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Praise for the 6th edition of Ethics in Psychotherapy and Counseling

"The 6th edition of *Ethics in Psychotherapy and Counseling* is a practical and indispensable guide for clinicians. The volume is filled with up-to-date information and actionable steps on ethics including telehealth and social media. What sets the book apart is its consistent attention to an ethics grounded in dignity, respect, and human rights. I am excited about its release!"
—Jennifer F. Kelly, PhD, ABPP, 2021 President, American Psychological Association

"This is the best psychology ethics book on the market; a must-have resource for any applied psychologist or mental health professional. The internationally recognized scholars and practitioners use research, case examples, legal decisions, and diversity-related topics to bring ethical dilemmas to life. This volume makes me excited to teach on ethics."
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"The 6th edition is a stunningly good book. If there is only one book you buy on ethics, this is the one."
—David H. Barlow PhD, ABPP, Professor of Psychology and Psychiatry Emeritus; Founder, Center for Anxiety and Related Disorders (CARD), Boston University

"No other ethics text comes close to matching its comprehensiveness. The 6th edition is a paradigm of excellence and should be required reading for all mental health practitioners."
—Derald Wing Sue, PhD, Professor of Psychology and Education Teachers College, Columbia University

"This 6th edition of *Ethics in Psychotherapy and Counseling* takes ethical reasoning and practice to a new level by addressing the complexity of video conferencing and the use of digital tools while emphasizing issues of diversity, equity, and inclusion. An absolute must-read for all clinicians."
—Martin Drapeau, PhD, Professor, McGill University; former editor of *Canadian Psychology*

"Like all areas of human functioning, ethics is influenced by culture. Yet, during my psychological training over 20 years ago, the recognition and inclusion of topics related to culture and other diverse aspects of the human experience (e.g., race, gender, religion, sexual orientation) in ethics were marginalized, if they were mentioned at all. In this 6th edition of *Ethics in Psychotherapy and Counseling*, the authors have updated an already classic book that is responsive to the emergent needs of this historical moment."
—Kevin O. Cokley, PhD, Professor of Educational Psychology and African and African Diaspora Studies, The University of Texas at Austin

"The authors of this 6th edition continue to represent the 'conscience of psychology.' The inclusion of new and important material makes this the essential handbook of ethics in contemporary psychology."
—Bonnie R. Strickland, PhD, Former President, American Psychological Association

"This is a MUST READ for both beginning and seasoned clinicians. KUDOS!"
—Don Meichenbaum, PhD, Research Director of the Melissa Institute for Violence Prevention, Miami

Cover Design: Wiley

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Also available as an e-book

ISBN 978-1-119-80429-1
90000
9 781119 804291

Pope
Vasquez
Chavez-Dueñas
Adames

ETHICS IN PSYCHOTHERAPY AND COUNSELING

6th Edition

WILEY

Ethics IN PSYCHOTHERAPY AND COUNSELING

6th Edition

A PRACTICAL GUIDE

Kenneth S. Pope
Melba J. T. Vasquez
Nayeli Y. Chavez-Dueñas
Hector Y. Adames

WILEY

CRITICAL PRAISE FOR ETHICS IN PSYCHOTHERAPY AND COUNSELING

(Continued from the outside back cover)

"*Ethics in Psychotherapy and Counseling* has always been the volume I turn to when confronted with a complex risk management question with ethical implications. It has never let me down. As changes in technology and the changes in the health care system precipitated by the Affordable Care Act, HIPAA, and the rapid growth of telepsychology generated by the COVID-19 pandemic, mental health professionals will be confronting, with little guidance, unique problems with considerable ethical ambiguity. In this time of rapid change, this comprehensive but down to earth [6th edition] will become an even more essential resource."

—**Eric Harris, JD, PhD**, Risk Management Consultant, The Trust (formerly American Psychological Association Insurance Trust)

"If you're one of the tens of thousands of psychologists who already own previous editions of this iconic volume, get the new version without delay. Pope, Vasquez, Chavez-Dueñas, and Adames have more than updated the previous edition: their new material on two topics of importance to psychology—social justice and Telehealth—have earned it a spot in every psychologist's library."

—**Douglas C. Haldeman, PhD,** John F. Kennedy University

"The 6th edition is a compassionate, must-have resource for both students and seasoned professionals. Its emphasis on the importance of self-knowledge, moral courage, humility, cultural awareness, and sound ethical reasoning makes a significant contribution to our understanding of what it means to be ethical."

—**Carole Sinclair, PhD**, Member and former Chair, Committee on Ethics, Canadian Psychological Association

"One of the most impressive aspects of the most recent edition of this book, the original of which was published in the last century, is the clarity, thoroughness, and compassion with which the authors respond not only to the traditional ethical dilemmas confronted by psychologists and counselors, but also the speed with which they rise to the occasion of new challenges and quandaries. From who else would we have expected to see an ethics book that already engages in a thorough, informative, and socially just discussion of the question of on-line delivery of services in the COVID era than from these authors? I have counted myself fortunate to have always had their sage counsel in writing at my side throughout the more than forty years of my own career. All practicing therapists need to own and read this book, and it makes a timely

addition to the reading list for an ethics class in this new decade, already replete with conundrums that no therapist from my cohort trained in the 1970s could have possibly imagined."

—**Laura S. Brown, PhD, ABPP**, Psychotherapy Consultant and Forensic Psychologist in Private Practice, Seattle WA, and Clinical Professor, Department of Psychiatry and Behavioral Sciences, University of Washington

"In this best-in-show textbook, Pope and Vasquez have added two co-authors (Chavez-Dueñas and Adames) to the 6th edition, to provide a practical guide to ethics in psychotherapy and counseling. In a changing world beset by a pandemic and the need for new approaches to social justice, where Zoom calls, FaceTime, and other innovations challenge the field, this book will be an essential guide for the therapist and clinical researcher."

—**Patrick O'Neill, PhD**, Professor Emeritus of Psychology (Acadia); Former President of the Canadian Psychological Association

"The 6th edition offers masterful guidance on ethical dilemmas, self-reflective critical thinking, blind spots, challenges of a pandemic, and the migration to videoconference treatment, and more. The authors parse culture and context, as well as human rights and addressing oppression in psychotherapy. All of it leads us further down the road toward social justice and improved health care. What a feat!"

—**Carol D. Goodheart, EdD**, Former President, American Psychological Association

"With the addition of co-authors Nayeli Y. Chavez-Dueñas and Hector Y. Adames, the 6th edition of Kenneth S. Pope and Melba J.T. Vasquez's outstanding book transports us into today's ethical challenges and conundrums. The engaging format continues to educate us about traditional ethical concepts while encouraging us to examine, reflect, and question our own ethical awareness. The extensive contributions regarding working competently with clients in a culturally diverse society, moral distress, and the concepts of emotional competence and power are especially eye-opening. Readers are kept focused on challenging decision-making but also on who they are or should aspire to be as self-reflective, competent practitioners. But this book is not just for students. Indeed, it is a must-read for all providers of mental health services."

—**Patricia Keith-Spiegel, PhD**, Past-Chair, American Psychological Association Ethics Committee

"The 6th edition of *Ethics in Psychotherapy and Counseling* updates and expands upon an established classic. It is an indispensable resource for clinicians of any discipline. This book's engaging prose and straightforward styling

will make it an easy read at your leisure, while its pithy examples and cultivated wisdom will make it your first stop in a crisis. Buy it now, and keep it where you'll always be able to find it."

—**Eric Y. Drogin, JD, PhD, ABPP** (Forensic), Harvard Medical School; Former Chair, American Psychological Association Committee on Professional Practice and Standards

"The turn of this decade has thrust mental health professionals into a new world of practice. The foundational concepts of ethical practice such as confidentiality, informed consent, and multiple roles are no longer enough. The extraordinary expectations for mental health professionals' new level of competence have no template at this time. This text squarely hits the four unchartered areas in our new world of practice: (a) what mental health professionals need to know to ethically engage in remote practice/videoconferencing (e.g., apps, social media); (b) significant changes in the APA and Canadian Code of Conduct enacted in the last three years; (c) how to respectfully respond to and treat clients living in systemic oppression; and (d) how to culturally enact competency and social justice in your practice. The fundamentals across research, practice, and training are also significantly revised. This text is unquestionably the cutting-edge primer for our new world of practice and is an essential companion for mental health professionals."

—**Linda F. Campbell, PhD**, Professor, The University of Georgia

"Pope and Vasquez demonstrate why they are leading ethics scholars in the 6th edition of their book, *Ethics in Psychotherapy and Counseling: A Practical Guide*, by adding to the authorship of the book two outstanding ethicists, Nayeli Y. Chavez-Dueñas and Hector Y. Adames. The trilogies of pandemics, racism, and economic challenges made it necessary to change our approach to ethics. Pope, Vasquez, Chavez-Dueñas, and Adames add the pandemics, telehealth, hackers, cultural humility, and broad diversities to challenge the reader's thinking on ethics, moral courage, and doing the right thing. This book goes to the head of the line in my new purchases. I will use the 6th edition in my classes and presentations!"

—**Rosie Phillips Davis, PhD, ABPP**, Past President, American Psychological Association; Professor, Counseling, Educational Psychology and Research

"The latest iteration of this must-read resource for psychotherapists and counselors now includes contributions by two new co-authors, broadening perspectives and providing expanded COVID-era content on serving clients in a politically volatile socially distant world. The 6th edition has increased attention to telehealth and on ethical practice in the context of hot social issues. Substantial new material addresses ethical practice across the full range

of differences among people, social justice, human rights, and societal oppression arising from racism, religious prejudice, and sexism/heterosexism. This well-crafted resource provides an enhanced level of ethical awareness to both experienced and novice practitioners."

—**Gerald P. Koocher, PhD, ABPP**, Senior Lecturer, Harvard Medical School Department of Psychiatry and Bioethics Center faculty member; former President, American Psychological Association.

"This impressive book is a superb resource on ethics in psychotherapy and counseling. In its 6th edition, expert practitioner-scholars Pope, Vasquez, Chavez-Dueñas, and Adames, expand psychotherapy ethics into an inclusive and multifocal field. A powerful blend of case scenarios, research findings, valuable theory, and practical responsibilities. I highly recommend this outstanding book to practitioners, researchers, students, and to interested members of the public."

—**Lillian Comas-Díaz, PhD,** Clinical Professor, George Washington University Department of Psychiatry and Behavioral Sciences

"As the latest stop on the road of excellence that began at the first edition, in the 6th edition of the classic text the authors have massively updated this practical guide with notes on COVID, virtual psychology, ethics changes in clinical codes, and other developments. By adding two additional authors and three new chapters, this deeply thoughtful work continues to serve as a guide through tangled ethical dilemmas."

—**Thomas G. Gutheil, MD**, Professor of Psychiatry, Harvard Medical School

"This extraordinary 6th edition by Pope, Vasquez, Chavez-Dueñas, and Adames continues their wonderful tradition of outstanding scholarship, day-to-day practicality, and responsiveness to the ever-changing health care environment, including the challenges of the COVID-19 pandemic, telepsychology practice, and interjurisdiction compacts. They nicely capture the manner in which clinicians of today must grapple with psychotherapy's complex realities. Readily readable, brilliant, and inspirational."

—**Pat DeLeon, PhD**, former President, American Psychological Association

"Voilà!! Pope and Vasquez and their insightful new co-authors, Drs. Chavez-Dueñas and Adames, share their layers of insight and wisdom that only come from years of both science and therapeutic practice. Their 6th edition continues to be the definitive source for understanding the increasingly complex nature of ethical decision-making in psychotherapy. This edition particularly addresses cutting edge issues in the ethical landscape that have become ever

more challenging, including the subtle and delicate nuances across cultures, contexts, and individual differences, with particular attention to race, gender, religion, and sexual orientation. This edition also discusses the nuances of ethical dilemmas related to the shifts in our cultural context, specifically the impact of the COVID-19. Moreover, the authors are to be commended for squarely promoting a social justice perspective within ethics with three totally new and outstanding chapters that provide in-depth discussions of ways of aligning our practice with social justice and human rights; issues that are too often overlooked or forgotten. Bravo to authors Pope, Vasquez, Chavez-Dueñas, and Adames on this excellent and timely contribution to our professional literature!!"

—**Puncky Heppner, PhD**, Distinguished Curators
Professor Emeritus, University of Missouri

"The 6th edition has been impressively expanded and updated. Pope, Vasquez, Chavez-Dueñas, and Adames have combined their remarkable personal and professional experiences. Using a blend of case law, research evidence, and ethics principles, the authors comment on topics such as COVID-19 and ethics, language and ethics, and malpractice."

—**Dick Suinn, PhD**, Former President,
American Psychological Association

"The 6th edition of *Ethics in Psychotherapy and Counseling: A Practical Guide* has been updated from the earlier editions to include, among other additions, materials related to the COVID-19 pandemic with materials related to virtual sessions over Zoom, FaceTime, etc. Drs. Pope and Vasquez have been joined by Professors Nayeli Y. Chavez-Dueñas and Hector Y. Adames in producing this invaluable resource."

—**David. H. Mills, PhD**, Former Director,
American Psychological Association Ethics Office

"Pope, Vasquez, Chavez-Dueñas, and Adames' foundational text guides us through an unflinching look in the mirror to wrestle with our ethical reflection. They do so with grace and caring, while holding to a fierce commitment to advancing social justice, and honoring the interlocking complexities of culture, oppression, and power. Yet beyond a call for reflection, it is ultimately a call to action that empowers readers to translate an ethical code into a lifelong practice of ethics."

—**Alvin N. Alvarez, PhD**, Dean, College of Health &
Social Sciences, San Francisco State University

"Talk about timely! Drs. Pope, Vasquez, Chavez-Dueñas, and Adames have responded to a clarion call to provide leadership and guidance to practitioners of the healing arts whose expertise, grounded in sound ethical and legal

judgment, will be tapped differently in this era of COVID-19, reawakened social protests, and appalling national leadership. This 6th edition represents a go-to reference for mental health professionals seeking calm in the storms of chaos, controversy, and confusion."

—William D. Parham, PhD, ABPP, Professor, Counseling Program Director, School of Education Loyola Marymount University; Director, Mental Health and Wellness Program National Basketball Players Association (NBPA)

Ethics in Psychotherapy and Counseling

Ethics in Psychotherapy and Counseling

A Practical Guide, Sixth Edition

Kenneth S. Pope, PhD, ABPP
Melba J. T. Vasquez, PhD, ABPP
Nayeli Y. Chavez-Dueñas, PhD
Hector Y. Adames, PsyD

Wiley

This edition first published 2021

Edition History
Jossey-Bass (1e, 1991); Jossey-Bass (2e, 1998); Jossey-Bass (3e, 2007); John Wiley & Sons, (4e, 2010); John Wiley & Sons, Inc. (5e, 2016)

Registered Office
John Wiley & Sons, Inc., 111 River Street, Hoboken, NJ 07030, USA

Editorial Office
111 River Street, Hoboken, NJ 07030, USA
For details of our global editorial offices, customer services, and more information about Wiley products visit us at www.wiley.com.

Wiley also publishes its books in a variety of electronic formats and by print-on-demand. Some content that appears in standard print versions of this book may not be available in other formats.

Library of Congress Cataloging-in-Publication Data
Names: Pope, Kenneth S., author. | Vasquez, Melba Jean Trinidad, author. | Chavez-Dueñas, Nayeli Y., author.
Title: Ethics in psychotherapy and counseling : a practical guide / Kenneth S. Pope, PhD, ABPP, Melba J. T. Vasquez, PhD, ABPP, Nayeli Y. Chavez-Dueñas, PhD, Hector Y. Adames, PsyD.
Description: Sixth Edition. | Hoboken : John Wiley & Sons, Inc., 2021. | Revised edition of Ethics in psychotherapy and counseling, [2016] | Includes bibliographical references and index.
Identifiers: LCCN 2021015270 (print) | LCCN 2021015271 (ebook) | ISBN 9781119804291 (paperback) | ISBN 9781119804314 (adobe pdf) | ISBN 9781119804307 (epub)
Subjects: LCSH: Counseling psychologists--Professional ethics. | Psychotherapy--Moral and ethical aspects. | Counseling psychologist and client.
Classification: LCC BF636.67 .P67 2021 (print) | LCC BF636.67 (ebook) | DDC 174/.91583--dc23
LC record available at https://lccn.loc.gov/2021015270
LC ebook record available at https://lccn.loc.gov/2021015271

Cover design by Wiley

Set in 10/12.5 Electra LT Std by Integra Software Services, Pondicherry, India

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For everyone who did the right thing when it was hard, took great courage, or came at great cost. And for all those—like those children taken from their families and put in cages, some of whom will never see their families again—who suffered because of our failure to do the right thing, our willingness to be passive, enabling bystanders, our shrugging and turning away.

And for Karen Olio, the wondrous love of my life.

—Ken Pope

To all those mentors and ancestors upon whose shoulders I stand, many known and many more unknown; to colleagues, friends, clients, and students, from whom I continue to learn; to my extended family, especially my parents, Ofelia Vasquez-Philo and Joe Vasquez, Jr. who motivated not only their family members but others to pursue education and to engage in social justice advocacy; and especially to my spouse and best friend, Jim H. Miller, who has provided the most significant encouragement in my life.

—Melba J. T. Vasquez

To Black and Indigenous people who believe that a better world is possible and continue to fight for it. To Immigrants whose dreams and hopes cross borders and transform this land. Para mi mamá Delfina Chavez-Dueñas y mi familia inmigrante de quien aprendí a luchar, trabajar duro, y seguir adelante a pesar de la adversidad. Para ti Itzael, el regalo mas grande que me mandaron los dioses para hacerme sonreír.

—Nayeli Y. Chavez-Dueñas

To all those who live their truth in the midst of suffering and oppression.
To those committed to the lives and liberation of Black people.
To my mami, papi, mama, and chosen family … ustedes son mi todo.

—Hector Y. Adames

CONTENTS

PART III: SPECIAL TOPICS

THE AUTHORS

KENNETH S. POPE is in independent practice as a licensed psychologist. He has chaired the ethics committee of the American Psychological Association (APA) and the American Board of Professional Psychology (ABPP). He received the 2015 Canadian Psychological Association John C. Service Member of the Year Award.

MELBA J.T. VASQUEZ is a licensed psychologist in independent practice in Austin, Texas. She has served on various ethics committees and task forces and served as the 2011 President of the American Psychological Association.

NAYELI Y. CHAVEZ-DUEÑAS is a licensed psychologist and professor in Chicago, Illinois. She co-founded and co-directs the Immigration, Critical Race, And Cultural Equity (IC-RACE) Lab. She earned the 2018 Distinguished Citizen Psychologist Award from the American Psychological Association.

HECTOR Y. ADAMES is a licensed psychologist and professor in Chicago, Illinois. He co-founded and co-directs the Immigration, Critical Race, And Cultural Equity (IC-RACE) Lab. He has chaired the Committee on Ethnic Minority Affairs of the American Psychological Association.

PREFACE

Welcome to the sixth edition! So much has changed since the 5th edition. The novel coronavirus (COVID-19) pandemic transformed—at least temporarily—psychotherapy and counseling from encounters primarily conducted in-person to virtual meetings convened over Zoom, FaceTime, and other video conferencing and digital tools. Creative innovation, surprising research findings, landmark legal decisions, demographic shifts, and new perspectives continue to bring change to psychotherapy and counseling, and to ethical standards, theory, and practice. To address these trends and changes, we've updated all the chapters in this new edition and have created some new chapters.

The authorship of this book has also changed. Ken Pope and Melba Vasquez co-authored the first five editions of this book, and they're still here. For this sixth edition, they reached out to two distinguished colleagues, Professors Nayeli Y. Chavez-Dueñas and Hector Y. Adames, both of whom are also licensed practitioners. Both Nayeli and Hector agreed to sign on as co-authors with Ken and Melba. The sixth edition benefits from four very diverse perspectives and co-authors who worked collaboratively to create an edition that motivate us all to strengthen and inform our ethical awareness and sense of personal and collective ethical responsibility.

The poor, unloved preface achieved sad notoriety as the least read part of most books. We'll keep this one short—limiting it to only a note on terminology. We hope the conciseness inspires you to read on, set yourself apart from the crowd, and gain elite status as a reader of the preface.

A NOTE ON TERMINOLOGY

This book discusses the varied and complex ethical issues that confront psychologists working as psychotherapists, other kinds of therapists (e.g., behavior therapists), and counselors. For brevity and convenience, we often use just one of these terms—rather than some hyphenated form of all three—in a sentence. Similarly, some therapists identify those to whom they provide services as clients; others use the term patients. Again, for brevity and convenience, we have used these terms interchangeably throughout the book.

ACKNOWLEDGEMENTS

We are deeply indebted to all those who contributed directly or indirectly to this book. We are grateful to all but have space to mention only a few. Emil Rodolfa, Ray Arsenault, Linda Campbell, Ursula Delworth, Barry Farber, Lisa Grossman, Kate Hays, Loralie Lawson, Karen Olio, and Janet Sonne are among those who read drafts of the current or previous editions and offered valuable suggestions for improvements.

We asked a number of prominent therapists with expertise in recognizing and responding to suicidal risk to discuss pitfalls of work in this area. Chapter 22 presents the advice that each of these experts gives to readers. We thank those who contributed discussions: David Barlow, Danny Brom, Chris Brownson, Marla Craig, Jessica Henderson Daniel, Norman Farberow, the late Erika Fromm, Rosa Garci-Peltoniemi, Jesse Geller, Judith Lewis Herman, Don Hiroto, Maryam Jernigan-Noesi, Nadine Kaslow, the late Helen Block Lewis, Marsha Linehan, Ricardo Munoz, David Rudd, Gary Schoener, Shweta Sharma, and Danny Wedding.

We also express our gratitude to graduate students Xochitl Cruz, Radia Mchabcheb, and Monica Zohar who helped with a laborious part of this text, its references.

We received exceptionally skillful and generous help from Rebecca McGovern and Xenia Lisanevich of Jossey-Bass Publishers in preparing the first edition; from Alan Rinzler, Katie Levine, Margaret Sebold, Joanne Clapp Fullagar, and Paula Goldstein of Jossey-Bass Publishers and Rachel Anderson of Satellite Publishing Services in preparing the second edition; from Alan Rinzler, Carol Hartland, Seth Schwartz, and Jennifer Wenzel of Jossey-Bass Publishers, along with Beverly Harrison Miller, in preparing the third edition; and from Patricia Rossi, Fiona Brown, and Kate Lindsay in preparing the fourth edition; and Marquita Flemming, Melinda Noack, and, Brian Grimm, in preparing the fifth edition; and Darren Lalonde, Monica Rogers, Arthi Kangeyan, Jo Egre, Christina Weyrauch, Patty Maher, and Ranchedha Djeassilane in preparing this sixth edition.

Part I

FOUNDATIONS

Chapter 1

HELPING WITHOUT HURTING

Psychotherapy holds out the promise of help for people who are hurting and in need. It can save lives and change lives. In therapy, clients can find their strengths and sense of hope. They can change course toward a more meaningful and healthy life. They can confront loss, tragedy, hopelessness, and the end of life in ways that do not leave them numb or paralyzed. They can discover what brings them joy and what sustains them through hard times. They can begin to trust, or to trust more wisely. They can learn new behaviors in therapy and how to teach themselves new behaviors after therapy ends. They can question what they always believed was a given. They can find out what matters most to them, and how to stop wasting time. They can become happier, or at least less miserable. They can become better able, as Freud noted, to love and to work. They can learn how to accept and love themselves just as they are and accept others who are different from them.

Our ethics acknowledge and affirm our profession's responsibilities. This book was written to help strengthen, deepen, and inform ethical awareness and the sense of personal ethical responsibility. Its job is to help you hold onto the ideals—including ethical ideals—that called you into the profession to begin with, to help you develop and fulfill those ideals. There will be so much—trust us on this—that tends to dull ethical awareness, to make ethics drift out of focus, to create barriers between you and your ideals, to replace ethics with pseudo-ethics and ethics placebos. Fatigue, endless paperwork, unrealistic expectations, illness, family crises, not being able to make ends meet, burnout, threats of job loss, insurance coverage that doesn't come close to meeting the needs of our clients, biases that have not been

addressed, and so many other forces can pressure us into cutting ethical corners. This book is intended to help you develop a strong and healthy resistance to such forces, to help you weather them without losing your ethical awareness and ideals.

We can often help, but if our ethics slip, we can needlessly hurt. Mishandled, the process of therapy and counseling can waste time and opportunity. It can betray clients' hope, good faith, hard work, and trust. It can leave them worse off than before they reached out for our help. It can erode trust in the health system and prevent people from seeking help in the future.

Realizing how much our ethical decisions can affect the lives of those who come to us for help is central to our ethical awareness. What we do can make a difference in whether a client loses hope and commits suicide or chooses to live, whether a battered partner finds shelter or returns to a toxic and dangerous relationship, whether a teenager with anorexia gets help or starves to death. Such stark examples tell only part of the story. So many people come to us facing what seem to be minor, hard-to-define problems, yet the hard, risky, unpredictable twists and turns of their therapy can lead to more meaningful, effective, and fulfilling lives.

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

Recognizing these responsibilities as they appear in our day-to-day work and deciding how to respond can be stressful, sometimes overwhelming. We may feel short of time, resources, or wisdom. We may feel pulled in different directions, stretched to or beyond the breaking point. The responsibilities can weigh us down, make us feel discouraged, rattle us, and make us want to run and hide. They can make us more vulnerable to other sources of stress and leave us prone to make flawed ethical decisions.

Uncertainty causes stress for some of us. We can't find that magical book that will tell us what to do, especially in a crisis. Research, guidelines, manuals, our own experience, and consultation help, but we can't know the best course in all situations, or even how the "best" course will turn out. We are constantly thrown back on our own judgment. If we believe a client *might* kill someone but there is no explicit threat or other legal justification under the state's law to hospitalize the client or breach confidentiality, what do we do? What diagnosis should we write down if we know that the insurance company won't cover treatment for the client's condition and believe that the client's need for treatment is urgent, a matter of life or death? Will using stress-reducing imagery techniques help a client (reducing stress and increasing the

client's effectiveness) or cause harm (enabling the client to adapt to an abusive job or relationship) is a question without an instantly clear, infallible answer. Does informed consent make sense if all it accomplishes is to cause a patient to turn away from life-saving treatment or stop them from sharing information critical to their treatment? The inescapable responsibility of making careful, informed professional judgment regarding issues of enormous complexity and potentially life-and-death implications can push even the most resourceful therapists to and beyond their limits.

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

Managed care stresses some therapists. For example, capitation contracts provide a limited sum of money to cover all services for a group of patients (e.g., a business that has contracted coverage for its employees with an agency). The agency providing services, having estimated the average number of sessions needed for each patient, must limit the total number of sessions to make a profit. Strict guidelines may limit how many sessions a therapist can provide. Therapists may feel pressure to terminate before the limit, even if they think services are still needed. Even if clinicians follow agency procedures, they may face charges before an ethics committee, licensing board, or malpractice court for patient abandonment, improper denial of treatment, or similar issues. Therapists may fear not only that a formal review agency will sanction them but also that the limited sessions fall far short of what their clients need.

Teaching or learning therapy is practiced on the living—this can stress us. As supervisors, we may grow uncomfortable with how the supervisee responds to the client differently from how we would, with our responsibility to evaluate the supervisee's work, and with the demands of our role as teacher, mentor, and gatekeeper. As supervisees, we may doubt our ability to carry out clinical responsibilities (especially when they involve suicidal or homicidal risks), dread making mistakes, feel uneasy about differences in values or theoretical orientation between ourselves and our supervisor, wonder if racial (or gender or sexual orientation or religious or political, or, or, or) differences between us and our supervisor are causing us to be viewed in a negative light, and figure that if we are completely honest in describing to our supervisor what we actually thought, felt, and did with our clients, we might be advised to look for another line of work.

Learning to work competently with clients from various identity groups can be challenging. Understanding and integrating racial and cultural issues and context is fundamental to our professional responsibilities. We can complete workshops, read, get supervision, take continuing education courses, but the challenge in gaining knowledge about various social groups will be an ongoing task. Knowledge about the various social identities that our clients represent will be necessary in assessing the degree to which we integrate various values, behaviors, and expectations in the course of treatment. Those potential identities include but are not limited to race, ethnicity, generation, gender, ability status, sexual orientation, gender identity, caste, religion, spirituality, immigration, employment, and the like. Working competently requires awareness, knowledge, and skills about people's identities and the ways in which overlapping forms of oppression (e.g., gendered-racism, gendered anti-Semitism) impact people's lives (for further reading on the theory of intersectionality as originally created by Black Women see Combahee River Collective, 1995; Crenshaw, 1991; for intersectionality in clinical practice see Adames et al., 2018; Chavez-Dueñas et al., 2019).

WHAT DO I DO NOW?

A fundamental stress that confronts therapists is the urgent, complex, inescapable question: "What do I do now?" Consider these scenarios:

- I'm staring at this insurance form, wondering if I should get creative with the diagnosis. They won't cover this new patient's condition, but they can't get the help they desperately need without the coverage.
- Thought I'd hit the jackpot when my new grad school therapy supervisor turned out to be nationally known and her recommendation to be key to the rest of my career, but she's telling me to do things that are ethically shifty.
- She's sitting here in front of me, crying and telling me I'm her last hope because her husband beats her, but there are no shelter beds open and she can't go to the police because her husband is a decorated police captain.
- The physician down the hall is a quack, but as long as I refer my patients to him, he sends me enough referrals to pay my bills.
- My immigrant client is struggling to obtain a green card (residence card), and has been waiting a much longer than average time period. I have contacts in the agency. Should I intervene to help facilitate the process? Is this an act of appropriate social justice?
- A pregnant teenage client is considering having an abortion. She has not shared the news with her parents and wants me to keep her pregnancy a secret. She fears being kicked out of the house if her parents find out about her pregnancy.

Doing psychotherapy confronts us with constant challenges. Each ethical challenge, large or small, subtle or staring us in the face, brings a tangle of questions. Is there a "right" thing to do? If so, how do I find out what it is? How do I actually go about doing it? What makes it right? Who says so? If I do it, what will happen to the patient? to me? to innocent—and not-so-innocent—bystanders?

We wrestle with personal questions that are hard to admit to ourselves or others. What am I tempted to do? What could I get away with? Would doing the right thing cost too much? make people mad at me? get me sued? get me fired? Would doing the wrong thing be all that bad? Would anyone find out? What would happen to me if they did? What if I'm not strong enough, not "good" enough to do the right thing? Can I duck this one and stick someone else with it?

These stinging questions always lead back to the basic question: What do I do now?

Strong, deep, informed ethical awareness helps us answer that question. It brings into focus how our choices affect the lives of our patients, our colleagues, and the public. It frees us from the sticky webs of habit, fatigue, fallacy, dogma, carelessness, hurry, and stress. It wakes us to new possibilities.

If this book helps you to strengthen, deepen, and inform your ethical awareness, it will help you find better answers to that basic question: What do I do now? This book will disappoint those looking for an ethics cookbook, an authority pointing out the right answer for every scenario, a substitute for ethical consideration, decision-making, and personal responsibility. We believe that approach fails in the real world, leading us to blunder with confidence.

Each of us must bring our own ethical awareness to the challenges, pitfalls, and opportunities that we face in each unique, constantly changing situation, to make the best choices. We emphasize eight basic assumptions about ethical awareness.

1. Ethical awareness is a continuous and active process that involves constant questioning and personal responsibility.

Our work requires constant alertness and mindful awareness of the ethical implications of what *we* choose to do and not do. Ethical awareness helps us to shoulder personal responsibility for our ethical choices, for what we choose to do and not do. We face the consequences for what we choose or not choose to do.

Ethical awareness helps us avoid quick certainties that shut down further questioning. It prompts us to rethink what seems to be a "given," to continuously look for more creative, more ethical, more effective solutions to problems.

Ethical awareness means setting aside arrogance and complacency. All of us have weaknesses, vulnerabilities, and blind spots—it comes with being human. The stark differences are not so much between those with many flaws and those with few but between those who are freely open to themselves and others about how their own shortcomings affect their work and those who tend to hide such shortcomings and see others as their inferiors.

Ethical awareness depends on our ability to take care of ourselves, to recognize when exhaustion, personal problems, or feelings like fear, anger, boredom, resentment, sadness, hopelessness, or anxiety hurt our work, and to do something about it.

2. Awareness of ethical codes is crucial, but formal codes cannot take the place of an active, thoughtful, creative approach to our ethical responsibilities.

Ethical awareness is strengthened and informed by pouring over the ethics codes that bear on our work. But formal standards and guidelines[1] are no substitute for an active, deliberative, and creative approach to our ethical responsibilities. Codes prompt, guide, and inform our ethical considerations; they do not shut it down or take its place.

Ethical awareness never allows us to follow a code in a rote, thoughtless manner. Each new client, whatever their similarities to previous clients, is unique. Each situation is unique and constantly changing—time and events never stand still. Our theoretical orientation, our community and the client's community, our race and culture and the client's race, culture, and so many other contexts and factors shape what we see and how we make sense of what we see. Each ethical choice must take these complexities and contexts into account.

Codes can steer us away from clearly unethical approaches. They can shine a light on key values and concerns. But they cannot tell us what form these values and concerns will take. Standards and guidelines can set forth essential tasks or point to aspirational goals but they never show us the best way to carry out those tasks and realize those goals with a unique client facing unique problems in a specific time and place with limited resources. Ethical decision-making is a process and codes are only one part of that process.

[1] Professional standards are considered to be mandatory while guidelines are aspirational in intent and highly recommended for best practice.

3. Awareness of laws is crucial, but legal standards should not be confused with ethical responsibilities.

A risk in the emphasis on legal standards is that meeting legal standards, which for some can mean finding ways around those standards (e.g., looking for loopholes), can start to replace ethical behavior. This practice is a high art in the political arena. Caught betraying the public trust, politicians often insist they did nothing wrong because no law was broken. When it turns out that a law *was* broken, politicians admit that their enemies are harping on a mere "technical violation of the law." Ethical awareness avoids the comfortable trap of aiming low, of striving only to get by without breaking any law.

Ethical awareness stays alert to possible conflicts between our ethical and our legal duties.

An overly exclusive focus on legal standards discourages ethical responsibility. Practicing "defensive therapy"—making risk management our main focus—can cause us to lose sight of our ethical responsibilities and the ethical consequences of what we say and do. When we originally discussed this tendency to confuse legal and ethical issues over 30 years ago in this book's first edition, the tendency had already begun to spread widely. It shows no signs of slowing down.

4. We believe that the overwhelming majority of therapists and counselors are conscientious, dedicated, caring individuals, committed to ethical behavior. But none of us is infallible.

All of us can—and do—make mistakes, overlook something important, work from a limited perspective, reach conclusions that are wrong, hold tight to cherished beliefs that are misguided or biased. We're aware of many barriers between us and our best work, but we may underestimate or overlook some of those barriers. Part of our responsibility is to question ourselves: What if I'm wrong about this? Is there something I'm overlooking? Could there be another way of understanding this situation? Are there other possibilities? Can I come up with a more creative, more effective, better way of responding?

5. Many of us find it easier to question the ethics of others than to question what we ourselves value, believe, and do. It is worth noticing if we often find ourselves stewing over just how ethically weak, dense, or shady others are while sparing ourselves from critical self-assessment.

It is a red flag if we spend more time trying to point out other people's weaknesses, flaws, mistakes, ethical blindness, destructive actions, or hopeless stupidity than we spend questioning and challenging ourselves in positive, effective, and productive ways that awaken us to new perspectives and possibilities. Questioning ourselves is at least as important as questioning others.

6. Most of us find it easier to question ourselves on those intriguing topics we know we don't understand, that we stumble onto with confusion, uncertainty, and doubt. The harder but more helpful work is to question ourselves about our casual certainties. What have we taken for granted and accepted without challenge? Nothing can be placed off limits for this questioning.

Certainties are hard to give up, especially when they feel like they are part of who we are. They become landmarks, helping us make sense of the world, guiding our steps. But perhaps an always-reliable theoretical orientation begins distorting our view of a new patient, leading us to interventions that make things worse. Or having always prided ourselves on the soundness of our psychological evaluations, we keep rereading our draft report in a case in which an unbiased description of our findings may bring about a tragic injustice, harming many innocent people, and begin to wonder if our feelings for the client led us to shade the truth. Or the heart of our internship has been the supervision, and we've made it a point to tell the supervisor everything important about every patient, except about getting so turned on with that one patient, the one who is not very vulnerable at all and does not really need therapy, the one we keep having fantasies of asking out after waiting a reasonable time after termination and then, if all goes well, proposing to.

Questioning our certainties means actively and repeatedly seeking out and listening respectfully to those who disagree with us and engaging them in openly exchanging views. It means actively searching out articles and books that challenge—and sometime attack—our assumptions, beliefs, and practices.

We must follow this questioning wherever it leads, even if we venture into territories that some might view as politically incorrect or—much harder for most of us—"psychologically incorrect" (Pope et al., 2006).

7. We often encounter ethical dilemmas without clear and easy answers.

As we try to help people who come to us because they are hurting and in need, we confront overwhelming needs unmatched by adequate resources, conflicting responsibilities that seem impossible to reconcile, systems that

work against the best interests of our clients, frustrating limits to our understanding and interventions, and countless other challenges. We may be the only person a desperate client can turn to, and we may be jerked every which way by values, events, limited time, and limited options. Our best efforts to sort through such challenges may lead us to a thoughtful, informed conclusion about the most ethical path that is in stark contradiction to the thoughtful, informed conclusions of a best friend, a formal consultant, our attorney, or the professional groups we belong to.

In the midst of these limitations, conflicts, disagreements, and complexities, we must make the best choices we can. We must each struggle to answer the question: What do I do now? And each of us must take responsibility for the decisions we ultimately make. We cannot shift personal responsibility for what we decide and what we do to another person, group, law, code, or custom. There is no escape from these struggles. They are part of our work.

8. We and our clients do not live in a vacuum. We live and develop in sociocultural contexts.

We are called to act in accordance with an ethic of human rights and social justice. We open our eyes and hearts to how discrimination, hatred, injustice, beatings, xenophobia, slavery, jail, starvation, torture, or genocide—based on factors like race, religion, immigration, culture, gender, sexual orientation, disability, politics—affect us, our clients, their families and communities, our supervisees, and the world we live and work in. We search for the most ethical response to social injustice. We don't shrug our shoulders and turn away. We face these issues with courage, honesty, caring, and a sense of personal responsibility to respond ethically.

Chapter 2

ETHICS IN REAL LIFE

Even the simplest ethical concept, standard, or guideline can fool us. We hear it in class. We read it in the code. We understand it. We can explain it in a test, give a lecture on it, or explain it to a jury. We know the concept, standard, or guideline, but it fools us when it shows up unexpected in the messiness of real life. It comes dressed in different clothes—and sometimes camouflage—and we don't recognize it.

Therapy offers countless challenges to recognizing how a specific ethical concept, standard, or guideline might be helpful or vital. One reason is that concepts, standards, and guidelines tend to be abstract, general, and sometimes ambiguous. Another reason is that psychotherapy can be such a complex set of interactions between unique people. Yet another is that psychotherapy can serve as the intense focus of need, hope, risk, and expectation. Lives can be at stake.

In the midst of this work, as it actually happens in real life, it can be hard to recognize those moments when we need to consider an abstract ethical concept, standard, or guideline.

This chapter provides examples of those moments as they happen in the messy textures of real life. None is based on a specific case (and none of the people are based on an actual clinician or patient), but each represents the kinds of challenges that therapists and counselors face in their day-to-day practice.

In each of the following fictional scenarios, the clinicians were trying to do their best. Readers may disagree over whether each clinician met the highest or even minimal ethical standards, and such disagreements can form the focus of classroom discussions, case conference presentations, or supervision consultation. In at least one or two instances, you may conclude that

what the clinician did was perfectly reasonable and perhaps even showed courage and profound ethical awareness. In some cases, you may feel that significant relevant information is missing. But in each instance, the professional's actions (or failures to act) become the basis of one or more formal complaints.

As you read each scenario, consider the situation from the point of view of each person mentioned as well as a member of an ethics committee, licensing board, or jury hearing the complaint.

RECORDS

After a full day of Zoom and Facebook sessions with her clients, Dr. Soo sits down at the computer to update her clinical files, making sure all the notes, billing information, digital copies of the day's Zoom and Facetime sessions (recorded with the full informed consent of her clients), and other records are current. She turns on the computer and … nothing. Just a blank screen. That's never happened before. Wait: A message scrolls into view:

> Greetings, Dr. Soo! I was able to hack into your computer—obviously!—and copy all your files. Yes, even your video files, which I found quite interesting. I even accessed those files you stashed in the cloud as backups. Your passwords weren't much of a challenge for my software and finding your key to unencrypt your encrypted files was something I did while multitasking. I left your files on your computer, but I used a much more sophisticated program to encrypt them so that you can't access them.
>
> I'll bet you're upset, even angry, but you needn't be. All can be set right as rain in just a step or two. All you need do is deposit $25,000 U.S. in bitcoin into the account specified at the bottom of the page within 72 hours, I'll send you the key that will unencrypt your files, and you'll never hear from me again.
>
> Easy, isn't it? A simple quid pro quo.
>
> Oh, one more thing, Dr. Soo. What if you don't pay within 72 hours? What if you think you don't even *need* to pay because you've got another copy of all your records hidden somewhere on a disk that is not connected to the internet and so inaccessible to me and my merry band of fun-loving rascals? Well, you should know that were I not to receive the bitcoin within 72 hours—and I have full confidence you won't let that happen—unencrypted copies of all your files will start appearing on all sorts of anonymous websites, and your clients and all others in your address book will receive notification along with links to some of those websites.
>
> In closing, allow me to wish you well, Dr. Soo, especially next Tuesday, where I see in your scheduler and notes you're expected to testify as an expert

witness on the clinical records you reviewed and the tests you administered. It would be *such* a shame if the judge and attorneys in that case were to be notified before you testified that you had guarded the confidentiality of all those records so well that they were now available for all to see on a whole array of websites. Bet that would lead to an interesting cross-examination? Might even lead to a little chat with the licensing board.

Bye-bye, doc! And thank you for making me feel so welcome. No two-factor identification when signing in to your computer, no ransomware protection, not even a virtual private network when you connect to the internet. I felt you were inviting me in.

To avoid having her clients' records and videos flashed across the web, Dr. Soo manages to get together $25,000 by emptying her savings and borrowing the rest, and sends off the bitcoin under the deadline. However, the files are never returned to her—They show up on a variety of anonymous websites. Several clients sue.

LUNCH

Josefina was a Black Cuban high school student. She worked part time as a cook. During the first session with Dr. Marcus she poured out a heart full of pain from the discrimination and racist abuse she'd endured at her mostly-White high school and at her job. Just being able to talk about it made her hurt less, she said. She didn't feel so suicidal as she had the last few weeks. The next session she showed up extremely distressed. She'd lost her job as a cook and could no longer pay for therapy.

Dr. Marcus, who did *pro bono* work conducting asylum assessments at a legal aid clinic, had never offered free therapy. He believed that patients would not value or work hard if therapy cost nothing. So, he suggested various ways they might barter for the fee. Josefina had nothing tangible to barter with but Dr. Marcus suggested that, since she had been a cook, if she were to cook him a meal and bring it with her to each session, he would accept that as payment. She gladly accepted, thrilled she'd be able to continue therapy.

After four more weekly sessions, Josefina failed to show up for her appointment. Instead Dr. Marcus was served notice of a malpractice suit filed by Josefina's parents. They alleged that he had taken advantage of and mistreated a minor. Josefina had been suffering from racial prejudice, discrimination, and abuse at her high school and job, and instead of respecting her and providing valid treatment, he had treated her in the most stereotypical manner possible and turned a minor into his personal maid, telling her she must bring him his lunch. Both the subsequent therapist and the expert witness hired by the family agreed that treating Josefina in this way was unethical and damaging.

THE MECHANIC

Ms. Huang, whose family had moved from mainland China to the United States 15 years ago, is a 45 year-old automobile mechanic. She agreed, at the strong urging of her employer, to seek psychotherapy for difficulties that seem to affect her work performance. She has been showing up late at her job, has often phoned in sick, and frequently appears distracted. She complains to her new therapist, Dr. Jackson, of the difficulties she is having coping both with psychomotor epilepsy, which has been controlled through medication, and with her progressive diabetes, for which she is also receiving medical care.

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

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

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

EVALUATING CHILDREN

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

Dr. Durrenberger schedules three sessions in which he sees Ms. Cain and her two children together and three individual sessions with each of the children. As he is preparing his report, he receives a subpoena to testify in a civil suit that Ms. Cain is filing against her ex-husband. She is suing for custody of

her children. During the trial, Dr. Durrenberger testifies that the children seem, on the basis of interviews and psychological tests, to have a stronger, more positive relationship with their mother. He gives his professional opinion that the children would be better off with their mother and that she should be given custody.

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

STAYING SOBER

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

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

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

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

THE INTERNSHIP

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

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

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

THE FATAL DISEASE

When George, a 19 year-old college student, began psychotherapy with Dr. Hightower, he told the doctor that he was suffering from a fatal disease. Two months into therapy, George felt that he trusted his therapist enough to tell her that the disease was AIDS (acquired immune deficiency syndrome).

During the next 18 months, much of the therapy focused on George's losing battle with his illness and his preparations for the end of life. After two stays in the hospital for pneumonia, George informed Dr. Hightower that he knew he would not survive his next hospitalization. He had done independent research and talked with his physicians, and he was certain that, if pneumonia developed again, it would be fatal due to numerous complications and that it would likely be a long and painful death. George said that when that time came, he wanted to die in the off-campus apartment he had lived in since he came to college—not in the hospital. He would, when he felt himself getting sicker, take some illicitly obtained drugs that would ease him into death. Dr. Hightower tried to dissuade him from this plan, but George refused to discuss it and said that if Dr. Hightower continued to bring up the subject, he would quit therapy. Convinced that George would quit therapy rather than discuss his plan, Dr. Hightower decided that the best course of action was to offer caring and support—rather than confrontation and argument—to a patient who seemed to have only a few months to live.

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

LIFE IN CHAOS

Mr. Alvarez, a 45 year-old professor of physics, has never before sought psychotherapy. He shows up for his first appointment with Dr. Brinks. He shares with Dr. Brinks that his life is in chaos. Dr. Brinks was granted full professor status about a year ago and about one month after that, his wife suddenly left him to live with another man. He became very depressed. About four months ago, he began to become anxious and to have trouble concentrating. He feels he needs someone to talk to so that he can figure out what happened. Mr. Alvarez and Dr. Brinks agree to meet twice every week for outpatient psychotherapy.

During the first few sessions, Mr. Alvarez says that he feels relieved that he can talk about his problems, but he remains very anxious. During the next few months, he begins talking about some traumatic experiences in his early childhood. He reports that he is having even more trouble concentrating.

Dr. Brinks assures him that this is not surprising, that problems concentrating often become temporarily worse when a patient starts becoming aware of painful memories that had been repressed. She suggests that they begin meeting three times a week, and Mr. Alvarez agrees.

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

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

LANGUAGE: THE INTERPRETER

Angelica, who was born in Bolivia and migrated to the US two years ago, is a 55 year-old mother of three. Following the advice of her physician and sister, she decides to seek psychotherapy to deal with insomnia, lack of appetite, and uncontrollable crying spells. Angelica only speaks Spanish and there are no bilingual therapists available at the clinic; however, Dr. Jones agrees to work with Angelica. Wanting to help Angelica, Dr. Jones agreed to do therapy with an interpreter, although this is the first time she is providing therapy services with an interpreter. She is sure that all interpreters know what to do. Dr. Jones proceeds to schedule Angelic's intake. During the clinical interview Angelica seemed to be worried and went back and forth with the interpreter. Dr. Jones, not speaking Spanish, is unable to follow what's happening and when she inquires, the interpreter only says that Angelica feels ashamed of speaking about her family's business. Dr. Jones, via the interpreter, tells Angelica not to worry and goes on to discuss informed consent and confidentiality. Angelica does not return to her second session and several months later, Dr. Jones receives a letter indicating that a civil law suit had been filed against her. According to the letter, Dr. Jones assured Angelica that all of the information that was shared in therapy would remain confidential, but somehow her husband, who has a long history of domestic violence, found out all of the details that Angelica disclosed to Dr. Jones during the intake interview. He became so violent toward Angelica that she spent several days in the intensive care unite (ICU) recuperating from the physical abuse.

COMPUTER COINCIDENCES

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

For many years they had maintained a small and very successful group practice. Then they modernized, bringing in state-of-the-art computers, elegantly networked and equipped with wonderful software that made the therapists' work so much easier.

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

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

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

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

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

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

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

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

■ ■ ■

These scenarios remind us of the need for constant alertness, constant awareness of the ways that seemingly simple and abstract ethical principles in the ethics codes can find their way into our work, often in unexpected ways and at unexpected times. Anticipating potential problems like these begins with our understanding of the ethics codes themselves, the topic of the next chapter.

Chapter 3

ETHICS THEORIES AND CODES

The work we do as therapists is complex, difficult, and emotional. Yet, as a mental health profession we have often struggled to capture with words exactly what we do and even what we profess to do as therapists. The challenge of describing what we do has been debated from the start of our profession.

In 1949, the Boulder Conference tried to define psychotherapy in a way that it could be used to train clinical and counseling psychologists. Carl Rogers, then president of the American Psychological Association (APA) in 1947, appointed David Shakow to chair a committee on defining and teaching psychotherapy. The Shakow Report, adopted at the 1947 APA convention, resulted in the Boulder Conference two years later.

On August 28, 1949, the recorder for the Boulder Task Force for defining both psychotherapy and the criteria for adequate training provided the following summary: "We have left therapy as an undefined technique which is applied to unspecified problems with a nonpredictable outcome. For this technique we recommend rigorous training" (Lehner, 1952, p. 547).

Since the Boulder Conference, other conferences and various groups have tried to define psychotherapy and the practice of psychology. For example, the *2002 Competencies Conference: Future Directions in Education and Credentialing in Professional Psychology* (Kaslow et al., 2004), identified competencies in professional psychology and discussed effective strategies for teaching and assessing these competencies (Kaslow, 2004; see also Belar, 2009; Fouad et al., 2009; Hatcher, 2015; Hatcher et al., 2013; Rodolfa et al., 2013). Similarly, the *European Association of Clinical Psychology and Psychological Treatment (EACLIPT) Task*

Force on Competences of Clinical Psychologists (2019) developed "a list of competences that should be acquired during regular studies of psychology with a clinical specialisation" (EACLIPT Task Force, 2019; see also Prado-Abril et al., 2019).

THEORIES OF ETHICS

The difficulty reaching agreement on a definition of therapy is echoed in the difficulty agreeing on a basic theory of ethics. In this section we briefly review four theories of ethics to illustrate the vast diversity of ethics theories, which can be viewed as a strength. Put succinctly, having multiple lenses through which we can examine and question professional ethics codes and our own ethical decision-making is an advantage.

Utilitarianism

Utilitarianism, developed by Epicurus, Jeremy Bentham, John Stuart Mill, Katarzyna de Lazari-Radek, and Peter Singer among others, holds that a guiding principle of ethics involves choosing whatever brings the most happiness and produces the least pain to the majority. According to Bentham (1780):

> Nature has placed mankind [humankind] under the governance of two sovereign masters, pain and pleasure. It is for them alone to point out what we ought to do, as well as to determine what we shall do. On the one hand the standard of right and wrong, on the other the chain of causes and effects, are fastened to their throne. They govern us in all we do, in all we say, in all we think …. The principle of utility recognizes this subjection, and assumes it for the foundation of that system, the object of which is to rear the fabric of felicity by the hands of reason and of law …. By the principle of utility is meant that principle which approves or disapproves of every action whatsoever … according to the tendency it appears to have to augment or diminish … happiness …. (p. 232–245).

Similarly, Mill (1863) wrote:

> The creed which accepts as the foundation of morals, Utility, or the Greatest Happiness Principle, holds that actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness. By happiness is intended pleasure, and the absence of pain; by unhappiness, pain, and the privation of pleasure (p. 9).

This may seem like a fairly simple, almost easy, approach to ethics. However, de Lazari-Radek and Singer (2017) emphasize that figuring out what promotes the most happiness in every situation may present more of a challenge than following a set of rules.

> The core precept of utilitarianism is that we should make the world the best place we can. That means that, as far as it is within our power, we should bring about a world in which every individual has the highest possible level of well-being. Although this may seem like mere common sense, it is often in opposition to traditional moralities. Most communities prescribe rules to be followed irrespective of whether the outcome will make the world better or worse. It is much easier to follow rules than to try to assess, each time one acts, which of the available options will have the best consequences (p. 711–717).

Kantian Ethics

Utilitarianism focuses on results, consequences. Kantian ethics focuses on will and intention. Kant (1785/1998) wrote:

> Nothing can possibly be conceived in the world, or even out of it, which can be called good, without qualification, except a good will. Intelligence, wit, judgement, and the other talents of the mind, however they may be named, or courage, resolution, perseverance, as qualities of temperament, are undoubtedly good and desirable in many respects; but these gifts of nature may also become extremely bad and mischievous if the will which is to make use of them, and which, therefore, constitutes what is called character, is not good …. A good will is good not because of what it performs or effects, not by its aptness for the attainment of some proposed end, but simply by virtue of the volition; that is, it is good in itself …. and considered by itself is to be esteemed much higher than all that can be brought about by it …. (p. 115–127).

Kant believed that we must always treat others as an end in themselves and never as simply a means to an end.

Feminist Ethics

Brabeck and Ting (2000) open a discussion of feminist ethics by quoting the striking claim that feminism itself cannot exist separate from ethics: "In 1991, the political scientist Jean Bethke Elshtain wrote, 'feminism without ethics is inconceivable' … According to Elshtain, all feminisms offer an ethical position that accompanies a political, activist agenda to achieve social justice and

improve women's lives" (Brabeck & Ting, 2000, p. 17). They then summarize five major themes running through feminist ethics, including:

1. The assumption that women and their experiences have moral significance.
2. The assertion that attentiveness and subjective knowledge can illuminate moral issues.
3. The claim that a feminist critique of male distortions must be accompanied by a critique of all discriminatory distortions.
4. The admonition that feminist ethics engage in analysis of the context and attend to the power dynamics of that context.
5. The injunction that feminist ethics require action directed at achieving social justice.

While ethics is an inextricable part of feminism, multiculturalism is an inextricable part of feminist ethics. Gartrell (2014) wrote that "any discussion of feminist ethics must incorporate diverse experiences due to race, ethnicity, class, and sexual orientation" (p. 137; see also Greene & Flasch, 2019; Hayden & Crockett, 2020; Powell et al., 2020).

Lerman (2014) discussed the work of the Feminist Therapy Institute in creating their own ethics code based on their conclusions about traditional ethics codes. Their view that most of the current ethics codes were not a good fit for feminist therapists included:

> The recognition that most codes are reactive rather than proactive, that ethics is frequently viewed as a good-bad dichotomy rather than as a continuum of actions generated by the complex nature of human interactions, that ethics codes do not customarily teach how to make ethical decisions, that ethics codes have usually ignored issues especially pertinent to minorities and women and that complaint procedures most frequently focus on legally protecting the professional rather than displaying compassion toward the client.

American Indian Ethics

In a commentary on the APA Ethics Code, The Society of Indian Psychologists (SIP; Garcia & Tehee, 2014) emphasized that:

> Indigenous people have a holistic and inter-relational view of health. This view means that the Western-based concepts of body, emotions, mind, spirit, community, and land cannot be separated and that an individual cannot be separated from their relationships, including the generations before them and the generations to come. There are no distinctions between physical health, mental health, and spiritual health, which also means that my physical health, mental health, and wellbeing are related to yours ("we are all related").

* They set forth 12 essential concepts, including:

1. All things are sacred. Sacredness is not religiosity but a recognition that everything has an important role to play in the universe. This idea of sacredness is respectful of reciprocal relationships, of family, of the community, of the environment, of the past, present, and of the future.
2. Life and development are understood in terms of cycles as opposed to a linear process.
3. Everything is connected. All beings (including the Earth, the environment, and events in the past, present, and future) respond to each other's actions. Every living system is a whole in itself, as well as part of a larger system. This explanation is an essential concept of full circle understanding.
4. Events in life can best be understood as lessons. There is an acknowledgment that this moment is part of the lesson of whom we were, are, and whom we are to become.
5. Respect and honoring are essential to true or long-lasting relationships. These need to be demonstrated in a way that recognizes the cultural context of the individual and the community.
6. Relevant healing places emphasis on the social, historical, and political contexts that have shaped Indigenous experiences, lives, and perceptions.
7. Relevant healing encourages balance and harmony within a person's life and in relationship to others; it encourages the growth of positive elements in a person's life and emphasizes the strengthening of resiliency.
8. Individuality is valued by how it improves the community. Collaboration is more highly valued than autonomy. Competition should enhance collaboration.
9. Sustainability is essential for all of us to survive and thrive. This generation is not the most important for all time. It is important to question: How can we live in a way that allows others to live? How can we live in a way that reflects respect to all those whom we impact?
10. Mystery, awe, wonder, intuition, and miracles occur naturally in everyday life. The fact that Western culture has not yet figured out how to measure them is irrelevant.
11. The best way to understand one's place and identity is in the context of past, present, and future within one's community. Any action may have broad consequences. It is important to consider how to act deliberately and thoughtfully.

* From "Society of Indian Psychologists commentary on the American Psychological Association's (APA) ethical principles of psychologists and code of conduct" by M. A. García & M. Tehee (Eds.), 2014. Society of Indian Psychologists (SIP). Retrieved from from http://www.aiansip.org. Copyright 2014 by M. A. García. Adapted with permission.

12. Compartmentalism misses the beauty of the Whole. The Whole is often much more complex and functional than the sum of each individual part. Working with the Whole acknowledges the mystery of those things still unknown and that cannot be readily observed or measured.

CODES, ACCOUNTABILITY, AND CONFLICTS

Difficulties defining psychotherapy with precision or agreeing on a basic philosophy of ethics do not free the profession from setting forth its own ethics. The hallmark of a profession is the recognition that the work its members carry out affects the lives of their clients, sometimes in direct, profound, and immediate ways. The powerful nature of this influence makes the customary rules of the marketplace—often resting on variations of the principle "Let the buyer beware"—inadequate.

Society asks and expects the profession to create and set forth a code of ethics that holds its members accountable. At its heart, this code calls for professionals to protect and promote the welfare of clients and avoid letting the professional's self-interests place the client at risk for harm.

Perhaps because society never completely trusts professions to enforce their own standards and perhaps because the professions have demonstrated that they, at least occasionally, are less than effective in governing their own behavior, society has established its own means for making sure that professions meet minimal standards in their work and that their clients are protected from incompetent, negligent, and dishonest practitioners. As a result, four major mechanisms have been developed to hold therapists and counselors accountable: (1) professional ethics committees; (2) state licensing boards; (3) civil (e.g., malpractice) courts; and (4) criminal courts. Each of these four mechanisms uses different standards, though they may overlap. Behavior may be clearly unethical and yet not form the basis for criminal charges.

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

That almost 1 out of 10 of the respondents reported engaging in sex with a client using the rationale of patient welfare or deeper moral value highlights

the risks, ambiguities, and difficulties of us evaluating the degree to which our own individual behavior is ethical.

Pope and Bajt (1988) reviewed the attempts of philosophers and the courts to judge those times when a person decides to go against the law (e.g., engage in civil disobedience). On one hand, for example, the US Supreme Court emphasized that in the United States, no one could be considered higher than the law: "In the fair administration of justice no man can be judge in his own case, however exalted his station, however righteous his motives, and irrespective of his race, color, politics, or religion" (*Walker* v. *City of Birmingham*, 1967, p. 1219–1220).

Conversely, courts endorsed Henry David Thoreau's (1849/1960) injunction that if a law "requires you to be the agent of injustice to another, then … break the law" (p. 242). The California Supreme Court, for example, tacitly condoned violation of the law only when the principles of civil disobedience are followed

> If we were to deny to every person who has engaged in … nonviolent civil disobedience … the right to enter a licensed profession, we would deprive the community of the services of many highly qualified persons of the highest moral courage (*Hallinan* v. *Committee of Bar Examiners of State Bar*, 1966, p. 239).

As Pope and Bajt note, civil disobedience (Gandhi, 1948; King, 1958, 1964; Plato, 1956a, 1956b; Thoreau, 1849/1960; Tolstoy, 1894/1951) is useful in many contexts for resolving this dilemma. The individual breaks a law considered to be unjust and harmful but does so openly, inviting the legal penalty both to demonstrate respect for the system of law and to call society's attention to the supposedly unjust law. King (1963) explained why civil disobedience can only be done openly, publicly, and never covertly:

> I hope you are able to see the distinction I am trying to point out. In no sense do I advocate evading or defying the law, as would the rabid segregationist. That would lead to anarchy. One who breaks an unjust law must do so openly, lovingly, and with a willingness to accept the penalty. I submit that an individual who breaks a law that conscience tells him is unjust, and who willingly accepts the penalty of imprisonment in order to arouse the conscience of the community over its injustice, is in reality expressing the highest respect for law (p. 8–9).

However, counselors and therapists often find this avenue of openness unavailable because of confidentiality requirements. If we as individuals and a profession are to address the possible conflicts between the law and our ethical responsibilities, one of the initial steps is to engage in frequent, open, and honest discussion of the issue. The topic needs open and active discussion in graduate courses, internship programs, case conferences, professional conventions, and informal meetings with colleagues.

AMERICAN PSYCHOLOGICAL ASSOCIATION APPROACH TO AN ETHICS CODE

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

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

Some members strongly opposed creating formal ethical standards, and many of their arguments appeared in the *American Psychologist*. Calvin Hall (1952), for example, wrote that any code, no matter how well formulated,

> plays into the hands of crooks …. The crooked operator reads the code to see how much he can get away with, and since any code is bound to be filled with ambiguities and omissions, he can rationalize his unethical conduct by pointing to the code and saying, "See, it doesn't tell me I can't do this," or "I can interpret this to mean what I want it to mean" (p. 430).

Hall endorsed accountability, but he believed that it could be enforced without an elaborate code. He recommended that the application form for APA membership contain this statement:

> As a psychologist, I agree to conduct myself professionally according to the common rules of decency, with the understanding that if a jury of my peers decides that I have violated these rules, I may be expelled from the association (p. 430–431).

Hall placed most of the responsibility on graduate schools. He recommended that "graduate departments of psychology, who have the power to decide who shall become psychologists, should exercise this power in such a manner as to preclude the necessity for a code of ethics" (p. 431).

The APA Committee on Ethical Standards (APA Committee) determined that because empirical research was a primary method of psychology, the code itself should be based on such research and should draw on the experience of APA members. As Hobbs (1948, p. 84) wrote, the method would produce "a code of ethics truly indigenous to psychology, a code that could be lived."

The board of directors accepted this recommendation, and a new committee was appointed to conduct the research and draft the code. Chaired by Nicholas Hobbs, the new committee members were Stuart Cook, Harold Edgerton, Leonard Ferguson, Morris Krugman, Helen Sargent, Donald Super, and Lloyd Yepsen (APA Committee, 1949).

In 1948, all 7,500 members of the APA were sent a letter asking each member "to share his [their] experiences in solving ethical problems by describing the specific circumstances in which someone made a decision that was ethically critical" (APA Committee, 1949, p. 17). The committee received reports of over 1,000 critical incidents. During the next years, the incidents, with their accompanying comments, were carefully analyzed, categorized, and developed into a draft code.

The First APA Code

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

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

The draft sparked much discussion and several revisions. Finally, in 1952, it was formally adopted as the Ethical Standards of Psychologists, and it was published in 1953.

In 1954, information on the complaints that the committee had handled for the past 12 years, during most of which there had been no formal code of ethics, was published in the *American Psychologist* ("Cases and Inquiries," 1954). During this period, the ethical principles most frequently violated were:

- Invalid presentation of professional qualifications (cited 44 times).
- Immature and inconsiderate professional relations (cited 23 times).
- Unprofessional advertisement or announcement (cited 22 times).
- Unwarranted claims for tests or service offered usually by mail (cited 22 times).
- Irresponsible public communication (cited 6 times).

The Empirical Approach to a Code Half a Century Later

APA pioneers provided an array of reasons to use an empirical approach to create the code of ethics for psychologists. But a critical incident survey of APA members could also serve other purposes. For instance, the actuarial data of ethics committees, licensing boards, and civil and criminal courts can reveal trends in ethical or legal violations as established by review agencies, empirical critical incident studies. They can also reveal ethical dilemmas and concerns that are encountered in day-to-day practice by a diverse range of psychologists and not just those who are subject to formal complaint.

The APA critical incident study undertaken in the 1940s was replicated in the 1990s and published in the *American Psychologist* (Pope & Vetter, 1992). In this study, 1,319 randomly sampled APA members were asked to describe incidents that they found ethically challenging or troubling. Table 3.1 describes 703 incidents in 23 categories provided by 679 psychologists.

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

Confidentiality

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

Blurred, Dual, or Conflictual Relationships

- "I live and maintain a … private practice in a rural area. I am also a member of a spiritual community based here. There are very few other therapists in the immediate vicinity who work with transformational, holistic, and feminist principles in the context of good clinical training that 'conventional' people can also feel confidence in. Clients often

Table 3.1. Ethical Problems Reported by a National Sample of APA Members.

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

Source: Adapted with permission from "Ethical Dilemmas Encountered by Members of the American Psychological Association: A National Survey," by K. S. Pope and V. A. Vetter, 1992, American Psychologist, 47, 397–411, p. 399. Available at http://kspope.com. Copyright 1992 by the American Psychological Association.

come to me because they know me already, because they are not satisfied with the other services available, or because they want to work with someone who understands their spiritual practice and can incorporate its principles and practices into the process of transformation, healing, and change. The stricture against dual relationships helps me to maintain a high degree of sensitivity to the ethics (and potentials for abuse or confusion) of such situations but doesn't give me any help in working

with the actual circumstances of my practice. I hope revised principles will address these concerns!"

- "Six months ago, a patient I had been working with for three years became romantically involved with my best and longest friend. I could write no less than a book on the complications of this fact! I have been getting legal and therapeutic consultations all along and continue to do so. Currently they are living together, and I referred the patient (who was furious that I did this and felt abandoned). I worked with the other psychologist for several months to provide a bridge for the patient. I told my friend soon after I found out that I would have to suspend our contact. I'm currently trying to figure out if we can ever resume our friendship and under what conditions." [This latter example is one of many that demonstrate the extreme lengths to which most psychologists are willing to go to ensure the welfare of their patients.]

Payment Sources, Plans, Settings, and Methods

- "A 7 year-old boy was severely sexually abused and severely depressed. I evaluated the case and recommended six months' treatment. My recommendation was evaluated by a managed health care agency and approved for 10 sessions by a nonprofessional in spite of the fact that there is no known treatment program that can be performed in 10 sessions on a 7-year-old that has demonstrated efficacy."
- "Much of my practice is in a private hospital that is in general very good clinically. However, its profit motivation is so very intense that decisions are often made for $ reasons that actively hurt the patients. When patients complain, this is often interpreted as being part of their psychopathology, thus re-enacting the dysfunctional families they came from. I don't do this myself and don't permit others to do so in my presence—I try to mitigate the problem—but I can't speak perfectly frankly to my patients and I'm constantly colluding with something that feels marginally unethical."
- "A managed care company discontinued a benefit and told my patient to stop seeing me, then referred her to a therapist they had a lower fee contract with."

Academic Settings, Teaching Dilemmas, and Concerns About Training

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

Forensic Psychology

- "A psychologist in my area is widely known to clients, psychologists, and the legal community to give whatever testimony is requested in court. He has a very commanding presence, and it works. He will say anything, adamantly, for pay. Clients/lawyers continue to use him because if the other side uses him, that side will probably win the case (because he's so persuasive, though lying)."
- "Another psychologist's report or testimony in a court case goes way beyond what psychology knows or his own data supports. How or whether I should respond."
- "I find it difficult to have to testify in court or by way of deposition and to provide sensitive information about a client. Although the client has given permission to provide this information, there are times when there is much discomfort in so doing."

Research

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

Conduct of Colleagues

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