Ethics for Psychologists

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Answer Sheet to NetCE by mail or fax, or complete online at www.NetCE.com. Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

Margaret Donohue, PhD, is a psychologist in Los Angeles, California. She received her doctorate from the California School of Professional Psychology in Los Angeles. Her clinical and forensic practice focuses on the areas of health and medical psychology especially complex psychological and neuropsychological assessments. She is licensed in both California and Nevada.

In addition to her private practice, Dr. Donohue currently teaches at The Chicago School of Professional Psychology in Los Angeles. She is actively involved with the California Psychological Association's Office of Professional Development as a Third Reviewer for courses for continuing education for psychologists. She is a member of the American Psychological Association, the Los Angeles County Psychological Association, and the National Register of Health Service Providers in Psychology.

Dr. Donohue has frequently provided ethical consultation to colleagues in the area of professional boundaries, ethics and psychological assessment, and ethics in professional practice. Her public speaking events have included being a panel presenter in the January 1987 Los Angeles conference on ethics and boundaries for lesbian therapists. She has also presented for the California Psychological Association on the personal impact of head injuries in neuropsychologists with Jonathan Greene, PhD, in 2006.

Dr. Donohue has published articles on Tarasoff notification and racism; quality evaluation in health care; benchmarking access to outpatient services in managed health organizations; treatment of anxiety in young children; and the development of assessment techniques in evaluations of young children and assessing organizational productivity and quality.

Faculty Disclosure

Contributing faculty, Margaret Donohue, PhD, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Senior Director of Development and Academic Affairs

Sarah Campbell

Director Disclosure

The director has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This intermediate course is designed for all licensed psychologists in all practice settings.

Accreditations & Approvals

AMERICAN PSYCHOLOGICAL ASSOCIATION

Continuing Education (CE) credits for psychologists are provided through the co-sponsorship of the American Psychological Association (APA) Office of Continuing Education in Psychology (CEP). The APA CEP Office maintains responsibility for the content of the programs.

Designations of Credit

NetCE designates this continuing education activity for 6 CE credits.

A complete Works Cited list begins on page 25.

Mention of commercial products does not indicate endorsement.

About the Sponsor

The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

Disclosure Statement

It is the policy of NetCE not to accept commercial support. Furthermore, commercial interests are prohibited from distributing or providing access to this activity to learners.

Course Objective

The purpose of this course is to provide psychologists with an understanding of ethical issues common to their practices and tools necessary for effective ethical decision making.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define general concepts at the core of an ethical psychology practice.
2. Outline the history of psychology and ethics in the United States.
3. Discuss the principle of competence and its significance in psychology.
4. Identify key aspects of informed consent.
5. Review the principles of privacy and confidentiality and the psychologist's responsibilities when protecting clients' privacy.
6. Describe the impact of technology and exploitation on the psychologist-client relationship
7. Outline components of ethical decision making and the process for complaints.

INTRODUCTION

General ethical concepts applicable to all psychologists regardless of setting include competence, informed consent, privacy and confidentiality, and avoiding harm or exploitation. This course provides specific information regarding each of the areas and how they apply to psychologists in a variety of settings with a variety of professional relationships. Psychologists also must be able to understand and differentiate the complex interactions between the American Psychological Association's (APA's) Ethical Principles of Psychologists and Code of Conduct, the ethical codes of various state psychological associations, regulations of state licensing boards, institutional policies and procedures, state and federal law, and community and local standards of practice. Common ethical issues and complaint procedures are also reviewed.

GENERAL CONCEPTS

As noted, there are four ethical standards applicable to all psychologists regardless of setting: competence, informed consent, privacy and confidentiality, and avoiding harm or exploitation [1]. Ethical rules and standards provide a frame of reference for guidance in decision making about the most appropriate action to take in a given situation. As experience and circumstances change, the ethical standards for psychologists evolve from a strict set of rules about behavior and conduct to becoming more aspirational in nature. The practice of being ethical changes to being more involved with thinking through the consequences of actions and more cognizant about the day-to-day impact of ethics on practice.

Ethics differs slightly from values, morals, and laws. Values are ways to determine what is more or less important in decision making [2; 3]. Morals are specifically about motivations and actions and how those motivations and actions are good and bad. Morals have a social component and pertain to rules that govern life in a social structure. Morals are based in culture, history, and generally religious authority. They are usually agreed upon by the culture and serve to form the basis of the laws in the society. The laws are an external system of constraints on behavior that apply equally to everyone within the society. Ethics are a self-imposed system for constraining behavior based on values and morals [2; 3]. It is also a system of moral values governing the conduct of a person or the members of a profession. Ethics form the basis of professional standards that are then codified into laws regulating the members of a profession.

Psychology has developed ethics and ethical decision making over several decades with multiple revisions to the APA Ethics Code. The APA Ethics Code has attempted to be scientifically based in principles that will allow for decision making and are generalizable to the profession as a whole. More recently, it has focused more on problem areas that serve as the basis of complaints against psychologists to licensing boards.

A HISTORY OF PSYCHOLOGY AND ETHICS IN THE UNITED STATES

The APA was founded in July 1892 at Clark University by a group of 26 men, many of whom accepted invitation to the group by mail. The first meeting involved the presentation of 6 research papers [4]. Its first president was G. Stanley Hall, and it began with 31 members [5]. It was the aspiration of the APA that the organization would provide guidance and assistance to members who were obtaining advanced degrees and becoming credentialed in new fields of expertise. There was a progressive movement in politics and a need for more professionals to assist in political demands.

Following the Civil War, the United States entered into a rapid growth phase. There was corruption in the building of the Transcontinental Railroad and there were Congressional scandals related to the misuse of governmental funds, bribery, and excess charges. In addition to corruption in the government, there was a high crime rate, a high poverty rate, concerns about the use of "greenbacks" (or Confederate money), and limitations in the monetary supply based on reliance on the gold standard. G. Stanley Hall had established Clark University as a research institution and founded the *American Journal of Psychology*. Psychology as a young field was moving into research, which was controversial, and away from work with healthy individuals and anthropology. The field was expanding to include work with animals, children, sick people, and the new practice of hypnosis [4; 5]. Ideas of what was and was not appropriate for the field began to coalesce. After World War II, the APA began to expand and grow quickly. The need for an ethical code and ethical standards came out of the expanding profession and out of situations in which psychologists found themselves without clarity for decision making.

The first Committee for Ethical Standards for Psychologists formed in 1947. The Committee worked on developing a description of critical situations in which psychologists made decisions involving ethical considerations. More than 2,000 members contributed to formulating the first Ethics Code in 1953. Consisting of 171 pages, it was a lengthy document, reflecting the post-war concerns of conflicts of the academic freedom movement, McCarthyism, and requests to design tests to support racial segregation [6]. The next edition, published in 1959, consisted of 18 principles and a preamble.

Today, the APA has more than 146,000 members and 54 divisions in subfields of psychology [7]. The 2002 edition of the revised Ethics Code consists of an introduction and an applicability section and separates the ethical code and laws regarding the professional practice of psychology. The APA's Ethical Principles of Psychologists and Code of Conduct was amended in 2010 to deal with conflicts of psychologists providing services to the military and potentially violating human rights and again in 2016 to ensure that psychologists take reasonable steps to avoid harming those with whom they work and to assert that psychologists do not participate in, facilitate, assist, or otherwise engage in torture [8]. The current Ethics Code consists of an introduction, a preamble, five general principles, and specific ethical standards.

ETHICAL STANDARDS

General ethical principles of psychology stem from a value that psychologists "work to develop a valid and reliable body of scientific knowledge based on research" [9]. The current Ethics Code has a stated goal of ensuring "the welfare and protection of the individuals and groups with whom psychologists work and education of the members, students, and the general public regarding ethical standards of the discipline" [8].

COMPETENCE

Competence is a fundamental ethical principle in the healthcare professions. Medicine and psychology define competence as, "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" [1; 10]. To be considered adequately or well qualified to practice psychology (i.e., competent) is a process of evaluation of a specific area. Both the individual psychologist and the profession as a whole strive to determine areas of competent practice and the basis on which to form those evaluations.

The profession has set forth educational standards for doctoral programs in psychology. This involves accreditation of schools and colleges at a regional level and setting forth standards for accreditation by the APA for graduate school. Internships and postdoctoral fellowships may also be accredited by the APA, the Association of Psychology Postdoctoral and Internship Centers, or both.

Following graduation and completion of internships and postdoctoral fellowships, licensing boards in states with licensure requirements for professional practice set additional minimum standards for competence. Some states require continuing education following licensure to remain current on the research and developments within the field. The psychology boards often work in conjunction with the Association of State and Provincial Psychology Boards to set standards for examination or certification and to facilitate mobility of licensure to other states, territories, or provinces.

Following licensure, recognition can be obtained from the National Register of Health Service Providers in Psychology, or certification from the Association of State and Provincial Psychology Board's Certificate of Professional Qualification in Psychology (CPQ). The American Board of Professional Psychology provides an additional examination to document competence in areas of expertise. Additionally, some types of training offer certification documenting training and skill in a particular technique or area.

Competence involves knowing all aspects about the services, treatment, evaluation, and decisions made in an area of expertise being provided. Clinical practice recommendations and evidence-based approaches provide guidelines regarding what constitutes effective practice. The purpose of the guidelines is to limit idiosyncratic, self-serving methodologies that may cause harm to an individual or to the profession.

The 2016 APA Ethics Code addresses competence in standard 2.0 [8]. The following sections are reprinted with permission:

2.01 Boundaries of Competence

(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.

(c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

(d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.

(e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.

(f) When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles.

2.02 Providing Services in Emergencies

In emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied. The services are discontinued as soon as the emergency has ended or appropriate services are available.

2.03 Maintaining Competence

Psychologists undertake ongoing efforts to develop and maintain their competence.

2.04 Bases for Scientific and Professional Judgments

Psychologists' work is based upon established scientific and professional knowledge of the discipline. (See also Standards 2.01e, Boundaries of Competence, and 10.01b, Informed Consent to Therapy.)

2.05 Delegation of Work to Others

Psychologists who delegate work to employees, supervisees, or research or teaching assistants or who use the services of others, such as interpreters, take reasonable steps to (1) avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity; (2) authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided; and (3) see that such persons perform these services competently. (See also Standards 2.02, Providing Services in Emergencies; 3.05, Multiple Relationships; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.02, Use of Assessments; 9.03, Informed Consent in Assessments; and 9.07, Assessment by Unqualified Persons.)

2.06 Personal Problems and Conflicts

(a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.

(b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance and determine whether they should limit, suspend, or terminate their work-related duties. (See also Standard 10.10, Terminating Therapy.)

Psychologists generally do not attempt to perform services for which they feel incompetent; they attempt to perform services they believe they can effectively offer. As time goes on, they may be swayed by financial considerations, misdirected ideas about trying to be helpful, or beliefs regarding what is appropriate. Consider the following scenarios:

- A psychologist accepts a new position at a company offering to provide training in a new area of services for her. After she is scheduled to see patients, she finds that the "training" consists only of being given copies of outlines of reports to follow. She begins to see patients but is immediately overwhelmed. The company complains she is not meeting performance standards. She turns in her resignation but is told she is already scheduled with patients and to leave prematurely would harm patients who had already waited weeks to be scheduled. She leaves, and the company files an ethics complaint against her.

- A psychologist joins a group practice to provide production testing for a large company under contract. The psychologist has taken a few semesters of testing while in graduate school but has done no testing in at least a decade. Although the psychologist seeks supervision independently, the supervising psychologist suggests the services currently being provided are so far below the standard of practice as to appear unethical. The psychologist decides to pursue other employment.

When starting a new position, it is important to know exactly what will be required to determine whether or not the psychologist will be competent to perform the task. Positions that are described as "training" or "under supervision" should provide to the psychologist a clear delineation of the supervision, training expectations, methods of evaluation, and feedback or evaluation procedures. In recent years, more focus has been given to models of training and supervision, including competency-based supervision.

Competency-Based Supervision

Competency-based supervision has been defined as, "an approach that explicitly identifies the knowledge, skills, and values that are assembled to form a clinical competency and develops learning strategies and evaluation procedures to meet criterion-referenced standards in keeping with evidence-based practices and requirements of the local clinical setting" [11]. The focus on competency-based standards came following the 2002 revision of the APA Ethical Principals and Code of Conduct. There was a shift in education from assessment of curricula to educational outcomes and an emphasis on accountability to the public in education. Over time, the competency model moved into supervision and training programs as well as graduate school programs.

Quality assessment and evaluation came out of program evaluation in business, then it slowly migrated to general health care, to the professional schools of psychology, to professional organizations, and finally to ideas about outcomes of services. The idea of determining objectively whether or not what was desired by the client was achieved and the expected outcome produced was quite novel in psychology prior to 1990. Along with this came the idea of developing benchmarks for quality and guidelines for achievement to ensure that quality was maintained throughout an organization. Research designs examining outcomes and "best practices" were developed. In addition, organizations started asking clients about their needs, expectations, and ideas. This led to the concept of partnerships or collaboration between psychologists and patients in creating a treatment plan. It also led to surveys from patients and appraisals for teachers, employers, supervisors, and healthcare providers regarding whether or not expectations were being met. The concept of competency started to have, as a basis for evaluation, objective data on outcome and self-assessment, expected developmental progressions, and benchmarks for achievement of foundational skills and abilities at various points in time along a continuum of professional development. In addition to foundational skills (the knowledge basis one needs to be competent), functional skills (the abilities one must demonstrate to be considered competent) were proposed.

Finally, the idea of outcome assessment (how does one know if what they are doing is working) was built into the model as a feedback loop for refinement of competency assessment. In an educational setting, these concepts were superimposed on a developmental perspective applicable to teachers, mentors, and supervisors. Eventually, the concepts were incorporated into psychology professional schools and APA accreditation processes for education in psychology.

In 2007, the Assessment of Competency Benchmarks Workgroup published their document for the APA entitled *The Assessment of Competency Benchmarks Workgroup: A Developmental Model for the Defining and Measuring of Competence in Professional Psychology* [12]. They created a three-dimensional "Cube Model," with foundational competencies and functional competencies forming the 12 core competencies for clinical practice. These were placed in a developmental model to guide supervisors from practicum training through advanced practice to lifelong learning.

Within the Cube Model, the foundational competencies consist of reflective practice self-assessment, scientific knowledge and methods, relationships, ethical and legal standards policy, individual and cultural diversity, and interdisciplinary systems. The functional competencies consist of assessment/diagnosis/case conceptualization, intervention, consultation, research/evaluation, supervision/teaching, and management/administration [12; 34].

The healthcare field in general began to look at models to assess value, the idea of the consumer of services being important to evaluate the services and outcomes of the services, and benchmarking quality for provision of health care. In the United States and Canada, psychology moved from a practice of completing hours and coursework and moved toward a focus on competency for accreditation standards as a benchmark for quality education. Competency-based education, training, and credentialing efforts in professional psychology included graduate, practicum, internship, and postdoctoral levels; licensure; post-licensure certifications; and board certification. General and specialty credentialing efforts in North America and internationally followed suit.

Cultural Competency

In addition, psychology became increasingly aware of cultural and community reactions to diverse groups feeling excluded, stigmatized, and alienated. Over a period of about 40 years, psychology evolved from a profession in which "even the rats were white" and a focus on pathology of differences, to a field in which diversity in all forms (cultural and ethnic differences; gender, racial, and sexual orientation; knowledge about different communities; sensitivity to disabilities, heritage, and individual strengths and weaknesses; and the value of diversity itself) became expectations of competence. Explore how cultural competence affects psychologists' practice in the following examples:

- A White psychologist is working with a group of predominantly African American and Hispanic clients on "anger issues" in a group practice. In talking with colleagues in the group practice, he discovers that his group on "anger management" consists of 75% African American men while the population of clients of the group practice is 85% White. In questioning the colleagues about their criteria for referring clients to the group, they feel that the expression of anger by their African American patients was "more of a problem" than the expression of anger by their White patients. A retrospective review of charts showed that the group on "anger" is capturing only about 15% of eligible clients. White clients are not being referred regardless of whether anger was a presenting problem.
- A psychologist seeks consultation regarding treatment of a gay male couple in family therapy. He indicates to the consultant that he is uncomfortable treating the couple now that they are legally married and are planning to adopt a child.
- A psychologist uses an interpreter to assist with the evaluation of a Spanish-speaking client. The psychologist asks the client, "Are you suicidal?" The interpreter translates, "You aren't suicidal, are you?"
- A psychologist is asked to provide interven-tion strategies to help a group home for developmentally disabled adults keep a male client and a female client from having a sexual relationship because it makes the staff uncomfortable.

Case Study

A psychologist decides to treat a family in therapy. The parents of two minor children decide at some point in treatment to get a divorce. Records are requested for a court hearing regarding custody of the children, and the therapist is asked to testify on behalf of the wife and to separately evaluate the children regarding custody.

There are a number of issues regarding competence in this scenario. The psychologist has been acting as a therapist, and attempting to transition to the role of impartial evaluator in a forensic setting requires expertise above what is routine for a treating therapist. The blurring of roles and boundaries suggests the family may not understand what is appropriate in the situation and how the role of a forensic evaluator in a custody case differs from the role of a treating family therapist. Records of the family may have been kept on each person individually or on the family as a whole, making the release of records, if indicated, problematic. Knowing how to keep records appropriately is an issue of competence. Finally, the therapist is being asked to testify on behalf of the wife in the divorce and custody proceeding. The relationship of the therapist at the start of the treatment clarifies to all parties the areas in which the therapist is competent. To enter into a separate relationship with just the wife will raise issues of boundaries and role clarification and may highlight areas that were not competently addressed at the outset of treatment.

INFORMED CONSENT

Informed consent in psychology has several aspects. The first part is that psychologists know what it is that they are anticipating in providing services and can provide that information clearly to the client. The second part is that the person receiving services is able to understand and make use of the information the psychologist is providing. The third part is that the person receiving the services has the legal ability to consent to the services to be provided. Fourth, the person receiving the services must have the intellectual and psychological capacity to consent to the services being provided. The fifth part is the client's ability to form rational decisions about the information being provided. Lastly, the documentation of the agreement to provide services and to consent to those services being provided is essential.

Informed consent is described as having two goals: to promote individual autonomy and to encourage rational decision making. This presumes that the individual entering into the relationship has done so voluntarily and is capable of understanding what the psychologist is disclosing.

Informed consent can be broken down into the following areas [13]:

- Information: What is disclosed, how, when, and by whom?
- Understanding: What did the client understand about what would happen? How did that understanding develop?
- Competency: Did the client have the cognitive and emotional capacity to understand what was being communicated? Did they actually understand?
- Voluntariness: Is the client free to choose or not? Are they subject to undue influence or coercion? Is someone else responsible for ensuring that the client will decide or is someone else deciding for the client?
- Decision: How are the decisions about treatment being made? What role does the disclosure play?

The 2016 APA Ethics Code documents the need for informed consent in psychology in Standard 3.10 [8]. The following section has been reprinted with permission:

3.10 Informed Consent

(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.

(d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

As discussed, informed consent means providing information on the nature of the services being provided, the anticipated course of services, any anticipated benefits from the services, any anticipated risks in having the services or not, and alternatives to the proposed course of services being suggested, including what might occur with no treatment. These components are required both legally as well as ethically. The first legally recognized use of the term "informed consent" comes from the Salgo v. Leland Stanford etc. Bd. Trustees, 154 Cal. App. 2d 560 [Civ. No. 17045. First Dist., Div. One. Oct. 22, 1957.] case [14]. In this case Mr. Salgo was not told that an angiogram might result in complications such as paralysis. From this case came the outline of the requirements that an individual be fully informed about the nature of procedures, risks, benefits, and alternatives, and that the understanding be documented in the medical record.

Over time, informed consent has grown to also include agreeing to the policies and procedures of the facility in which the person is being seen. These include policies regarding:

- Scheduling: Frequency of meetings, time frames for scheduling, time frames for changing or cancelling appointments, and issues that would impact scheduling, such as availability of the psychologist due to other obligations
- Cancellation: The method of cancellation or rescheduling of services, charges for missed sessions, emergency notification procedures

- Payment for services: Cost of services, which services are covered, use of third-party payors (such as insurance), when payment is expected, whether credit cards or checks are acceptable, the expected time frames for payment for services, the procedure if an insurance company or other third-party payor declines to pay for services, and fees for other services such as evaluations, court testimony and depositions, reports, record review, and photocopying records to another party
- Record keeping: The manner in which records will be kept, how they are kept, length of record retention, information regarding protected health information, patient rights and access to records, legal access to records by the court or others (i.e., who has access to records besides the psychologist, how is security maintained, how and to whom records may be released), and whether the records will include any audio or video tapes, phone logs, or email correspondence
- Supervision: What information can be discussed with other professionals, including interns and postdoctoral fellows. If the psychologist is providing formal supervision, does the supervisee have an understanding of the exact expectations of the relationship and requirements for hours or completion of the program? Does the supervisee understand the role of the supervisor and has he or she communicated that role to the client? What evaluation methods will be used for the supervision? What is expected in case of a crisis for the client or supervisee?
- Collaboration with others: What will be discussed, which people or organizations have access to protected health information, how collaboration will occur, what roles others will have. Limitations regarding the people or organizations the psychologist is allowed to talk with and what information may be shared should be clarified.
- Rights and responsibilities: What is expected of the client, rights clients have regarding their treatment, what clients have a right to know prior to agreeing to a specific treatment, what clients should expect from the psychologist providing treatment, how treatment will proceed, what clients should do if they are not satisfied with treatment, what regulatory agencies are available to advocate on behalf of a client. Clients should also be advised of the limitations of any rights they are likely to believe they have, such as situations in which they are seen on behalf of the court and information will be provided back to the court.
- Children and adolescents: Consent for treatment, obligations to reveal records to parents or guardians on demand, limitations to confidentiality, obligations to reveal information legally for personal or community safety
- Availability: When, how, and where patients can interact with the psychologist, expectations of privacy and confidentiality, use of insurance or changes in insurance reimbursement, how to make contact in an emergency or between sessions, options available for dealing with emergencies

- Use of insurance or third-party payors: Information regarding Health Insurance Portability and Accountability Act (HIPAA). (Records are transmitted, accessed, and used electronically for providing services, to handle billing, for healthcare operations, and as required by law, and clients should be advised regarding the standardized formatting of information to be transmitted electronically, such as for insurance billing, and the use of reasonable state-of-the-art protective measures for computer security, such as limiting access by use of passwords or encryption, backing up stored information before moving hardware, and maintaining patient privacy.) Also discuss the use of insurance, collection of copayments, the insurance company's request for records and information, and the right to decline to use insurance for services.

Many of the difficulties psychologists have with reference to ethical complaints involve clients not fully understanding the nature of the services, including the policies and procedures of the office, the risks and benefits, and the alternatives available. A simple signature on a form can document what is expected and thought to be understood but is not sufficient for establishing informed consent. Informed consent is not a single process that takes place at the outset of treatment; it is involved in every step of the treatment process and often must be revisited as treatment progresses through different stages. Consider how informed consent may or may not have been attained in the following scenarios:

- Mr. X is contacted by his employer for an evaluation by Dr. J prior to returning to work after an injury. He signs paperwork at Dr. J's office and completes an initial intake form. He did not bring his reading glasses to the appointment, and the office clerk has to show him where to put his signature on the form and read questions to him so he can understand what is required. When Mr. X sees Dr. J, there is no mention from the clerk that his reading glasses are not available or the fact that he was unable to sign forms without assistance. Dr. J simply asks Mr. X if he had any questions prior to the evaluation. Mr. X says, "No." The evaluation is then completed, and the report is provided to Mr. X's employer. Mr. X is upset that information was not kept confidential and that he was not allowed to return to work. He did not understand the purpose of the evaluation or the fact that it was going to be used by his employer in determining whether he could return to work. Dr. J had a form signed by Mr. X that spelled out all of this information. The fact that Mr. X viewed the form as a formality and was not able to read it was not known to Dr. J.
- Dr. S decides that in vivo desensitization is the best form of treatment for Ms. Z's fear of spiders. Ms. Z consents to therapy. When Dr. S actually brings a spider into the office, however, Ms. Z runs from the room sobbing, indicating that she "had no idea" that actual spiders were to be used in her treatment.
- Miss C is 5 years of age and is afraid of anyone wearing a mask or costume. Her parents bring her into treatment for her fearfulness. Dr. D explains to Miss C directly the purpose of treatment and how treatment would progress. Dr. D outlines to Miss C and her parents that the patient will start by drawing masks and throwing them out and that at any part of drawing she can stop or just close her eyes. She would progress to using dolls and putting dolls in masks. Again, she could stop or close her eyes. She would then put dolls in costumes. Eventually, she would be expected to go on a field trip to see people dressed in animal costumes and is expected to do that without being scared or afraid. In addition to her parents understanding what is involved in treatment, Miss C is explained the treatment in detail.

It is possible to abdicate or waive the informed consent process. In these cases, the client must demonstrate an understanding of the right to have information about treatment and be involved in decisions about the treatment process. The client then may specifically indicate that he or she wants the psychologist to make those decisions on the client's behalf. This is often referred to as an "opt-out" procedure and involves research with minimal risk, in which full disclosure will be detrimental; emergency process and potentially life-saving techniques are being studied; or a substitute for the consent process is not readily available and failure to provide treatment would result in harm.

There are also cases in which the person is not competent to make decisions due to being a minor or having been found by the court to be incompetent. In these cases, assent or dissent to treatment will not authorize or constitute a valid refusal, and a substitute for informed consent would be required. This is contrasted with someone who may be psychotic, intoxicated, severely intellectually disabled, or unconscious and is unable to make rational decisions and understand the information that is being presented by the psychologist. When reviewing the following case examples, analyze how issues of incompetence might apply:

- Mr. I is an autistic adult being evaluated for a sheltered workshop program at the request of his parents. He has been recognized as incompetent by the court, and his parents are his legal guardians.
- Ms. P has taken a Minnesota Multiphasic Personality Inventory and wants to review the results. Her psychologist determines that such information may worsen her depression and increase her already present suicidal ideation and withholds the information based on therapeutic privilege.
- Ms. T is unconscious following a suspected overdose when brought to an emergency department for evaluation by a psychologist.

In each of these situations, the decision about treatment will be made by someone other than the patient. Family members or friends, the treating psychologist, a governmental authority, or hospital authority will provide third-party consent.

In general, psychiatric patients who are involuntarily hospitalized must be provided with informed consent to treatment. In California, the law also requires that voluntarily hospitalized patients be told specifically of their right not to be treated without their informed consent [15]. For individuals in California who are developmentally delayed and involuntarily hospitalized, the hospital is required to have a patient advocate available to provide informed consent on behalf of the patient and advocate on his or her behalf.

PRIVACY AND CONFIDENTIALITY

There are distinctions between privacy, confidentiality, and privileged communications. Privacy is an essential part of the professional psychologist's treating relationship with a patient, consultant, or supervisee. What is revealed in the treatment relationship must remain private so the treatment will be effective. The patient, consultant, or supervisee must feel free to readily disclose information to join into the treatment relationship.

Examples of privacy issues include:

- There is little soundproofing between offices, and discussions between a client and therapist can be overheard easily in the next room.
- A psychologist discusses a client on an online ListServ in ways that make the client identifiable.
- A psychologist recognizes a client at a social party, makes eye contact, then immediately leaves, making it obvious there is some relationship between the psychologist and client to others in attendance.
- A client contacts a psychologist on Facebook requesting to be "friends."

Confidentiality concerns information that is gathered by a psychologist. Federal and state laws govern which records must be kept, and the Ethics Code stipulates that psychologists are to keep records [8]. The nature and extent of the records will vary based on the purpose, setting, and context of the psychological services [16]. Records benefit both the client and the psychologist, allowing a delineated treatment plan, notation of services provided, monitoring of treatment, and assistance in legal or ethical proceedings or when transferring care to another provider. Guidelines for record keeping were set forth by the APA and were approved in February 2007. The guidelines expired in 2017. As of that date, users are encouraged to contact the APA Practice Directorate to determine whether the guidelines remain in effect [16]:

- Responsibility for records: Psychologists generally have responsibility for the maintenance and retention of their records.
- Content of records: A psychologist strives to maintain accurate, current, and pertinent records of professional services as appropriate to the circumstances and as may be required by the psychologist's jurisdiction. Records include information such as the nature, delivery, progress, and results of psychological services and related fees.
- Confidentiality of records: The psychologist takes reasonable steps to establish and maintain the confidentiality of information arising from service delivery.
- Disclosure of record-keeping procedures: When appropriate, psychologists inform clients of the nature and extent of record-keeping procedures (including a statement on the limitations of confidentiality of the records according to Ethics Code Standard 4.02).
- Maintenance of records: The psychologist strives to organize and maintain records to ensure their accuracy and to facilitate their use by the psychologist and others with legitimate access to them.
- Security: The psychologist takes appropriate steps to protect records from unauthorized access, damage, and destruction.
- Retention of records: The psychologist strives to be aware of applicable laws and regulations and to retain records for the period required by legal, regulatory, institutional, and ethical requirements.
- Preserving the context of records: The psychologist strives to be attentive to the situational context in which records are created and how that context may influence the content of those records.
- Electronic records: Electronic records, like paper records, should be created and maintained in a way that is designed to protect their security, integrity, confidentiality, and appropriate access, as well as their compliance with applicable legal and ethical requirements.
- Record keeping in organizational settings: Psychologists working in organizational settings (e.g., hospitals, schools, community agencies, prisons) strive to follow the record-keeping policies and procedures of the organization as well as the APA Ethics Code.
- Multiple-client records: The psychologist carefully considers documentation procedures when conducting couple, family, or group therapy in order to respect the privacy and confidentiality of all parties.
- Financial records: The psychologist strives to ensure accuracy of financial records.

- Disposition of records: The psychologist plans for transfer of records to ensure continuity of treatment and appropriate access to records when the psychologist is no longer in direct control, and in planning for record disposal, the psychologist endeavors to employ methods that preserve confidentiality and prevent recovery.

Confidentiality is a concern in each of the following cases:

- A client refers a friend or family member for treatment.
- Information regarding clinical treatment of a client is overheard.
- Patient records are stolen from a parked car.
- A family member requests information regarding a client's issues.
- A release of records is requested for one member of a couple being seen jointly, and the records contain information about the other member as well.

Privileged communication is defined as the legal right of an individual to keep confidential disclosures from any judicial proceeding or court of law. The legal definition may vary according to state statutes and laws. The California Evidence Code section 1014 notes [17]:

The patient, whether or not a party (to a legal proceeding), has a privilege to refuse to disclose, and to prevent from disclosing, a confidential communication between patient and psychotherapist if the privilege is claimed by:

(a) The holder of the privilege (e.g., the client).

(b) A person who is authorized to claim the privilege by the holder of the privilege (e.g., parent or legal guardian).

(c) The person who was the psychotherapist at the time of the confidential communication, but the person may not claim the privilege if there is no holder of the privilege in existence or if he or she is otherwise instructed by a person authorized to permit disclosure (e.g., the client, parent, or legal guardian).

Issues of privilege include:

- A client puts his or her mental health at issue in a workers' compensation case.
- A client is mandated for evaluation by federal or state law.
- A child seeks treatment independently from his or her family.
- A victim of crime seeks treatment.
- A psychologist seeks to limit information to a government agency regarding treatment following receipt of a subpoena.
- A psychologist seeks to obtain evaluation records of a patient undergoing a legally mandated evaluation and has authorization from the patient but not from the holder of privilege (the legally mandated referral agency).

The APA Ethics Code addresses standards of privacy and confidentiality in Standard 4: Privacy and Confidentiality. This standard is reprinted with permission in the following sections [8]:

4.01 Maintaining Confidentiality

Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. (See also Standard 2.05, Delegation of Work to Others.)

4.02 Discussing the Limits of Confidentiality

(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent.)

(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

(c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.

4.03 Recording

Before recording the voices or images of individuals to whom they provide services, psychologists obtain permission from all such persons or their legal representatives. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing with Informed Consent for Research; and 8.07, Deception in Research.)

4.04 Minimizing Intrusions on Privacy

(a) Psychologists include in written and oral reports and consultations, only information germane to the purpose for which the communication is made.

(b) Psychologists discuss confidential information obtained in their work only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

4.05 Disclosures

(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.

(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (See also Standard 6.04e, Fees and Financial Arrangements.)

4.06 Consultations

When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation. (See also Standard 4.01, Maintaining Confidentiality.)

4.07 Use of Confidential Information for Didactic or Other Purposes

Psychologists do not disclose in their writings, lectures, or other public media, confidential, personally identifiable information concerning their clients/patients, students, research participants, organizational clients, or other recipients of their services that they obtained during the course of their work, unless (1) they take reasonable steps to disguise the person or organization, (2) the person or organization has consented in writing, or (3) there is legal authorization for doing so.

Exceptions to Confidentiality

There are basic exceptions to confidentiality based on the ideas of doing no harm and providing a benevolent relationship to the community in which a psychologist works. Breaches of confidentiality can produce feelings of betrayal and loss of trust in the therapeutic relationship, and such breaches are made only when it is necessary to do so. One exception to confidentiality is to ensure the safety of the person in treatment or any others. If a person divulges intent to harm or kill him- or herself, then it is the duty of the therapist to assist the patient in maintaining his or her safety. This may include breaching confidentiality to law enforcement, family members, hospital personnel, or treating physicians to ensure that no harm comes to the patient. The APA Ethics Code notes, "Psychologists [should] take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable" [8].

Suicide and Self-Harm

Out of the obligation of psychologists to minimize harm where it is foreseeable and unavoidable comes a duty to assist with civil commitment and involuntary hospitalization [18]. Suicide is a serious public health problem that affects people of all ages. For Americans, suicide is the 11th leading cause of death. It resulted in 48,183 lives lost in 2021 [19]. The top three methods used in suicides are firearm, suffocation, and poisoning [19].

More people survive suicide attempts than actually die. In 2020, 187,000 people received medical care for self-inflicted injuries at emergency departments across the United States [19]. Complicating evaluation and treatment is the issue of attempting to predict how likely persons expressing suicidal ideation are to actually harm themselves. Clinical assessment has relied almost exclusively on an individual's self-report [20]. According to the *Harvard Medical School Guide to Suicide Assessment and Intervention*, "There is no psychological test, clinical technique, or biological marker sufficiently sensitive and specific to support accurate short-term prediction of suicide in an individual person" [21]. Risk management strategies are used to lessen the risk of suicide and strengthen the ethical and legal documentation of that evaluation. Several guidelines have been established for psychologists working with suicidal patients [3]:

- Be familiar with the current literature regarding risk factors, epidemiology, and management of the suicidal patient. It is equally important for clinicians to be knowledgeable of the law of the jurisdiction and current developments in the field.
- Take a complete patient history that includes indicators of suicide risk based upon diagnostic criteria and known risk factors for suicide. Throughout treatment, when risk is elevated the clinician should ask specific, forensically significant questions about depression and suicidal feelings and thoughts.
- Obtain releases to consult with past therapists and secure the patient's medical and mental health records.
- Use the *Diagnostic and Statistical Manual of Mental Disorders* diagnostic criteria to accurately diagnose patients and guide treatment.
- Recognize limitations (e.g., time restraints, appointment availability), understand technical proficiencies (training, education, and experience), and be aware of emotional tolerance levels when working with suicidal patients.
- Good record keeping is paramount. The model risk-benefit progress note should include: (a) an assessment of suicide risk; (b) the information alerting the clinician to that risk; (c) which high-risk factors were present in that situation and in the patient's background; (d) what low-risk factors were present; (e) what information, namely the patient's history and the clinician's professional judgment, led to actions taken and rejected.

- Routinely seek consultations from professional colleagues who have expertise in treating suicidal patients.
- Consult with legal counsel to determine if the insurance carrier needs to be notified of a serious suicide attempt or completed suicide.

Harm of Others

The same types of issues arise with concerns that a patient will harm others. Following legal landmark cases (e.g., 1976 California Supreme Court decision on Tarasoff v. Regents of the University of California; 1983 Hedlund v. Superior Court; and 2004 Ewing v. Goldstein), states have enacted laws to require psychologists to warn those at risk and persons in close relationship to the object of the person's threat and to include information from family members, not just the patient directly. In the Ewing case, the APA dissented from the ruling, stating that "requiring a therapist to warn intended victims when notified by a family member would have a 'chilling effect' on patients" [1]. The facts of the case document some information that is often omitted from discussion regarding the ethical issues involved in the case. The following is from Ewing v. Goldstein, 15 Cal. Rptr. 3d 864 - Cal: Court of Appeals, 2nd Appellate Dist., 8th Div. 2004 [22]:

> Respondent Dr. David Goldstein is a marriage and family therapist. Between 1997 and June 2001, Goldstein provided personal therapeutic services to Geno Colello, a former member of the Los Angeles Police Department. Goldstein treated Colello for work-related emotional problems and problems concerning his former girlfriend, Diana Williams.
>
> Beginning in early 2001, Colello became increasingly depressed and despondent over the termination of his relationship with Williams. Colello's feelings of depression significantly increased in mid-June, after learning of her romantic involvement with another man.

Goldstein last met with Colello at his office on June 19, 2001. Goldstein spoke with Colello on the telephone on June 20 and again on June 21, when he asked Colello if he was feeling suicidal. Colello "was not blatantly suicidal, but did admit to thinking about it." Goldstein asked Colello to consider checking himself into a psychiatric hospital and also sought and obtained Colello's permission to speak with his father, Victor Colello.

Colello had dinner with his parents on June 21. He was extremely depressed. Colello talked to his father about how he had lost the desire to live and about his building resentment toward Williams' new boyfriend. He told his father "he couldn't handle the fact that [Williams] was going with someone else," and said he "was considering causing harm to the young man that [Williams] was seeing." Colello's father contacted Goldstein and told him what Colello had said. Goldstein urged Colello's father to take Colello to Northridge Hospital Medical Center, where Goldstein arranged for him to receive psychiatric care. Colello was voluntarily admitted the evening of June 21, under the care of Dr. Gary Levinson, a staff psychiatrist.

On June 22, Levinson told Colello's father he planned to discharge Colello. Concerned that his son was being released prematurely, Colello's father called Goldstein. Goldstein contacted Levinson, with whom he had not yet spoken and explained why Colello should remain hospitalized. Levinson told Goldstein that Colello was not suicidal and would be discharged. Goldstein urged Levinson to re-evaluate Colello and keep him hospitalized through the weekend. He did not do so.

Colello was discharged on June 22. Goldstein had no further contact with his patient. On June 23, Colello murdered Williams' new boyfriend, Keith Ewing, and then committed suicide.

> Keith's parents, Cal and Janet Ewing, sued Goldstein for wrongful death based on professional negligence. The Ewings alleged Colello posed a foreseeable danger to their son and had directly or indirectly through third persons communicated to Goldstein his intention to kill or cause serious physical harm to him. They alleged Goldstein failed to discharge his duty to warn their son or a law enforcement agency of the risk of harm his patient posed to their son's safety.

What is often omitted in discussions about this case is the fact that Geno Colello was a police officer and had access to weapons and substantial knowledge and training in using them. Complicating the clinical treatment decision making was the fact that June 22, when Geno Colello was released from the hospital, was a Friday and Geno Colello was not scheduled to be seen by Dr. Goldstein until the next week. Dr. Goldstein appropriately questioned the validity of Dr. Levinson's assessment in light of contradictory information from the family but failed to do anything to make his own assessment of the patient and failed to notify law enforcement or the potential victim or family members of the potential threat. Had Dr. Goldstein gone to the hospital and independently evaluated Geno Colello and determined he was not a threat, then the Ewing family would not have reasonably been able to assert professional negligence.

The risks for notification of the victim of potential harm are not unsubstantial. In one case in which a patient made the assertion that he "could get a gun in exchange for a couple of tacos" and shoot his former employer, the patient was arrested by the police department after the former employer called them. While charges in the case were eventually dropped, the patient faced some time in jail as well as legal expenses [23]. In a similar case in Louisiana, a patient was arrested and charged with extortion after his threats were conveyed to the workers' compensation carrier for his employer [24].

When a patient reveals he or she has harmed a child or an elder, there are state laws that may require the notification of the police or some other legal authority [25]. The same may be true of a dependent adult [26]. If a child indicates he or she is a victim of a crime, the psychologist is required under child abuse laws to report the abuse [25].

Other Exceptions

Until November 1999, there was no patient-psychotherapist confidentiality for psychologists involved in treating or evaluating military personnel. There is now limited confidentiality (***Appendix***) [27]. Psychologists are also allowed to breach privacy when a patient seeks psychological services to enable him- or herself to commit a crime or avoid detection for having committed a crime [1].

Under some circumstances, the holder of privilege to release information is not the patient. This is true when the court has ordered an evaluation and the psychologist is court-appointed, when there are legal proceedings to establish sanity or competency, or when the patient has put his or her mental state at issue in a legal proceeding, such as a malpractice claim, a personal injury claim, or a claim for disability benefits due to a mental disorder. Confidentiality is also voided in cases when a patient sues a therapist for breach of duty or a therapist sues a patient for inappropriate behavior.

Patients are able to allow the release of their records by signing an authorization. The authorization must comply with state law, if any applies, and with any federal regulations, such as HIPAA. Two exceptions are if a patient requests to view his or her own clinical record and the therapist believes that such a release may harm the patient, or if a parent or guardian wishes to view the clinical record of his or her child and the psychologist believes that releasing the records would have a detrimental effect on treatment, the safety of the child, or the child's well-being [28]. When a patient dies, a psychologist may release records concerning the conveyance of a will or deed, but clinical records generally remain confidential even after the death of a patient.

Technology

The use of technology in psychotherapy impacts confidentiality, privacy, privilege, and even how therapy is conducted. It is now common for therapists to have websites, and the use of search engines enables patients and therapists alike to obtain information that previously was not generally available. Some psychologists have embraced the use of technology, setting up telehealth services and offering treatment via video-conferencing, e-mail, and cell phone, while others have incorporated policy statements on the use of Google, Facebook, and Twitter into their practices [29; 30]. While the APA Ethics Code is not continually revised to reflect the rapid advances in technology, supplementary publications (e.g., the *Guidelines for the Optimal Use of Social Media in Professional Psychological Practice* and the *Guidelines for the Practice of Telepsychology*) are informed by the Ethics Code and legal regulatory requirements and are available to assist providers in maintaining compliance with HIPAA laws [30; 32; 35]. While point-to-point contacts with computers may be secure, remote access and the use of video conferencing (e.g., Skype) and other Internet-based phone services or the utilization of cloud computing, email, and social networking sites may limit privacy and confidentiality. In all of these instances, patients must be advised that others may have access to their information. Well-understood protocols for all individuals using technological systems (e.g., psychologists, billing agencies, patients, support staff) should be in place to limit the risk of others obtaining data they are not entitled to. The use of laptop and tablet computers increases the risk of data being stolen or lost; password encryption is required. Up-to-date virus protection is also required to limit dissemination of information or being immobilized. Clients should be informed of the risks of the use of technology prior to their use in therapy [30; 32; 35].

AVOIDING HARM AND EXPLOITATION

Ethics codes for psychologists have always been concerned with preventing the infliction of harm on others. Principal A of the APA Ethics Code deals with beneficence and nonmaleficence [8]:

> Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.

Harm may or may not be intentional; it may result from incompetence or lack of awareness. However, exploitation is more deliberate and consists of using someone unfairly or benefiting unjustly from someone. Some harmful relationships may not be exploitative, while other relationships are both harmful and exploitative. Incompetence that results in harm has been addressed earlier in this course. Harm from a lack of awareness may arise when the psychologist has issues that impact his or her mental or physical well-being, a lack of insight into his or her own perceptions and biases, and/or a lack of understanding of the foreseeable consequences of a course of action. Harmful and exploitative relationships generally involve boundary violations

and role-confusion, such as sexual involvement with a patient, research subject, supervisee, or student. The involvement of third parties as payors, grant funders, or other types of relationships that include remuneration may create a conflict of interest situation. Conflicts of interest may also arise when the psychologist is acting in multiple roles, such as in providing an objective assessment in a forensic case as well as being a patient advocate in treatment.

ETHICAL DECISION MAKING

In many situations, psychologists need a framework for determining the most ethical course of action. The theoretical orientation of the psychologist may provide some guidance, such as in how much to disclose about one's personal life or whether or not nonsexual touch is permitted. For others, religious views dictate overriding concepts of morality and values and guide ethical decision making. Models have been proposed to assist with ethical decision making in forensic cases, general ethical decisions, and health care [33; 36]. Nagy documents seven different models for ethical decision making [1; 37; 38; 39; 40; 41; 42; 43; 44]:

- Worst case scenarios
- Eight-step model
- 10-step process
- Nine questions for multiple role relationships
- Five-step model
- Three-factor model
- Four-factor model

Other possible frameworks include an 18-step model and the formulation of ethical issues from a feminist perspective [45; 46]. Consultation with colleagues and/or legal counsel can assist a psychologist in formulating a decision when faced with an ethical dilemma.

COMPLAINTS AND CHARGES

When psychologists violate ethical standards or state or federal laws, people who believe they were harmed can file a complaint with the state licensing authority or can institute a lawsuit against the psychologist. If the psychologist is a member of the APA, a grievance can be filed through the APA Ethics Office. The psychologist has the option to withdraw membership when contacted to begin the preliminary investigation. The process of investigation is lengthy and can take more than a year. The psychologist may seek legal advice from an attorney in responding to the investigation. The Ethics Office ultimately will make a decision whether or not to impose sanctions on the psychologist. These sanctions can range from:

- Reprimand: There is a violation, but no harm came to an individual or to the profession of psychology.
- Censure: There is harm to someone, but it is not substantial.
- Expulsion: There are egregious acts resulting in harm to another or to the profession.
- Stipulated resignation: Serious violations have occurred whereby the psychologist is allowed to resign but may reapply when they comply with certain stipulations or directives. Because the APA is not a licensing authority, even if one resigns or is expelled, he or she is still allowed to practice unless the state licensing authority chooses to investigate and decides to suspend or revoke the license.

The APA Ethics Office can also issue directives in addition to these sanctions. These include:

- Cease and desist order: Requires the psychologist to stop the unethical conduct
- Corrective actions: Steps to ensure that the unethical conduct will not recur, including supervision, additional education, treatment, or probation and monitoring to ensure compliance

The state licensing board is part of a regulating agency designed to protect consumers. Complaints are reviewed by a state Ethics Committee. States vary in types of disciplinary actions they may take, and the procedures differ from those of the APA. In California, complaints are reviewed through an administrative law process. The process starts when a member of the public files a complaint. At that particular stage, the professional receives a Letter of Inquiry of a Complaint requiring a response in a very short period of time. If the case is not resolved at this level, the matter may lose its confidentiality and the licensing board may file an accusation, which is a public document somewhat like an indictment. There are very precise procedures following an accusation that the attorney must know in order to properly defend the client. Cases may go to trial before an administrative law judge following a set of rules called the Administrative Procedure Act, which is part of California Government Code Section 11340 [31]. Professionals facing a trial may call witnesses, cross-examine every witness called by the licensing board, call experts, and offer a variety of types of evidence. In trial, there tends to be relaxed rules of evidence, such as allowing hearsay as evidence in proceedings against a professional. After the trial, the judge issues a decision that goes back to the licensing board for adoption or nonadoption. States can issue a variety of penalties, including a letter of warning, probation, suspension, and revocation of licensure.

Psychologists can also face civil lawsuits and criminal charges for serious issues. Psychologists usually notify their malpractice insurance provider when faced with such charges and are assigned an attorney. The legal process is different than in administrative law and more formal rules of evidence and a higher burden of proof apply.

By understanding the APA Ethics Code and laws governing the practice of psychology, psychologists can reduce the likelihood of receiving an ethical complaint.

CONCLUSION

Ethical theory is complicated, and its application is challenging. Ethical decision making tackles many pressing issues facing psychologists. In order to chart a problem-solving course, all psychologists need specific tools to assist in this endeavor.

Familiarity with and adherence to the APA Ethics Code can offer a degree of protection from the various pitfalls of practicing psychology in contemporary American society, such as administrative sanctions and malpractice suits. Following federal, state, and local laws, along with any/all ethical codes or rules where practicing, offers further protection from legal or administrative action; however, ethical principles are primarily intended to benefit the client. It is the goal of ethics to instill clients and the public with trust in psychologists and a sense of autonomy while ensuring client safety.

Psychologists should update skills in law and ethics routinely. The psychologist with a good understanding of ethics is equipped to deal with questions regarding care plans and, when confronted with difficult choices or ethical dilemmas, is capable of consistently making ethically sound decisions and justifying those decisions. Furthermore, discussion of newer ethical issues advances the practice and scope of psychology.

APPENDIX

WHITE HOUSE, Washington, D.C.—Sec. 2. Part III of the Manual for Courts-Martial, United States, Military Commission Rules of Evidence, Rule 513. Psychotherapist-patient privilege [27].

(a) *General Rule*. A patient has a privilege to refuse to disclose and to prevent any other person from disclosing a confidential communication made between the patient and a psychotherapist or an assistant to the psychotherapist, in a case arising under the Uniform Code of Military Justice, if such communication was made for the purpose of facilitating diagnosis or treatment of the patient's mental or emotional condition.

(b) *Definitions*. As used in this rule of evidence:

(1) A "patient" is a person who consults with or is examined or interviewed by a psychotherapist for purposes of advice, diagnosis, or treatment of a mental or emotional condition.

(2) A "psychotherapist" is a psychiatrist, clinical psychologist, clinical social worker, or other mental health professional who is licensed in any State, territory, possession, the District of Columbia, or Puerto Rico to perform professional services as such, or who holds credentials to provide such services from any military healthcare facility, or is a person reasonably believed by the patient to have such license or credentials.

(3) An "assistant to a psychotherapist" is a person directed by or assigned to assist a psychotherapist in providing professional services, or is reasonably believed by the patient to be such.

(4) A communication is "confidential" if not intended to be disclosed to third persons other than those to whom disclosure is in furtherance of the rendition of professional services to the patient or those reasonably necessary for such transmission of the communication.

(5) "Evidence of a patient's records or communications" is testimony of a psychotherapist, or assistant to the same, or patient records that pertain to communications by a patient to a psychotherapist, or assistant to the same, for the purposes of diagnosis or treatment of the patient's mental or emotional condition.

(c) *Who May Claim the Privilege*. The privilege may be claimed by the patient or the guardian or conservator of the patient. A person who may claim the privilege may authorize trial counsel, defense counsel, or any counsel representing the patient to claim the privilege on his or her behalf. The psychotherapist or assistant to the psychotherapist who received the communication may claim the privilege on behalf of the patient. The authority of such a psychotherapist, assistant, guardian, or conservator to so assert the privilege is presumed in the absence of evidence to the contrary.

(d) *Exceptions*. There is no privilege under this rule:

(1) when the patient is dead;

(2) when the communication is evidence of child abuse or neglect, or in a proceeding in which one spouse is charged with a crime against a child of either spouse;

(3) when federal law, state law, or service regulation imposes a duty to report information contained in a communication;

(4) when a psychotherapist or assistant to a psychotherapist believes that a patient's mental or emotional condition makes the patient a danger to any person, including the patient;

(5) if the communication clearly contemplated the future commission of a fraud or crime or if the services of the psychotherapist are sought or obtained to enable or aid anyone to commit or plan to commit what the patient knew or reasonably should have known to be a crime or fraud;

(6) when necessary to ensure the safety and security of military personnel, military dependents, military property, classified information, or the accomplishment of a military mission; or

(7) when an accused offers statements or other evidence concerning his mental condition in defense, extenuation, or mitigation, under circumstances not covered by R.C.M. 706 or Mil. R. Evid. 302. In such situations, the military judge may, upon motion, order disclosure of any statement made by the accused to a psychotherapist as may be necessary in the interests of justice.

(e) *Procedure to Determine Admissibility of Patient Records or Communications.*

(1) In any case in which the production or admission of records or communications of a patient other than the accused is a matter in dispute, a party may seek an interlocutory ruling by the military judge. In order to obtain such a ruling, the party must:

(A) file a written motion at least 5 days prior to entry of pleas specifically describing the evidence and stating the purpose for which it is sought or offered, or objected to, unless the military judge, for good cause shown, requires a different time for filing or permits filing during trial; and

(B) serve the motion on the opposing party, the military judge and, if practical, notify the patient or the patient's guardian, conservator, or representative that the motion has been filed and that the patient has an opportunity to be heard as set forth in subparagraph (e)(2).

(2) Before ordering the production or admission of evidence of a patient's records or communication, the military judge shall conduct a hearing, which shall be closed. At the hearing, the parties may call witnesses, including the patient, and offer other relevant evidence. The patient shall be afforded a reasonable opportunity to attend the hearing and be heard. However, the hearing may not be unduly delayed for this purpose. The right to be heard under this rule includes the right to be heard through counsel, including Special Victims' Counsel under section 1044e of title 10, United States Code. In a case before a court-martial composed of a military judge and members, the military judge must conduct the hearing outside the presence of the members.

(3) The military judge may examine the evidence or a proffer thereof in camera, if such examination is necessary to rule on the production or admissibility of protected records or communications. Prior to conducting an in-camera review, the military judge must find by a preponderance of the evidence that the moving party showed:

(A) a specific, credible factual basis demonstrating a reasonable likelihood that the records or communications would contain or lead to the discovery of evidence admissible under an exception to the privilege;

(B) that the requested information meets one of the enumerated exceptions under subdivision (d) of this rule;

(C) that the information sought is not merely cumulative of other information available; and

(D) that the party made reasonable efforts to obtain the same or substantially similar information through non-privileged sources.

(4) Any production or disclosure permitted by the military judge under this rule must be narrowly tailored to only the specific records or communications, or portions of such records or communications, that meet the requirements for one of the enumerated exceptions to the privilege under subdivision (d) of this Rule and are included in the stated purpose for which the records or communications are sought under subdivision (e)(1)(A) of this Rule.

(5) To prevent unnecessary disclosure of evidence of a patient's records or communications, the military judge may issue protective orders or may admit only portions of the evidence.

(6) The motion, related papers, and the record of the hearing must be sealed in accordance with R.C.M. 701(g)(2) or 1113 and must remain under seal unless the military judge, the Judge Advocate General, or an appellate court orders otherwise.

Works Cited

1. Nagy TF. *Essential Ethics for Psychologists: A Primer for Understanding and Mastering Core Issues*. Washington, DC: American Psychological Association; 2011.
2. Corey G, Corey MS, Corey C. *Issues and Ethics in the Helping Professions*. 10th ed. Independence, KY: Cengage Learning; 2018.
3. Gladding ST. *Counseling: A Comprehensive Profession*. 8th ed. Upper Saddle River, NJ: Merrill; 2017.
4. Fernberger SW. The American Psychological Association 1892–1942. *Psychol Rev*. 1943;50(3):33-60.
5. American Psychological Association. APA History and Archives. Available at https://www.apa.org/about/apa/archives. Last accessed May 25, 2023.
6. Fisher CB. *Decoding the Ethics Code: A Practical Guide for Psychologists*. 4th ed. Thousand Oaks, CA: Sage Publications; 2016.
7. American Psychological Association. About APA. Available at https://www.apa.org/about. Last accessed May 25, 2023.
8. American Psychological Association. Ethical Principles of Psychologists and Code of Conduct: Including 2010 and 2016 Amendments. Available at https://www.apa.org/ethics/code/index. Last accessed May 25, 2023.
9. American Psychological Association. Ethical Principles of Psychologists and Code of Conduct. Available at https://www.apa.org/ethics/code/ethics-code-2017.pdf. Last accessed May 25, 2023.
10. Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA*. 2002;287(2):226-235.
11. Falendar CA, Shafranske EP. Competence in competency-based supervision practice: construct and application. *Prof Psychol Res Pr*. 2007;38(3):232-240.
12. American Psychological Association. Assessment of Competency Benchmarks Work Group: A Developmental Model for the Defining and Measuring of Competence in Professional Psychology. Available at https://www.ccptp.org/assets/2011-Conference-Resources/benchmark_competencies_document_-_feb_2007.pdf. Last accessed May 25, 2023.
13. Lidz CW, Meisel A, Zerubavel E, Carter M, Sestak RM, Roth LH. *Informed Consent: A Study of Decisionmaking in Psychiatry*. New York, NY: Guilford Press; 1984.
14. Justia US Law. Salgo v. Leland Stanford etc. Bd. Trustees. Available at https://law.justia.com/cases/california/court-of-appeal/2d/154/560.html. Last accessed May 25, 2023.
15. California Department of Healthcare Services. Rights for Individuals in Mental Healthcare Facilities. Available at https://www.dhcs.ca.gov/services/Documents/DHCS_Handbook_English.pdf. Last accessed May 25, 2023.
16. American Psychological Association. Record Keeping Guidelines. Available at https://www.apa.org/practice/guidelines/record-keeping. Last accessed May 25, 2023.
17. California Legislative Information. Evidence Code Section 1014. Available at http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1014.&lawCode=EVID. Last accessed May 25, 2023.
18. Parry J, Gilliam FP. *Handbook on Mental Disability Law*. Washington, DC: American Bar Association; 2002.
19. Centers for Disease Control and Prevention. FastStats: Suicide and Self-Harm Injury. Available at https://www.cdc.gov/nchs/fastats/suicide.htm. Last accessed May 25, 2023.
20. Nock MK, Banaji MR. Prediction of suicide ideation and attempts among adolescents using a brief performance-based test. *J Consult Clin Psychol*. 2007;75(5):707-715.
21. Jacobs D, Brewer M, Klein-Benheim M. Suicide assessment: an overview and recommended protocol. In: Jacobs DG (ed). *Harvard Medical School Guide to Suicide Assessment and Intervention*. San Francisco, CA: Jossey-Bass; 1999: 3-39.
22. Ewing v. Goldstein (2004), Cal.App.4th. Available at https://caselaw.findlaw.com/ca-court-of-appeal/1010184.html. Last accessed May 25, 2023.
23. Applebaum GT. Racism, workers' compensation evaluations and Tarasoff laws. *Am J Forensic Psychol*. 1993;11(2):61-67.
24. United States of America, Plaintiff-Appellant, v. John C. Auster, Defendant-Appellee, United States Court of Appeals for the Fifth Circuit. Available at http://www.ca5.uscourts.gov/opinions/pub/07/07-30084-CV0.wpd.pdf. Last accessed May 25, 2023.
25. California Penal Code Section 11164-11174.3. Available at https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=PEN&division=&title=1.&part=4.&chapter=2.&article=2.5. Last accessed May 25, 2023.
26. California Welfare and Institutions Code Section 15630. Available at https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=9.&title=&part=3.&chapter=11.&article=3. Last accessed May 25, 2023.
27. Joint Service Committee on Military Justice. Manual for Courts-Martial, United States: 2019 Edition. Available at https://jsc.defense.gov/Portals/99/Documents/2019%20MCM%20(Final)%20(20190108).pdf. Last accessed May 25, 2023.
28. California Health and Safety Code Section 123115. Available at http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=123115. Last accessed May 25, 2023.
29. Gavazzi J. Social Media and Ethics: Psychologists Self-Reflect When Engaging Through Technology. Available at https://www.ethicalpsychology.com/2016/04/social-media-ethics-psychologists-self.html. Last accessed May 25, 2023.
30. American Psychological Association. APA Guidelines for the Optimal Use of Social Media in Professional Psychological Practice. Available at https://www.apa.org/about/policy/guidelines-optimal-use-social-media.pdf. Last accessed May 25, 2023.

31. California State Legislature. Government Code Section 11340-11342.4. Available at https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=GOV&division=3.&title=2.&part=1.&chapter=3.5.&article=1. Last accessed May 25, 2023.
32. American Psychological Association. Guidelines for the Practice of Telepsychology. Available at https://www.apa.org/practice/guidelines/telepsychology. Last accessed May 25, 2023.
33. Bush SS, Connell MA, Denney RL. *Ethical Practice in Forensic Psychology: A Guide for Mental Health Professionals. 2nd ed.* Washington, DC: American Psychological Association; 2019.
34. Fouad NA, Grus CL, Hatcher RL, et al. Competency Benchmarks: A Model for Understanding and Measuring Competence in Professional Psychology Across Training Levels. Available at https://drjeffchang.webs.com/benchmarks.pdf. Last accessed May 25, 2023.
35. American Psychological Association. The HIPAA Final Rule: What You Need to Do Now. Available at https://www.apaservices.org/practice/update/2013/07-25/hipaa-final-rule.pdf. Last accessed May 25, 2023.
36. Hanson SL, Kerkhoff TR, Bush SS. *Health Care Ethics for Psychologists: A Casebook*. Washington, DC: American Psychological Association; 2005.
37. Sonne JL. Nonsexual Multiple Relationships: A Practical Decision-Making Model for Clinicians. Available at https://kspope.com/site/multiple-relationships.php. Last accessed May 25, 2023.
38. Bransford JD, Stein BS. *The Ideal Problem Solver: A Guide to Improved Thinking, Learning, and Creativity*. 2nd ed. New York, NY: Worth Publishers; 1993.
39. Gottlieb MC. Avoiding exploitative dual relationships: a decision-making model. *Psychotherapy (Chic).* 1993;30(1):41-48.
40. Härtel CEJ, Härtel GF. SHAPE-assisted intuitive decision making and problem solving: information-processing-based training for conditions of cognitive busyness. *Group Dynamics.* 1997;1(3):187-199.
41. Bell T. Death Threats, Interfering Daughters and Other Worst-Case Scenarios. Presented at the Cincinnati Children's Hospital Medical Center Conference on Medical Interpreting. August 21, 2010. Available at https://www.slideshare.net/terenabell/cincy-pres. Last accessed May 25, 2023.
42. Keith-Spiegel P, Koocher GP. *Ethics in Psychology: Professional Standards and Cases*. 2nd ed. New York, NY: Random House; 1998.
43. Canadian Psychological Association. Canadian Code of Ethics for Psychologists. Available at https://cpa.ca/aboutcpa/committees/ethics/codeofethics. Last accessed May 25, 2023.
44. Younggren JN, Gottlieb MC. Managing risk when contemplating multiple relationships. *Prof Psychol Res Pr.* 2004;35(3):255-260.
45. Brabeck MM (ed). *Practicing Feminist Ethics in Psychology*. Washington, DC: American Psychological Association; 2000.
46. Pope K. Ethical Standards and Practice Guidelines for Assessment, Therapy, Counseling, and Forensic Practice. Available at https://www.kspope.com/ethcodes/index.php. Last accessed May 25, 2023.