier access to uncovering disciplinary actions by the public (Van Horn, 2004). The NASW, for example, posts the names (and adjudicating chapter location) of those social workers with sanctions still in force for the past 10 years on its public website. Many licensing boards provide access to their findings and sometimes images of the actual records. Others make it more difficult. The psychology licensing board in Nevada, for example, will supply information about a specific individual, but the request must be in writing (i.e., no fax, e-mail, or on online searching). Minnesota offers a list of names and the status of the action taken, and more information will be forthcoming by e-mail or fax (or 25 cents a page for hard copies) on request. Some states, like Colorado, provide names and actions taken, but no further information or hint of the violation. The California Board of Psychology also lists names going back many years, but one can also sign up to be on an e-mail list that periodically sends out updates on actions as well as the names, license number, and city of residence for accused psychologists and the general nature of the charge.

Although there is no doubt that some practitioners should lose their license and never practice again, many therapists who committed an apparently more minor act years ago remain easily discoverable despite the possibility that many of them learned a good lesson and are completely rehabilitated and fit to practice. That many mental health professionals wear a “scarlet cyberletter” on their reputation that will last, perhaps forever, is a cautionary tale.

Ethics Complaints Not Pursued

Ethics committees cannot pursue every complaint. We conclude this last chapter with

descriptions of the most common reasons the APA declines to consider a complaint.

1. *When there is no provision in the code.* It would be impossible for an ethics code to detail every conceivable inappropriate act, poor decision, or questionable level of care.

Case 18–22: Tim Nopenny, a graduate student, complained that Don Staunch, Ph.D., director of a clinical internship program, discriminated against him and any other applicants with limited financial resources living some distance from the facility. The program required applicants to appear for a personal interview. Tim claimed that he did not have the funds to make the trip and requested a Skype interview. Dr. Staunch explained that on-site applicant visits involved interacting with a number of individuals, including current students, and a tour of the facility.

Although an ethics committee sympathized with Tim Nopenny’s predicament, nothing in the ethics code prohibits administering reasonably justifiable selection policies.

2. *When an ethics committee is not the appropriate mediator.* Sometimes, an ethics committee refuses to process complaints when it becomes clear that the committee will be unable to make any reasonable contribution to a solution. This occurs most often when two or more individuals are involved in an interpersonal conflict that bubbles over into their professional relationship; when the infraction involved an act that might conceivably be unethical but is virtually impossible for ethics committees to evaluate or investigate; when the issues are related to other than ethical aspects regarding standards of practice or interprofessional political disputes; or when other sources of redress are clearly more appropriate.

Case 18–23: Edgar Potshot, Ph.D., had a long-standing and intense dislike for his colleague, Nick Nitpick, Ph.D. Potshot complained that Nitpick engaged in unprofessional conduct when he told the counseling center receptionist that Potshot had “shit for brains.” When the committee asked Nitpick about the incident, he

countercharged that Potshot had been making outrageous remarks to their colleagues about him for years.

An ethics committee realized that it was not going to resolve the ethical issues or the intense and ingrained interpersonal difficulties between these wrangling colleagues. A duplicate letter informed both men that the committee would not be accepting the case and pointed out that this was a no-win situation for them and their workplace environment. The letter stressed the professional responsibilities of both parties and urged them to embark on some course of action that would lead to neutralization of the destructive nature of their working relationship.

Ethics committees may sometimes inform complainants that other sources of redress are more appropriate and suggest that these be pursued. In such instances, the committee may take on the role of facilitator by serving as a resource or referral agent.

Case 18–24: An ethics committee received a charge alleging that Rob Filch, Ph.D., had bilked the complainant's niece out of most of her father's inheritance when Filch was on staff at an outpatient psychiatric facility where the young woman was being treated. Dr. Filch allegedly told the young woman's uncle that she begged him to take the money because she hated her now-deceased father and wanted nothing to do with him. He added that he was "willing to help her out." The uncle insisted that Filch was capitalizing on his niece's mental condition.

Ethics committees have neither the necessary resources to investigate such a complaint nor the authority to make appropriate restitution should that be warranted. The complainant was advised to seek legal counsel.

3. *When respondents are not members of the professional organization.* Professional associations are voluntary membership organizations, and the jurisdiction of their ethics committees extends only to current members. It is not uncommon to receive complaints against licensed mental health professionals who are not members of the particular association.

These cannot be processed, although information can be offered to the complainant about alternative sources of redress with jurisdiction. Complaints against licensed practitioners can be referred to state boards, many of which adopt or follow the ethics code, or an organization with an oversight committee to which the individual does belong. However, as we noted, there is considerable variability in the responsiveness of many of these regulating bodies, except in those instances when the alleged infraction poses imminent harm to the public.

Case 18–25: A group of students presented evidence from their own "sting operation" to support allegations regarding Sammy Scam, Ph.D., owner of a consulting firm. He would interact with students he did not know and never met briefly on the phone or online. Then, for a \$200 fee, he would supply letters of reference in support of their applications to graduate school or for employment.

Dr. Scam's degree was legitimate, but he was not a member of any professional association and was not licensed. Scam was especially difficult to restrain because, despite the impropriety of the service he performed, its illegality was not clear-cut. (Of course, the students soliciting this service are also worrisome.)

Complaints are also received about individuals without appropriate training. Most medium-to-large-size communities have individuals who offer services that appear to strongly resemble those of regulated professionals, but these people have neither suitable formal training nor the credentials to qualify them for licensure or membership in a professional association. Some of these individuals have purchased impressive-looking but fake credentials from "diploma mills" to hang on their walls. An estimated 400 diploma mills and 300 counterfeit diploma websites bring in millions of dollars from those who want to appear to be who they are not (Bear, 2004). Except for the most blatant transgressors, most of those who sport phony credentials shy away from using the protected titles that only state-licensed mental health professionals can legally use to identify

their practice to the public. Instead, they devise unprotected titles that sound legitimate, such as “personal counselor” or “relationship expert.”

Untrained individuals offering psychotherapy-type services often become slippery when pursued because whenever a complaint appears imminent, they usually pick up stakes and relocate. In some states, a complaint can be investigated by authorities if an unwary complainant was reasonably led to believe that the individual was a licensed mental health professional. But, generally speaking, the public does not have adequate protection from these counterfeit practitioners.

Membership in a professional association does not guarantee competence or virtuous qualities, and lack of membership in a professional organization does not suggest incompetence or impoverished character. However, consumers have additional protection when their therapists have voluntarily agreed to ethical scrutiny by virtue of their membership in organizations with peer control mechanisms.

4. When complaints are against groups, agencies, corporations, or institutions. Whereas a complainant can name more than one person in a single complaint, each respondent must be known to the ethics committee by name, and the involvement of each in the dispute must be specified. Ethics committees are not set up to deal with an organization or a corporation, as is possible in the courts. Even a cursory reading of ethics codes reveals a focus on the ethical responsibilities of individuals. Thus, when complaints are received against a government agency, an academic department, a mental health clinic, or other business, the material is returned to the complainant.

5. When complaints are anonymous. Occasionally, an ethics committee receives an unsigned complaint. Usually, the reason for anonymity is noted, and it is typically fear of retribution. Ethics committees are often concerned, especially when a letter presents information that is well documented and the alleged infraction is grievous. But, the rules and procedures of ethics committees allow the respondent the right to know his or her accuser and to due process. Thus, unless the complaint

contains information that can be substantiated in some other way (e.g., all the necessary information to move forward is available through public sources), the committee cannot move forward.

Related to the anonymous complainant are those who reveal their identity but insist that the committee not disclose it to the respondents. In such cases, the committee is able to explain the procedures—including which safeguards the committee is able to extend—and defend the requirement for making identities known to respondents. Some then agree to pursue the case according to the necessary procedures, while others choose to withdraw their complaints.

6. When the complaints are improper. Occasionally, ethics committees receive complaints that, based on the available evidence, are judged frivolous and intended to harm or harass someone rather than to protect the public. In such cases, formal ethics committee inquiries may be unwarranted. When the complainant is not a member of the APA and the allegation appears to be harassing, speculative, or internally inconsistent, it will usually be disregarded, as illustrated in the next case.

Case 18–26: Nute Rankled, M.D., wrote to an ethics committee complaining that Charlton Rebuff, Ph.D., an APA member, had promised to refer clients to him. However, Rebuff failed to follow through with his offer.

Dr. Rankled may find himself disappointed that Dr. Rebuff did not measure up to expectations, and Rebuff may not be a standup individual, but there is nothing in this scenario that should involve an ethics committee. It appears that Rankled is attempting to use an ethics committee to aggravate Rebuff.

If the complainant is a member of the APA and the committee decides that the charge was frivolous and intended to harm the respondent, then he or she may receive an unwelcome surprise. It is an ethics violation *in and of itself* for APA members to issue complaints containing a reckless disregard for the facts against other members (APA: 1.07) or appear to abuse the

ethics committee process. (See also ACA I.2.e.) The next case involves two APA members.

Case 18–27: At the holiday office party of the 72nd Street Counseling Center, Johnny Sot, Ph.D., had too much to drink. He entered into an argument about the future direction of the center with Tilly Sober, Psy.D., and shoved her against the food table, knocking over a large shrimp platter. Sober was basically unharmed, but her silk dress was ruined. Dr. Sober successfully sued Dr. Sot in small claims court for the cost of her dress. In return, Sot contacted an ethics committee and attempted to press charges of fraud against Sober for “telling the court that her ugly dress cost \$200 when he saw the same one in a shop window for \$99.”

An ethics committee might have faced a dilemma had Sober pressed a charge against Sot because his abusive act was committed in a professional workspace (a counseling center) but not in a professional context (off-hours social party). However, the committee was confident in tagging Sot for a frivolous and likely vengeful motivation regarding the alleged value of the dress.

7. When complaints arrive beyond designated time limits. The ethics committee expects that complaints should be filed within specified periods of time after the alleged violation occurred or came to the complainant’s attention. With a few narrow exceptions, the APA rules and procedures allow an elapsed time of 3 years when the complaint is issued by an APA member. For nonmembers and student affiliates, the time is extended to 5 years. The reason for the discrepancy is that members are expected to be more aware of the ethics code and redress procedures and to act promptly. Most nonmembers, on the other hand, are unlikely to possess such knowledge, and it may not become available to them for some period of time. In addition, other factors could interfere with punctual reporting. In some cases, the nonmembers suffered emotionally in ways that were immobilizing for an extended period, and they were incapable of pursuing their complaints until the trauma had been worked through or had dissipated.

Students may wish to wait until after graduation before pressing charges against one of their trainers or educators. Under certain conditions involving more serious situations, these limits can be extended further.

The next case was heard by an ethics committee, under the special provision, even though 8 years had passed since the alarming episode occurred.

Case 18–28: Arthur Stunned agreed, as requested, to disrobe and turn his back to Frank Digit, Ph.D. Mr. Stunned charged that Digit then, without warning, shoved his thumb into Stunned’s anus. Digit then declared that Stunned would now never feel fear again because he had been “set free.” Stunned was so traumatized by this “therapy” technique that he left treatment and did not confide to anyone about his ordeal for 7 years. He did eventually correspond with Dr. Digit and saved the response letter from Digit describing the technique and why it was designed to be beneficial.

Mr. Stunned, with the support of his new therapist, requested that the APA hear the case. The ethics committee agreed to do so. Dr. Digit was expelled from the organization, and a report was sent to the licensing board in the state where he practiced.

8. Infractions not committed in the course of professional work. Committees may face a difficult situation when a member embarrasses the profession or puts the public in jeopardy, but the act was not perpetrated while in the role of a professional. Maintaining a distinction between professional and personal behavior is rooted in our nation’s cultural value that emphasizes every citizen’s right to a private life (Pipes, Holstein, & Aguirre, 2005).

When people are unhappy with a mental health practitioner’s private behavior, they may try to involve an ethics committee. Strictly private behavior, however, does not fall under the APA ethics code and is specifically marked as off limits for adjudication unless the psychologist commits a felony or equivalent criminal act. However, given the erosion into our privacy, whether from security measures after 9/11 or invasive technology and media (including

social media and blogs), the line between private and public behavior is increasingly porous, making it difficult to sort acts into two distinct categories.

A public relations problem occurs when the private actions of a therapist are dishonorable and made public. For example, a therapist who is a racist, a scoundrel, and an exploiter is untouchable by an ethics committee as long as the display of these undesirable traits does not amount to a felony or is known to spill into his or her professional work. This individual will not be scrutinized despite the fact that most of us would not want to embrace this person as a colleague and would doubt the quality of professional services provided. After all, if one is morally impaired in the personal realm, how likely is it that their professional services are unaffected? What do you think about the next case, which was adapted from a local paper's headlines?

Case 18–29: Lush Juiced, Psy.D., was found passed out on a sidewalk in front of a bar, unable to stand. He pled guilty to a misdemeanor and admitted to the court that he has a “sometimes drinking problem.” He promised to seek help. The judge fined Dr. Juiced \$500 and accepted his word that he would voluntarily seek treatment.

Dr. Juiced presents an interesting dilemma. We can probably assume that his alcoholism likely interferes with the quality of the counseling services he provides and would like to see him mandated to treatment. However, a client has not complained, and he was convicted of a misdemeanor. In another instance, a counselor was stopped for speeding, and the police found a small amount of cocaine on his person. This counselor's license to practice was ultimately revoked given that possession of cocaine was a felony in his state. Thus, which behavior can lead to sanctions depends on how it is legally classified, and this differs among the states.

Even individuals who serve on ethics committees do not always agree that charges of unethical conduct should be rejected when therapists were acting strictly as private citizens

or in some other nonprofessional role, especially if the misconduct was menacing or bizarre or became a shameful or upsetting media story. When that individual's profession is prominently noted, the public trust of all practitioners in the field is tarnished, at least temporarily. One of our friends showed us an article in his local paper describing a psychotherapist whose wife divorced him because he insisted that the entire family sleep in a plastic pyramid, believing that this would increase their longevity. Our friend added, “Why would I ever get counseling? Most of them are crazier than I will ever be.”

Of course, in many instances, similar to the debacle at the 72nd Street Counseling Center (Case 18–27), ethics committees would not be the appropriate recourse for mediating private disputes. The next case is illustrative.

Case 18–30: Bucky Numbers, who worked as an accountant in the same office building with Snap Depart, Ph.D., complained to an ethics committee that the psychologist had exploited him and was responsible for his current high-anxiety state. The two had started talking about going into business together, and Numbers created elaborate plans. Then, he claimed, Dr. Depart abruptly broke off their relationship without explanation.

After clarifying with the parties that a professional relationship was never established, the ethics committee informed Mr. Numbers that it cannot intervene in relationship failures between consenting adults functioning in their roles as private citizens.

Private acts often reveal a person's moral compass, and ideally all mental health practitioners are of good character. Although beyond the reach of ethics committees, what do you think of the individual in the next case?

Case 18–31: Mat Carpet, Ph.D., claimed his valuable Persian rug, worth many thousands of dollars, was ruined during a recent heavy storm. However, Dr. Carpet had actually purchased the deeply discounted water-damaged rug from a local store several days after the storm and placed it in his home for the insurance adjuster to review. After

the adjustor left, Dr. Carpet took the damaged rug back to the store for a refund.

On the surface, Dr. Carpet's act seems like a foolhardy indiscretion of no professional consequence. Or is it? Questions of Dr. Carpet's character are obvious, especially because a complicated fraud was premeditated, requiring him to traipse around town with a large rug. Do his questionable values have an impact on his clinical decision making and his respect for clients?

Stromberg (1991/1992) agreed that it is often difficult to prove that the consumers were, in fact, harmed by therapists' private actions. He argued, however, that ethics committees should be empowered to consider any conduct that seems reasonably likely to impair professional functioning or violates the values that the profession is sworn to uphold. The American Psychiatric Association (2013) does include a standard requiring psychiatrists to conduct themselves with propriety in their profession as well as in all actions of their lives. The Previous APA codes included a standard that allowed for opening a case if a private behavior compromised the public's trust in psychology. Despite the seeming reasonableness of such a provision, there were drawbacks aside from venturing into private lives. Such acts would have to draw attention, mostly likely from the media (including the Internet), which creates a biased sample as well as the underlying message, "Just don't get caught." Opinions regarding what exactly lowers the public trust would have to be assumed, and the calls could vary among who is making the judgment.

As noted, conditions do apply for which the APA Ethics Committee can act, even when the behavior involved was strictly in the private realm; this occurs when a member has been found guilty of a felony or equivalent criminal act regardless of the direct relevance of the crime to that person's professional activities. A "show cause" proceeding offers a short period of time for the psychologist/felon to explain why the APA should not expel him or her from the organization.

Case 18–32: Andrew Bumpoff, Ph.D., was convicted of the attempted murder of his wife when the young man he hired to do the killing confessed after questioning by the police. The man claimed that Dr. Bumpoff had taken out a large insurance policy on his wife's life and promised the man one quarter of the payoff if he would break into the house on a particular evening when Dr. Bumpoff was seeing clients, shoot the wife, and take a few expensive items to make it look like a robbery. The trial was widely publicized, and Dr. Bumpoff's profession was prominently woven into every story.

Dr. Bumpoff's behavior was so extreme that his unfitness as a therapist seems beyond debate. Other actual cases of private misconduct resulting in expulsions using a show cause procedure include those involving a clinical psychologist who strangled his housekeeper to death and another who abused drugs with clients in group therapy sessions. One psychology professor purposely set the university administration building on fire, and another professor was found to be spying for Cuba. The same show cause process can be used for members who have had their licenses revoked or suspended by a state board or have been expelled or suspended by a state or local association.

We conclude our book with a simple message: The potential hazards while practicing therapy are numerous, and the consequences of stumbling can be considerable. However, a commitment to practicing within the bounds of your competence and remaining self-aware while maintaining the highest ethical standards will minimize every risk and sustain a satisfying and vital career.

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