CHAPTER 6

Standards on

Human Relations

*3. Human Relations*

**3.01 Unfair Discrimination**

In their work-related activities, psychologists do not engage in unfair discrimination based on age,

gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability,

socioeconomic status, or any basis proscribed by law.

Psychologists respect the dignity and worth of all people and appropriately consider

the relevance of personal characteristics based on factors such as age, gender,

gender identity, race, ethnicity, culture, national origin, religion, sexual orientation,

disability, or socioeconomic status (Principle E: Respect for People’s Rights and

Dignity). Much of the work of psychologists entails making valid discriminating

judgments that best serve the people and organizations they work with and fulfilling

their ethical obligations as teachers, researchers, organizational consultants, and

practitioners. Standard 3.01 of the APA Ethics Code (APA, 2002b) does not prohibit

such discriminations.

􀀵 The graduate psychology faculty of a university used differences in standardized test

scores, undergraduate grades, and professionally related experience as selection criteria

for program admission.

􀀵 A research psychologist sampled individuals from specific age, gender, and cultural

groups to test a specific hypothesis relevant to these groups.

􀀵 An organizational psychologist working for a software company designed assessments

for employee screening and promotion to distinguish individuals with the

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Standard 3.01 does not require psychologists offering therapeutic assistance to

accept as clients/patients all individuals who request mental health services. Discerning

and prudent psychologists know the limitations of their competence and accept to

treat only those whom they can reasonably expect to help based on their education,

training, and experience (Striefel, 2007). Psychologists may also refuse to accept

clients/patients on the basis of individuals’ lack of commitment to the therapeutic

process, problems they have that fall outside the therapists’ area of competence, or their

perceived inability or unwillingness to pay for services (Knapp & VandeCreek, 2003).

Psychologists must, however, exercise reasonable judgment and precautions to

ensure that their work does not reflect personal or organizational biases or prejudices

that can lead to injustice (Principle D: Justice). For example, the American

Psychological Association’s (APA’s) *Resolution on Religious, Religion-Based, and/or*

*Religion-Derived Prejudice* (APA, 2007d) condemns prejudice and discrimination

against individuals or groups based on their religious or spiritual beliefs, practices,

adherence, or background.

Standard 3.01 prohibits psychologists from making unfair discriminations based

on the factors listed in the standard.

requisite information technology skills to perform tasks essential to the positions from

individuals not possessing these skills.

􀀵 A school psychologist considers factors such as age, English language proficiency, and

hearing or vision impairment when making educational placement recommendations.

􀀵 A family bereavement counselor working in an elder care unit of a hospital regularly

considered the extent to which factors associated with the families’ culture or religious

values should be considered in the treatment plan.

􀀵 A psychologist conducting couples therapy with gay partners worked with clients to

explore the potential effects of homophobia, relational ambiguity, and family support

on their relationship (Green & Mitchell, 2002).

􀀴 The director of a graduate program in psychology rejected a candidate for program

admission because the candidate indicated that he was a Muslim.

􀀴 A consulting psychologist agreed to a company’s request to develop pre-employment

procedures that would screen out applicants from Spanish-speaking cultures based on

the company’s presumption that the majority of such candidates would be undocumented

residents.

􀀴 A psychologist working in a Medicaid clinic decided not to include a cognitive component

in a behavioral treatment based solely on the psychologist’s belief that lowerincome

patients were incapable of responding to “talk therapies.”

􀀴 One partner of a gay couple who recently entered couple counseling called their psychologist

when he learned that he tested positive for the HIV virus. Although when

working with heterosexual couples the psychologist strongly encouraged clients to

inform their partners if they had a sexually transmitted disease, she did not believe such

an approach was necessary in this situation based on her erroneous assumption that

all gay men engaged in reckless and risky sexual behavior (see Palma & Iannelli, 2002).

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**Discrimination Proscribed by Law**

Standard 3.01 prohibits psychologists from discriminating among individuals on

any basis proscribed by law. For example, industrial–organizational psychologists

need to be aware of nondiscrimination laws relevant to race, religion, and disability

that apply to companies for which they work (e.g., ADA, www.ada.gov; Title VII of

the Civil Rights Act of 1964, www.eeoc.gov/laws/statutes/titlevii.cfm, archive.eeoc

.gov/types/religion.html; Workforce Investment Act of 1998, www.doleta.gov/

usworkforce/wia/wialaw.txt). Psychologists conducting personnel performance

evaluations should avoid selecting tests developed to assess psychopathology (see

*Karraker v. Rent-a-Center,* 2005). In addition, under ADA (1990), disability-relevant

questions can only be asked of prospective employees after the employer has made

a conditional offer. In some instances, ADA laws for small businesses also apply to

psychologists in private practice, such as wheelchair accessibility. In addition,

HIPAA prohibits covered entities from discriminating against an individual for filing

a complaint, participating in a compliance review or hearing, or opposing an act or

practice that is unlawful under the regulation (45 CFR 164.530[g]).

**3.02 Sexual Harassment**

Psychologists do not engage in sexual harassment. Sexual harassment is sexual solicitation,

physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection

with the psychologist’s activities or role as a psychologist, and that either (1) is unwelcome,

is offensive, or creates a hostile workplace or educational environment, and the psychologist

knows or is told this; or (2) is sufficiently severe or intense to be abusive to a reasonable person

in the context. Sexual harassment can consist of a single intense or severe act or of multiple

persistent or pervasive acts. (See also Standard 1.08, Unfair Discrimination Against Complainants

and Respondents.)

It is always wise for psychologists to be familiar with and comply with applicable

laws and institutional policies regarding sexual harassment. Laws on sexual

harassment vary across jurisdictions, are often complex, and change over time.

Standard 3.02 provides a clear definition of behaviors that are prohibited and considered

sexual harassment under the Ethics Code. When this definition establishes

a higher standard of conduct than required by law, psychologists must comply

with Standard 3.02.

According to Standard 3.02, sexual harassment can be verbal or nonverbal

solicitation, advances, or sexual conduct that occurs in connection with the psychologist’s

activities or role as a psychologist. The wording of the definition was

carefully crafted to prohibit sexual harassment without encouraging complaints

against psychologists whose poor judgments or behaviors do not rise to the level of

harassment. Thus, to meet the standard’s threshold for sexual harassment, behaviors

have to be either so severe or intense that a reasonable person would deem

them abusive in that context, or, regardless of intensity, the psychologist was aware

or had been told that the behaviors are unwelcome, offensive, or creating a hostile

workplace or educational environment.

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For example, a senior faculty member who places an arm around a student’s

shoulder during a discussion or who tells an off-color sexual joke that offends a

number of junior faculty may not be in violation of this standard if such behavior

is uncharacteristic of the faculty member’s usual conduct, if a reasonable

person might interpret the behavior as inoffensive, and if there is reason to

assume the psychologist neither is aware of nor has been told the behavior is

offensive.

A hostile workplace or educational environment is one in which the sexual

language or behaviors of the psychologist impairs the ability of those who are the

target of the sexual harassment to conduct their work or participate in classroom

and educational experiences. The actions of the senior faculty member described

above might be considered sexual harassment if the psychologist’s behaviors

reflected a consistent pattern of sexual conduct during class or office hours, if

such behaviors had led students to withdraw from the psychologist’s class, or if

students or other faculty had repeatedly told the psychologist about the discomfort

produced.

􀀴 A senior psychologist at a test company sexually fondled a junior colleague during an

office party.

􀀴 During clinical supervision, a trainee had an emotional discussion with her female

supervisor about how her own experiences recognizing her lesbian sexual orientation

during adolescence were helping her counsel the gay and lesbian youths

she was working with. At the end of the session, the supervisor kissed the trainee

on the lips.

According to this standard, sexual harassment can also consist of a single intense

or severe act that would be considered abusive to a reasonable person.

A violation of this standard applies to all psychologists irrespective of the status,

sex, or sexual orientation of the psychologist or individual harassed.

**3.03 Other Harassment**

Psychologists do not knowingly engage in behavior that is harassing or demeaning to persons

with whom they interact in their work based on factors such as those persons’ age, gender, gender

identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language,

or socioeconomic status.

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According to Principle E: Respect for People’s Rights and Dignity, psychologists

should eliminate from their work the effect of bias and prejudice based on factors

such as age, gender, gender identity, race, ethnicity, national origin, religion, sexual

orientation, disability, language, and socioeconomic status. Standard 3.03 prohibits

behaviors that draw on these categories to harass or demean individuals with

whom psychologists work, such as colleagues, students, research participants, or

employees. Behaviors in violation of this standard include ethnic slurs and negative

generalizations based on gender, sexual orientation, disability, or socioeconomic

status whose intention or outcome is lowering status or reputation.

The term *knowingly* reflects the fact that evolving societal sensitivity to language

and behaviors demeaning to different groups may result in psychologists unknowingly

acting in a pejorative manner. The term *knowingly* also reflects awareness that

interpretations of behaviors that are harassing or demeaning can often be subjective.

Thus, a violation of this standard rests on an objective evaluation that a psychologist

would have or should have been aware that his or her behavior would be

perceived as harassing or demeaning.

This standard does not prohibit psychologists from critical comments about

the work of students, colleagues, or others based on legitimate criteria. For

example, professors can inform, and often have a duty to inform, students that

their writing or clinical skills are below program standards or indicate when a

student’s classroom comment is incorrect or inappropriate. It is the responsibility

of employers or chairs of academic departments to critically review, report on,

and discuss both positive and negative evaluations of employees or faculty.

Similarly, the standard does not prohibit psychologists conducting assessment or

therapy from applying valid diagnostic classifications that a client/patient may

find offensive.

**3.04 Avoiding Harm**

Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees,

research participants, organizational clients, and others with whom they work, and to minimize

harm where it is foreseeable and unavoidable.

As articulated in Principle A: Beneficence and Nonmaleficence, psychologists

seek to safeguard the welfare of those with whom they work and avoid or minimize

harm when conflicts occur among professional obligations. In the rightly practiced

profession and science of psychology, harm is not always unethical or avoidable.

Legitimate activities that may lead to harm include (a) giving low grades to students

who perform poorly on exams; (b) providing a valid diagnosis that prevents a

client/patient from receiving disability insurance; (c) conducting personnel reviews

that lead to an individual’s termination of employment; (d) conducting a custody

evaluation in a case in which the judge determines one of the parents must relinquish

custodial rights; or (e) disclosing confidential information to protect the

physical welfare of a third party.

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**Steps for Avoiding Harm**

Recognizing that such harms are not always avoidable or inappropriate,

Standard 3.04 requires psychologists to take reasonable steps to avoid harming

those with whom they interact in their professional and scientific roles and to

minimize harm where it is foreseeable and unavoidable.

These steps often include complying with other standards in the Ethics Code,

such as the following:

􀀵 Parents of a fourth-grade student wanted their child placed in a special education

class. After administering a complete battery of tests, the school psychologist’s

report indicated that the child’s responses did not meet established definitions for

learning disabilities and therefore did not meet the district’s criteria for such

placement.

􀀵 A forensic psychologist was asked to evaluate the mental status of a criminal

defendant who was asserting volitional insanity as a defense against liability in

his trial for manslaughter. The psychologist conducted a thorough evaluation

based on definitions of volitional insanity and irresistible impulse established by

the profession of psychology and by law. While the psychologist’s report noted

that the inmate had some problems with impulse control and emotional instability,

it also noted that these deficiencies did not meet the legal definition of volitional

that would bar prosecution (see also Hot Topic “Human Rights and

Psychologists’ Involvement in Assessments Related to Death Penalty Cases” in

Chapter 4).

􀀴 A psychologist conducted therapy over the Internet for clients/patients in a rural area

120 miles from her office. The psychologist had not developed a plan with each client/

patient for handling mental health crises. During a live video Internet session, a client

who had been struggling with bouts of depression showed the psychologist his gun

and said he was going outside to “blow his head off.” The psychologist did not have

the contact information of any local hospital, relative, or friend to send prompt emergency

assistance.

􀀴 A psychologist with prescription privileges prescribed a Food and Drug Administration

(FDA)-approved neuroenhancer to help a young adult patient suffering from performance

anxiety associated with his responsibilities as quarterback for his college varsity

football team. The psychologist failed to discuss the importance of gradual reduction in

dosage, and she was dismayed to learn that her patient had been hospitalized after he

abruptly discontinued the medication when the football season ended (APA, 2011a;

McCrickerd, 2010; I. Singh & Kelleher, 2010).

􀀴 Consistent with Standard 10.10a, Terminating Treatment, a psychologist treating a

client/patient with a diagnosis of borderline disorder terminated therapy when she

realized the client/patient had formed an iatrogenic attachment to her that was clearly

interfering with any benefits that could be derived from the treatment. However, her

failure to provide appropriate pretermination counseling and referrals contributed to

the client’s/patient’s emergency hospitalization for suicidal risk (Standard 10.10c,

Terminating Treatment).

**HMO**

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*Is Use of Aversion Therapies Unethical?*

Aversion therapy involves the repeated association of a maladaptive behavior or

cognition with an aversive stimulus (e.g., electric shock, unpleasant images, nausea)

to eliminate pleasant associations or introduce negative associations with the undesirable

behavior. Aversion therapies have proved promising in treatments of drug

cravings, alcoholism, and pica (Bordnick, Elkins, Orr, Walters, & Thyer, 2004;

Ferreri, Tamm, & Wier, 2006; Thurber, 1985) and have been used with questionable

effectiveness for pedophilia (Hall & Hall, 2007). It is beyond the purview of this

volume to review literature evaluating the clinical efficacy of aversion therapies for

different disorders. However, even with evidence of clinical efficacy, aversion therapies

have and will continue to require ethical deliberation because they purposely

subject clients/patients to physical and emotional discomfort and distress. In so

doing, they raise the fundamental moral issue of balancing doing good against

doing no harm (Principle A: Beneficence and Nonmaleficence).

Psychologists should consider the following questions before engaging in aversion

therapy:

Have all empirically and clinically validated alternative therapeutic approaches

been attempted?

Is there empirical evidence that the aversive therapeutic approach has demonstrated

effectiveness with individuals who are similar to the client/patient in

mental health disorder, age, physical health, and other relevant factors?

(Standard 2.04, Bases for Scientific and Professional Judgments)

􀀵 Clarifying course requirements and establishing a timely and specific process for providing

feedback to students (Standard 7.06, Assessing Student and Supervisee Performance)

􀀵 Selecting and using valid and reliable assessment techniques appropriate to the nature

of the problem and characteristics of the testee to avoid misdiagnosis and inappropriate

services (Standards 9.01, Bases for Assessments, and 9.02, Use of Assessments)

􀀵 When appropriate, providing information beforehand to employees and others who

may be directly affected by a psychologist’s services to an organization (Standard 3.11,

Psychological Services Delivered To or Through Organizations)

􀀵 Acquiring adequate knowledge of relevant judicial or administrative rules prior to

performing forensic roles to avoid violating the legal rights of individuals involved in

litigation (Standard 2.01f, Boundaries of Competence)

􀀵 Taking steps to minimize harm when, during debriefing, a psychologist becomes aware

of participant distress created by the research procedure (Standard 8.08c, Debriefing)

􀀵 Becoming familiar with local social service, medical, and legal resources for clients/

patients and third parties who will be affected if a psychologist is ethically or legally

compelled to report child abuse, suicide risk, elder abuse, or intent to do physical harm

to another individual (Standard 4.05b, Disclosures)

􀀵 Monitoring patient’s physiological status when prescribing medications (with legal

prescribing authority), particularly when there is a physical condition that might complicate

the response to psychotropic medication or predispose a patient to experience

an adverse reaction (APA, 2011a).

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To what extent is the behavior endangering the life or seriously compromising

the well-being of the client/patient?

For this particular patient, will the discomfort and distress of the aversive

treatment outweigh its potential positive effects?

To what extent is the urgency defined by the needs of third parties rather than

the client/patient? (Standards 3.05, Multiple Relationships; 3.07, Third-Party

Requests for Services; and 3.08, Exploitative Relationships)

Am I competent to administer the aversive treatment? (Standards 2.01a,

Boundaries of Competence, and 2.05, Delegation of Work to Others)

If aversive treatment is the only remaining option to best serve the needs of

the client/patient, how can harm be minimized?

Have I established appropriate monitoring procedures and termination criteria?

􀀵 Prescribing psychologists trained in addiction treatments opened a group practice to

provide assessment and individual and group therapy for substance abuse and comorbid

disorders. Occasionally, some clients who were long-term cocaine users could not

overcome their cravings despite positive responses to therapy. In such cases, the team

would offer the client a chemical aversion therapy with empirical evidence of treatment

efficacy. The therapy was supervised by a member of the team who was a prescribing

psychologist and who had acquired additional training in this technique (see

also Standard 2.01, Competence).

􀀵 Prior to initiating the aversion therapy, clients/patients were required to undergo a

physical examination by a physician to rule out those for whom the treatment posed

a potential medical risk. The treatment consisted of drinking a saltwater solution

containing a chemical that would induce nausea. Saltwater was used to avoid creating

a negative association with water. As soon as the client began to feel nauseated,

he or she was instructed to ingest a placebo form of crack cocaine using drug paraphernalia.

A bucket was available for vomiting. Patients were monitored by a physician

assistant and the prescribing psychologist during the process and recovery for

any medical or iatrogenic psychological side effects (Standard 3.09, Cooperation With

Other Professionals). Following the recommended minimum number of sessions,

patients continued in individual psychotherapy, and positive and negative reactions to

the aversion therapy continued to be monitored (see Bordnick et al., 2004).

**Need to Know: When HMOs**

**Refuse to Extend Coverage**

When health maintenance organizations refuse psychologists’ request to extend coverage for

clients/patients whose reimbursement quotas have been reached, psychologists may be in

violation of Standard 3.04 if they (a) did not take reasonable steps at the outset of therapy to

estimate and communicate to patients and their insurance company the number of sessions

anticipated, (b) did not familiarize themselves with the insurers’ policy, (c) recognized a need

for continuing treatment but did not communicate with insurers in an adequate or timely

fashion, or (d) were unprepared to handle client/patient response to termination of services.

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Often, violation of Standard 3.04 will occur in connection with the violation of

other standards in this code that detail the actions required to perform psychological

activities in an ethically responsible manner. For example:

􀀴 Providing testimony on the poor parenting skills of an individual whom the psychologist

has never personally examined that contributed to that individual’s loss of child

custody (Standard 9.01b, Bases for Assessments)

􀀴 Engaging in a sexual relationship with a current therapy client/patient that was a

factor leading to the breakup of the client’s/patient’s marriage (Standard 10.05,

Sexual Intimacies With Current Therapy Clients/Patients)

􀀴 Asking students to relate their personal experience in psychotherapy to past and current

theories on mental health treatment when this requirement was not stipulated in

admissions or program materials, causing some students to drop out of the program

(Standard 7.04, Student Disclosure of Personal Information)

􀀴 Deceiving a research participant about procedures that the investigator expected

would cause some physical pain (Standard 8.07b, Deception in Research)

􀀴 Invalidating the life experience of clients from diverse cultural backgrounds by defining

their cultural values or behaviors as deviant or pathological and denying them culturally

appropriate care (D. W. Sue & Sue, 2003; Standard 2.01b, Boundaries of Competence).

Some contexts require more stringent protections against harm. For example,

psychologists working within institutions that use seclusion or physical restraint

techniques to treat violent episodes or other potentially injurious patient behaviors

must ensure that these extreme methods are employed only upon evidence of their

effectiveness, when other treatment alternatives have failed, and when the use of

such techniques is in the best interest of the patient and not for punishment, for

staff convenience or anxiety, or to reduce costs (Jerome, 1998).

􀀴 The director of psychological services for a children’s state psychiatric inpatient ward

approved the employment of time-out procedures to discipline patients who were disruptive

during educational classes. A special room was set up for this purpose. The director

did not, however, set guidelines for how the time-out procedure should be implemented.

For example, he failed to set limits on the length of time a child could be kept in the room

and not require staff monitoring, did not ensure the room was protected against fire

hazard, and did not develop policies that would permit patients to leave the room for

appropriate reasons. The director was appalled to learn that staff had not monitored

a 7-year-old who was kept in the room for over an hour and was discovered crying and

self-soiled (see, e.g., Dickens v. Johnson County Board of Education, 1987; Goss v. Lopez,

1975; Hayes v. Unified School District, 1989; Yell, 1994).

**Psychotherapy and Counseling Harms**

Psychologists should also be aware of psychotherapies or counseling techniques

that may cause harm (Barlow, 2010). If psychological interventions are powerful

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enough to improve mental health, it follows that they can be equally effective in worsening

it. In the normative practice of mental health treatment, the diversity of patient/

client mental health needs and the fluid nature of differential diagnosis will mean that

some therapeutic approaches will fail to help alleviate a mental health problem. In such

circumstances, psychologists will turn to other techniques, seek consultation, or offer

an appropriate referral. In other circumstances, negative symptoms are expected to

increase then subside during the natural course of evidence-based treatment (e.g.,

exposure therapy). When treating naturally deteriorating conditions (e.g., Alzheimer’s

disease), a worsening of symptoms does not necessarily indicate treatment harms

(Dimidjian & Hollon, 2010). By contrast, harmful psychotherapies are defined as those

that produce outcomes worse than what would have occurred without treatment

(Dimidjian & Hollon, 2010; Lilienfeld, 2007). Such harmful effects are easiest to detect

for mental health problems whose natural course is constant. In all these circumstances,

failure to terminate treatment when it becomes clear that continuation would

be harmful is a violation of Standard 3.04 and Standard 10.10a, Terminating Therapy.

**Need to Know: How to Detect Harm**

**in Psychotherapy and Counseling**

Psychologists should be aware of the evolving body of knowledge on potential contributors

to the harmful effects of psychotherapy and keep in mind the following suggestions

drawn from Beutler, Blatt, Alimohamed, Levy, and Angtuaco (2006), Castonguay, Boswell,

Constantino, Goldfried, and Hill (2010), and Lilienfeld (2007):

Obtain training in and keep up to date on the flexible use of interventions and

treatment alternatives to avoid premature use of clinical interpretations, rigid theoretical

frameworks, and singular treatment modalities.

Be familiar with the degree to which each client/patient and treatment setting match

those reported for a specific EBP and look for multiple knowledge sources as support

for different approaches (readers may also want to refer to the Need to Know section

on “Navigating the Online Search for Evidence-Based Practices” in Chapter 5).

Monitor change suggesting client/patient deterioration or lack of improvement;

continuously evaluate what works and what interferes with positive change.

Attend to treatment-relevant characteristics such as culture, sexual orientation,

religious beliefs, and disabilities and be aware of the possibility of over- or underdiagnosing

these clients’/patients’ mental health needs.

Carefully attend to client’s/patient’s disclosures of frustration with treatment and

use the information self-critically to evaluate the need to modify diagnosis, adjust

treatment strategy, or strengthen relational factors that may be jeopardizing the

therapeutic alliance.

**Equipoise and Randomized Clinical Trials**

Important questions of treatment efficacy and effectiveness driving the conduct

of randomized clinical trials (RCTs) for mental health treatments raise, by their very

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nature, the possibility that some participants will fail to respond to experimental

treatment conditions or experience a decline in mental health during the trial. To

comply with Standard 3.04, research psychologists should develop procedures to

identify and address such possibilities. Such steps can include (a) scientifically and

clinically informed inclusion and exclusion criteria for patient participation, (b) the

establishment of a data safety monitoring board to evaluate unanticipated risks that

may emerge during a clinical trial, and (c) prior to the initiation of the research,

establishing criteria based on anticipated risks for when a trial should be stopped to

protect the welfare of participants. For additional information on guidance from the

Office of Human Research Protections, readers can refer to http://www.hhs.gov/

ohrp/policy/advevntguid.html.

􀀵 There is professional and scientific disagreement over the risks and benefits of

prescribing methylphenidate (e.g., brand name Ritalin) for treatment of attentiondeficit/

hyperactivity disorder (ADHD) in children less than 6 years of age. An interdisciplinary

team of behavioral and prescribing psychologists sought to empirically

test the advantage of adding psychopharmaceutical treatment to CBT for 3- to

5-year-old children previously diagnosed with ADHD. To avoid unnecessarily exposing

children to the potential side effects of medication, the team decided that preschoolers

would first participate in a multi-week parent training and behavioral

treatment program and that only those children whose symptoms did not significantly

improve with the behavioral intervention would continue on to the medication

clinical trial.

**3.05 Multiple Relationships**

(a) A multiple relationship occurs when a psychologist is in a professional role with a person and

(1) at the same time is in another role with the same person, (2) at the same time is in a relationship

with a person closely associated with or related to the person with whom the psychologist

has the professional relationship, or (3) promises to enter into another relationship in the future

with the person or a person closely associated with or related to the person. A psychologist

refrains from entering into a multiple relationship if the multiple relationship could reasonably be

expected to impair the psychologist’s objectivity, competence, or effectiveness in performing his

or her functions as a psychologist, or otherwise risks exploitation or harm to the person with

whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment or risk

exploitation or harm are not unethical.

Individual psychologists may perform a variety of roles. For example, during

the course of a year, a psychologist might see clients/patients in private practice,

teach at a university, provide consultation services to an organization, and conduct

research. In some instances, these multiple roles will involve the same person or

persons who have a close relationship with one another and may be concurrent or

sequential.

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**Not All Multiple Relationships Are Unethical**

Multiple relationships that would not reasonably be expected to cause impairment

or risk exploitation or harm are not unethical. For example, it is not unethical

for psychologists to serve as clinical supervisors or dissertation mentors for students

enrolled in one of their graduate classes because supervision, mentoring, and

teaching are all educational roles.

Standard 3.05 does not prohibit attendance at a client’s/patient’s, student’s,

employee’s, or employer’s family funeral, wedding, or graduation; the participation

of a psychologist’s child in an athletic team coached by a client/patient; gift giving

or receiving with those with whom one has a professional role; or entering into a

social relationship with a colleague as long as these relationships would not reasonably

be expected to lead to role impairment, exploitation, or harm. Incidental

encounters with clients/patients at religious services, school events, restaurants,

health clubs, or similar places are also not unethical as long as psychologists react

to these encounters in a professional manner. Nonetheless, psychologists should

always consider whether the particular nature of a professional relationship might

lead to a client’s/patient’s misperceptions regarding an encounter. If so, it is advisable

to keep a record of such encounters. For example:

􀀵 A client with a fluctuating sense of reality coupled with strong romantic transference

feelings for a treating psychologist misinterpreted two incidental encounters with his

psychologist as planned romantic meetings. The client subsequently raised these incidents

in a sexual misconduct complaint against the psychologist. The psychologist’s

recorded notes, made immediately following each encounter, were effective evidence

against the invalid accusations.

*Posttermination Nonsexual Relationships*

The standard does not have an absolute prohibition against posttermination

*non*sexual relationships with persons with whom psychologists have had a previous

professional relationship. However, such relationships are prohibited if the

posttermination relationship was promised during the course of the original

relationship or if the individual was exploited or harmed by the intent to have the

posttermination relationship. Psychologists should be aware that posttermination

relationships can become problematic when personal knowledge acquired

during the professional relationship becomes relevant to the new relationship

(see S. K. Anderson & Kitchener, 1996; Sommers-Flanagan, 2012).

􀀵 A psychologist in independent practice abruptly terminated therapy with a patient

who was an editor at a large publishing company so that the patient could review a

book manuscript that the psychologist had submitted to the company.

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*Clients in Individual and Group Therapy*

In most instances, treating clients/patients concurrently in individual and

group therapy does not represent a multiple relationship because the practitioner

is working in a therapeutic role in both contexts (R. E. Taylor & Gazda, 1991), and

Standard 3.05 does not prohibit such practice. Psychologists providing individual

and group therapy to the same clients/patients should consider instituting special

protections against inadvertently revealing to a therapy group information shared

by a client/patient in individual sessions. As in all types of professional practice,

psychologists should avoid recommending an additional form of therapy based on

the psychologist’s financial interests rather than the client’s/patient’s mental health

needs (Knauss & Knauss, 2012; Standard 3.06, Conflict of Interest).

**Need to Know: Ethical “Hot Spots”**

**of Combined Therapy**

Brabender and Fallon (2009) have identified ethical “hot spots” of combined therapy that

should be addressed at the outset of plans to engage clients/patients in individual and

group therapy. First, clients/patients should know that they have a choice in being offered

an additional therapy beyond what they expected, and their concerns about costs in time

and money should be respected and discussed (Standard 10.01, Informed Consent to

Therapy; 10.03, Group Therapy). Second, the psychologists should describe how private

information disclosed in individual therapy will be protected from transfer during group

sessions (Standard 4.02, Discussing the Limits of Confidentiality). Finally, psychologists

should explain their policies on client/patient decisions to choose to terminate one of the

treatment modalities (Standard 10.10a, Terminating Therapy).

**Judging the Ethicality of Multiple Roles**

Several authors have provided helpful decision-making models for judging

whether a multiple relationship may place the psychologist in violation of Standard

3.04 (Brownlee, 1996; Gottlieb, 1993; Oberlander & Barnett, 2005; Younggren &

Gottlieb, 2004). The majority looks at multiple relationships in terms of a continuum

of risk. From these models, the ethical appropriateness of a multiple relationship

becomes increasingly questionable with

increased incompatibility in role functions and objectives;

the greater power or prestige the psychologist has over the person with whom

there is a multiple role;

the greater the intimacy called for in the roles;

the longer the role relationships are anticipated to last;

the more vulnerable the client/patient, student, supervisee, or other subordinate

is to harm; and

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the extent to which engaging in the multiple relationship meets the needs of

the psychologist rather than the needs of the client/patient.

**Potentially Unethical Multiple Relationships**

*Entering Into Another Role*

Psychologists may encounter situations in which the opportunity to enter a new

relationship emerges with a person with whom they already have an established

professional role. The following examples illustrate multiple relationships that,

with rare exception, would be prohibited by Standard 3.05a because each situation

could reasonably be expected to impair psychologists’ ability to competently and

objectively perform their roles or lead to exploitation or harm.

􀀴 A psychologist agreed to see a student in the psychologist’s introductory psychology

course for brief private counseling for test anxiety. At the end of the semester, to avoid

jeopardizing the student’s growing academic self-confidence, the psychologist refrained

from giving the student a legitimate low grade for poor class performance. The psychologist

should have anticipated that the multiple relationship could impair her objectivity and

effectiveness as a teacher and create an unfair grading environment for the rest of the class.

􀀴 A company hired a psychologist for consultation on how to prepare employees for a

shift in management anticipated by the failing mental health of the chief executive

officer (CEO). A few months later, the psychologist agreed to a request by the board

of directors to counsel the CEO about retiring. The CEO did not want to retire and told

the psychologist about the coercive tactics used by the board. The psychologist realized

too late that this second role undermined both treatment and consultation

effectiveness because the counseling role played by the psychologist would be viewed

as either exploitative by the CEO or as disloyal by the board of directors.

􀀴 A school psychologist whose responsibilities in the school district included discussing

with parents the results of their children’s psychoeducational assessments regularly

recommended to parents that they bring their children to his private practice for

consultation and possible therapy.

􀀴 As part of their final class assignment, a psychologist required all students in her

undergraduate psychology class to participate in a federally funded research study

that she was conducting on college student drinking behaviors.

􀀴 A psychologist treating an inmate for anxiety disorder in a correctional facility agreed

with a request by the prison administrator to serve on a panel determining the

inmate’s parole eligibility (Anno, 2001).

􀀴 A graduate student interning at an inpatient psychiatric hospital asked her patients if

they would agree to participate in her dissertation research.

􀀴 An applied developmental psychologist conducting interview research on moral

development and adolescent health risk behaviors, often found herself giving advice

to adolescent female participants who asked for her help during the interviews.

*Forensic Roles*

Forensic psychologists may be called upon for a variety of assessment roles that

differ in their goals and responsibilities from those of treating psychologists.

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Whereas the responsibility of the treating psychologist is to help clients/patients

achieve mental health, the responsibility of forensic psychologists serving as experts

for the court, the defense, or plaintiff is to provide objective information to assist

the finder of facts in legal determinations. In most instances, psychologists who take

on both roles concurrently or sequentially will be in violation of Standard 3.05a.

For example, in the treatment context, the format, information sought, and

psychologist–client/patient relationship are guided by the psychologist’s professional

evaluation of client/patient needs. Information obtained in a standardized or

unstructured manner or in response to practitioner empathy and other elements of

the therapeutic alliance is a legitimate means of meeting treatment goals.

However, when mixed with the forensic role, the subjective nature of such inquiries

and the selectivity of information obtained impair the psychologist’s objectivity

and thus ability to fulfill forensic responsibilities. Moreover, the conflicting objectives

of the treating and forensic roles will be confusing and potentially intimidating to

clients/patients, thereby undermining the psychologist’s effectiveness in functioning

under either role. Gottlieb and Coleman (2012) advise forensic psychologists to play

only one role in legal matters and to notify parties if a role change is contemplated.

􀀴 A forensic psychologist was hired by the court to conduct a psychological evaluation

for a probation hearing of a man serving a jail sentence for spousal abuse. At the end

of the evaluation, the psychologist suggested that if the inmate were released, he and

his wife should consider seeing her for couple’s therapy.

Bush et al. (2006) suggest that one potential exception to multiple relationships

in forensic contexts may be seen in psychologists who transition from the role of

forensic evaluator to trial consultant. For example, in some contexts it might be

ethically permissible for a psychologist originally retained by a defense attorney to

evaluate a client to also perform consultative services to the attorney regarding the

testimony of other psychologists during a trial if (a) the psychologist provided

only an oral report on his or her diagnostic impressions and (b) the psychologist

would not be called on to provide court testimony. Psychologists should, however,

approach such a multiple relationship with caution if, by ingratiating themselves

with the attorney, they intentionally or unintentionally bias their evaluation or

otherwise violate Standard 3.05a, Multiple Relationships, or 3.06, Conflict of Interest.

(For additional discussion of the role of forensic experts, see the Hot Topics in

Chapters 8 and 12 on psychologists providing testimony in courts.)

**Personal–Professional Boundary Crossings**

**Involving Clients/Patients, Students,**

**Research Participants, and Subordinates**

Boundaries serve to support the effectiveness of psychologists’ work and create

a safe place for clients/patients, students, employees, and other subordinates to

benefit from the psychologists’ services (Burian & Slimp, 2000; Russell & Peterson,

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1998). Boundaries protect against a blurring of personal and professional domains

that could jeopardize psychologists’ objectivity and confidence of those with whom

they work that psychologists will act in their best interests. Unethical multiple relationships

often emerge after psychologists have engaged in a pattern that “progresses

from apparently benign and perhaps well-intended boundary crossings to

increasingly intrusive and harmful boundary violations and multiple relationships”

(Oberlander & Barnett, 2005, p. 51). Boundary crossings can thus place psychologists

on a slippery slope leading to ethical misconduct (Gutheil & Gabbard, 1993;

Norris, Gutheil, & Strasburger, 2003; Sommers-Flanagan, 2012).

Clients/patients, students, research participants, and supervisees have less experience,

knowledge, and power compared with psychologists providing assessment, treatment,

teaching, mentoring, or supervision. Consequently, they are unlikely to recognize

inappropriate boundary crossings or to express their concerns. It is the psychologist’s

responsibility to monitor and ensure appropriate boundaries between professional and

personal communications and relationships (Gottlieb, Robinson, & Younggren, 2007).

Sharing aspects of their personal history or current reactions to a situation with

those they work with is not unethical if psychologists limit these communications

to meet the therapeutic, educational, or supervisory needs of those they serve.

􀀵 A graduate student expressed to his dissertation mentor his feelings of inadequacy

and frustration upon learning that a manuscript he had submitted for publication was

rejected. The mentor described how she often reacted similarly when first receiving

such information but framed this disclosure within a “lesson” for the student on rising

above the initial emotion to objectively reflect on the review and improve his chances

of having a revised manuscript accepted.

􀀵 A psychologist in private practice was providing CBT to help a client conquer feelings

of inadequacy and panic attacks that were interfering with her desired career

advancement. After several sessions, the psychologist realized that the client’s distorted

belief regarding the ease with which other people and the psychologist, in

particular, attained their career goals was interfering with the effectiveness of the

treatment. The psychologist shared with the client a brief personal story regarding

how he experienced and reacted to a career obstacle, limiting the disclosure to elements

the client could use in framing her own career difficulties.

Boundary crossings can become boundary violations when psychologists share personal

information with clients/patients, students, or employees to satisfy their own needs.

􀀴 A psychologist repeatedly confided to his graduate research assistant about the economic

strains his marriage was placing on his personal and professional life. After

several weeks, the graduate student began to pay for the psychologist’s lunches when

they were delivered to the office.

􀀴 A psychologist providing services at a college counseling center was having difficulties

with her own college-aged son’s drinking habits. She began to share her concerns

about her son with her clients and sometimes asked their advice.

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*Research*

Boundary crossings can also lead to bidirectional coercion, exploitation, or

harm. For example, the intimacy between researchers and study participants inherent

in ethnographic and participant observation research can create ambiguous or

blurred personal–professional boundaries that can threaten the validity of data

collected (Fisher, 2004, 2011). Study participants may feel bound by a personal

relationship with an investigator to continue in a research project they find distressing,

or investigators may feel pressured to yield to participant demands for involvement

in illegal behaviors or for money or other resources above those allocated for

participation in the research (Singer et al., 1999).

􀀴 A psychologist was conducting ethnographic research on the lives of female sex workers

who were also raising young children. In an effort to establish a sense of trust with

the sex workers, she spent many months in the five-block radius where they worked,

sharing stories with them about her own parenting experiences. One day, when the

police were conducting a drug raid in the area, a participant the psychologist had

interviewed numerous times begged the psychologist to hold her marijuana before

the police searched her, crying that she would lose her child if the drugs were discovered.

The psychologist felt she had no choice but to agree to hide the drugs because

of the personal worries about the safety of her own children that she had shared with

the participant (adapted from Fisher, 2011).

*Nonsexual Physical Contact*

Nonsexual physical contact with clients/patients, students, or others over whom

the psychologist has professional authority can also lead to role misperceptions that

interfere with the psychologist’s professional functions. While Standard 3.05 does

not prohibit psychologists from hugging, handholding, or putting an arm around

those with whom they work in response to a special event (e.g., graduation, termination

of therapy, promotion), or showing empathy for emotional crises (e.g.,

death in the family, recounting of an intense emotional event), such actions can be

the first step toward an easing of boundaries that could lead to an unethical multiple

relationship.

Whenever such circumstances arise, psychologists should evaluate, before

they act, the appropriateness of the physical contact by asking the following

questions:

Is the initiation of physical contact consistent with the professional goals of

the relationship?

How might the contact serve to strengthen or jeopardize the future functioning

of the psychologist’s role?

How will the contact be perceived by the recipient?

Does the act serve the immediate needs of the psychologist rather than the

immediate or long-term needs of the client/patient, student, or supervisee?

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Is the physical contact a substitute for more professionally appropriate

behaviors?

Is the physical contact part of a continuing pattern of behavior that may

reflect the psychologists’ personal problems or conflicts?

**Need to Know: Professional Boundaries**

**and Self-Disclosure Over the Internet**

The Internet has complicated psychologists’ control over access to personal information.

Psychologists can control some information disclosed on the Internet through

carefully crafted professional blogs, participation on professional or scientific listservs,

and credentials or course curricula posted on individual or institutional websites.

However, accidental self-disclosure (Zur, Williams, Lehavot, & Knapp, 2009) can occur

when clients/patients, students, employees, or others (a) pay for legal online background

checks that may include information on divorce or credit ratings, (b) conduct

illegal searches of cell phone records, or (c) use search engines to find information that

the psychologist may not be aware is posted online. Even when psychologists refuse

“friending” requests, it is increasingly easy for individuals to find information on social

networks such as Facebook through the millions of interconnected links and “mutual

friends” who may have personal postings from and photos of the psychologist on their

websites (Luo, 2009; L. Taylor, McMinn, Bufford, & Change, 2010; Zur et al., 2009).

Given the risks of accidental self-disclosure, psychologists should consider the following

to limit access to personal information (Barnett, 2008; Lehavot, Barnett, & Powers,

2010; Nicholson, 2011):

Set one’s social network settings to restrict access to specifically authorized

visitors only.

Consider whether posted personal information, if accessed, would cause harm to

those with whom you work; undermine your therapeutic, teaching, consultation, or

research effectiveness; or compromise the public’s trust in the discipline.

Periodically search one’s name online using different combinations (e.g., Dr. Jones,

Edward Jones, Jones family).

Consult with experts on how to remove personal or inaccurate information from

the Internet.

When appropriate discuss your Internet policies during informed consent or the

beginning of other professional relationships (see “Need to Know: Setting an Internet

Search and Social Media Policy During Informed Consent” in Chapter 13).

**Relationships With Others**

Psychologists also encounter situations in which a person closely associated with

someone with whom they have a professional role seeks to enter into a similar professional

relationship. For example, the roommate of a current psychotherapy client/

patient might ask the psychologist for an appointment to begin psychotherapy. A

CEO of a company that hires a psychologist to conduct personnel evaluations might

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ask the psychologist to administer psychological tests to the CEO’s child to determine

whether the child has a learning disability. With few exceptions, entering into

such relationships would risk a violation of Standard 3.05a because it could reasonably

be expected that the psychologist’s ability to make appropriate and objective

judgments would be impaired, which in turn would jeopardize the effectiveness of

services provided and result in harm.

Receiving referrals from current or recent clients/patients should raise ethical

red flags. In many instances, accepting into treatment a friend, relative, or others

referred by a current client can create a real or perceived intrusion on the psychologist–

patient relationship. For example, a current client/patient may question whether the

psychologist has information about him or her gained from the person he or she

referred or whether the psychologist is siding with one person or the other if there

is a social conflict. Psychologists must also guard against exploiting clients/patients

by explicitly or implicitly encouraging referrals to expand their practice (see also

Standard 3.06, Conflict of Interest).

Some have suggested that treating psychologists should consider a referral from

a current client/patient in the same way they would evaluate the therapeutic meaning

of a “gift” (E. Shapiro & Ginzberg, 2003). In all circumstances, psychologists

must evaluate the extent to which accepting a referral can impair their objectivity

and conduct of their work or lead to exploitation or harm. One way of addressing

this issue is to clearly state to current patients the psychologist’s policy of not

accepting patient referrals and, if a situation arises requiring an immediate need for

treatment, to provide a professional referral to another psychologist (see also

Standard 2.02, Providing Services in Emergencies).

When practicing psychologists receive referrals from former clients/patients, it is

prudent to consider (a) whether the former client/patient may need the psychologist’s

services in the future, (b) whether information obtained about the new referral

during the former client’s/patient’s therapy is likely to impair the psychologist’s

objectivity, and (c) the extent to which the new referral’s beliefs about the former

client’s/patient’s relationship with the psychologist is likely to interfere with treatment

effectiveness.

*Preexisting Personal Relationships*

Psychologists may also encounter situations in which they are asked to take on a

professional role with someone with whom they have had a preexisting personal

relationship. Such multiple relationships are often unethical because the preexisting

relationship would reasonably be expected to impair the psychologist’s objectivity

and effectiveness.

􀀴 A psychologist agrees to spend a few sessions helping his nephew overcome anxiety

about going to school.

􀀴 At a colleague’s request, a psychologist agrees to administer a battery of tests to

assess whether the colleague has adult attention deficit disorder.

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*Sexual Multiple Relationships*

Sexual relationships with individuals with whom psychologists have a current

professional relationship are always unethical. Because of the strong potential for

harm involved in such multiple relationships, they are specifically addressed in

several standards of the Ethics Code that will be covered in greater detail in

Chapters 10 and 13 (Standards 7.07, Sexual Relationships With Students and

Supervisees; 10.05, Sexual Intimacies With Current Therapy Clients/Patients; 10.06,

Sexual Intimacies With Relatives or Significant Others of Current Therapy Clients/

Patients; 10.07, Therapy With Former Sexual Partners; and 10.08, Sexual Intimacies

With Former Therapy Clients/Patients).

*“Reasonably Expected”*

It is important to note that the phrase “could reasonably be expected” indicates

that violations of Standard 3.05a may be judged not only by whether actual impairment,

harm, or exploitation has occurred but also by whether most psychologists

engaged in similar activities in similar circumstances would determine that entering

into such a multiple relationship would be expected to lead to such harms.

􀀵 A judge asked a psychologist who had conducted a custody evaluation to provide

6-month mandated family counseling for the couple involved followed by a reevaluation

for custody. The psychologist explained to the judge that providing family counseling

to individuals whose parenting skills the psychologist would later have to

evaluate could reasonably be expected to impair her ability to form an objective

opinion independent of knowledge gained and the professional investment made in

the counseling sessions. She also explained that such a multiple relationship could

impair her effectiveness as a counselor if the parents refrained from honest engagement

in the counseling sessions for fear that comments made would be used against

them during the custody assessment. The judge agreed to assign the family to another

psychologist for counseling.

**Unavoidable Multiple Relationships**

In some situations, it may not be possible or reasonable to avoid multiple relationships.

Psychologists working in rural communities, small towns, American

Indian reservations, or small insulated religious communities or who are qualified

to provide services to members of unique ethnic or language groups for which

alternative psychological services are not available would not be in violation of this

standard if they took reasonable steps to protect their objectivity and effectiveness

and the possibility of exploitation and harm (Werth et al., 2010).

Such steps might include seeking consultation by phone from a colleague to

help ensure objectivity and taking extra precautions to protect the confidentiality

of each individual with whom the psychologist works. Psychologists can also

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explain to individuals involved the ethical challenges of the multiple relationships,

describe the steps the psychologist will take to mitigate these risks, and

encourage individuals to alert the psychologist to multiple relational situations of

which the psychologist might not be aware and that might place his or her effectiveness

at risk.

􀀵 A rabbi in a small orthodox Jewish community also served as the community’s sole

licensed clinical psychologist. The psychologist was careful to clearly articulate to his

clients the separation of his role as a psychologist and his role as their rabbi. His work

benefited from his ability to apply his understanding of the orthodox faith and community

culture to help clients/patients with some of the unique psychological issues

raised. He had been treating a young woman in the community for depression when

it became clear that a primary contributor to her distress was her deep questioning of

her faith. The psychologist knew from his years in the community that abandoning

orthodox tenets would most likely result in the woman being ostracized by her family

and community. As a rabbi, the psychologist had experience helping individuals

grapple with doubts about their faith. However, despite the woman’s requests, he was

unwilling to engage in this rabbinical role as a part of the therapy, believing that helping

the woman maintain her faith would be incompatible with his responsibility as a

psychologist to help her examine the psychological facets of her conflicted feelings.

The rabbi contacted the director of an orthodox rabbinical school who helped him

identify an advanced student with experience in Jewish communal service who was

willing to come to the community once a week to provide a seminar on Jewish studies

and meet individually with congregants about issues of faith. The psychologist

explained the role conflict to his patient. They agreed that she would continue to see

the psychologist for psychotherapy and meet with the visiting rabbinical student to

discuss specific issues of faith. Readers may also wish to refer to the Hot Topic in

Chapter 13 on the role of religion and spirituality in psychotherapy.

**Correctional and Military Psychologists**

Psychologists working in correctional settings and those enlisted in the military

often face unique multiple relationship challenges. In some prisons, correctional

administrators believe that all employees should provide services as officers. As

detailed by Weinberger and Sreenivasan (2003), psychologists in such settings may

be asked to search for contraband, use a firearm, patrol to prevent escapes, coordinate

inmate movement, and deal with crises unrelated to their role as a psychologist.

Any one of these roles has the potential to undermine the therapeutic

relationship a psychologist establishes with individual inmates by blurring the roles

of care provider and security officer. Such potentially harmful multiple relationships

are also inconsistent with the Standards for Psychological Services in Jails,

Prisons, Correctional Facilities, and Agencies (Althouse, 2000).

As required by Standard 1.03, Conflicts Between Ethics and Organizational

Demands, prior to taking a position as a treating psychologist or whenever correctional

psychologists are asked to engage in a role that will compromise their health

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provider responsibilities, they should clarify the nature of the conflict to the administrator,

make known their commitment to the Ethics Code, and attempt to resolve

the conflict by taking steps to ensure that they do not engage in multiple roles that

will interfere with the provision of psychological services.

􀀵 A psychologist working in a correctional facility had successfully established his primary

role as that of mental health treatment provider with both prison officials and

inmates. He was not required to search his patients for contraband or to perform any

other security-related activities. As required of all facility staff, he received training in

the use of firearms and techniques to disarm prisoners who had weapons. On one

occasion, several newly admitted inmates suddenly began to attack some of the older

prisoners with homemade knives. As one of the few correctional staff members present

at the scene, the psychologist assisted the security staff in disarming the inmates.

Although none of the attacking inmates were in treatment with him, he did discuss

the incident with his current patients to address any concerns they might have about

the therapeutic relationship.

Psychologists in the military face additional challenges (Kennedy & Johnson,

2009). W. B. Johnson, Bacho, Heim, and Ralph (2006) highlight multiple role obligations

that may create a conflict between responsibilities to individual military

clients/patients and to their military organization: (a) as commissioned officers,

psychologists’ primary obligation is to the military mission; (b) embedded psychologists

must promote the fighting power and combat readiness of individual

military personnel and the combat unit as a whole; (c) since many military psychologists

are the sole mental health providers for their unit, there is less room for

choice of alternative treatment providers; (d) there is less control and choice

regarding shifts between therapeutic and administrative role relationships (e.g.,

seeing as a patient a member about whom the psychologist previously had to render

an administrative decision); and (e) like rural communities, military communities

are often small, with military psychologists having social relationships with

individuals who may at some point become patients.

To minimize the potential harm that could emerge from such multiple relationships,

Johnson et al. (2006) suggest that military psychologists (a) strive for a neutral

position in the community, avoiding high-profile social positions; (b) assume

that every member of the community is a potential client/patient and attempt to

establish appropriate boundaries accordingly, for example, limiting self-disclosures

that would be expected in common social circumstances; (c) provide informed

consent immediately if a nontherapeutic role relationship transitions into a therapeutic

one; (d) be conservative in the information one “needs to know” in the

therapeutic role to avoid to the extent feasible threats to confidentiality that may

emerge when an administrative role is required; (e) collaborate with clients/

patients on how best to handle role transitions when possible and appropriate; and

(f) carefully document multiple role conflicts, how they were handled, and the

rationale for such decisions.

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(b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship

has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best

interests of the affected person and maximal compliance with the Ethics Code.

There will be instances when psychologists discover that they are involved in a

potentially harmful multiple relationship of which they had been unaware. Standard

3.05b requires that psychologists take reasonable steps to resolve the potential harms

that might arise from such relationships, recognizing that the best interests of the

affected person and maximal compliance with other standards in the Ethics Code

may sometimes require psychologists to remain in the multiple roles.

􀀵 A military psychologist provided therapy to an enlisted officer who was ordered to enter

treatment for difficulties in job-related performance. During treatment, the client and

psychologist were assigned to a field exercise in which the client would be under

the psychologist’s command. To reassign the client to a different officer for the exercise,

the psychologist would need to speak with a superior who was not a mental health

worker. Recognizing that the client’s involvement in therapy would have to be revealed

in such a discussion, the psychologist explained the situation to the enlisted member

and asked permission to discuss the situation with her superiors. The client refused to

give permission. The psychologist was the only mental health professional on the base,

so transferring the client to another provider was not an option. The psychologist therefore

developed a specific plan with the client for how they would relate to each other

during the field exercise and how they would discuss in therapy issues that arose. (This

case is adapted from one of four military cases provided by Staal & King, 2000.)

􀀵 A psychologist responsible for conducting individual assessments of candidates for an

executive-level position discovered that one of the candidates was a close friend’s

husband. Because information about this prior relationship was neither confidential

nor harmful to the candidate, the psychologist explained the situation to company

executives and worked with the organization to assign that particular promotion

evaluation to another qualified professional.

􀀵 A psychologist working at a university counseling center discovered that a counseling

client had enrolled in a large undergraduate class the psychologist was going to teach.

The psychologist discussed the potential conflict with the client and attempted to help

him enroll in a different class. However, the client was a senior and needed the class

to complete his major requirements. In addition, there were no appropriate referrals

for the student at the counseling center. Without revealing the student’s identity, the

psychologist discussed her options with the department chair. They concluded that

because the class was very large, the psychologist could take the following steps to

protect her objectivity and effectiveness as both a teacher and a counselor: (a) a

graduate teaching assistant would be responsible for grading exams and for calculating

the final course grade based on the average of scores on the exams and (b) the

psychologist would monitor the situation during counseling sessions and seek consultation

if problems arose.

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(c) When psychologists are required by law, institutional policy, or extraordinary circumstances

to serve in more than one role in judicial or administrative proceedings, at the outset they

clarify role expectations and the extent of confidentiality and thereafter as changes occur. (See

also Standards 3.04, Avoiding Harm, and 3.07, Third-Party Requests for Services.)

Standard 3.05c applies to instances when psychologists are required to serve in

more than one role in judicial or administrative proceedings because of institutional

policy or extraordinary circumstances. This standard does *not* permit psychologists

to take on these multiple roles if such a situation can be avoided. When

such multiple roles cannot be avoided, Standard 3.05c requires, as soon as possible

and thereafter as changes occur, that psychologists clarify to all parties involved the

roles that the psychologist is expected to perform and the extent and limits of confidentiality

that can be anticipated by taking on these multiple roles.

In most situations, psychologists are expected to avoid multiple relationships

in forensically relevant situations or to resolve such relationships when they

unexpectedly occur (Standard 3.05a and b). When such circumstances arise (e.g.,

performing a custody evaluation and then providing court-mandated family

therapy for the couple involved), the conflict can often be resolved by explaining

to a judge or institutional administrator the ethically problematic nature of the

multiple relationship (Standards 1.02, Conflicts Between Ethics and Law,

Regulations, and Other Governing Legal Authority; 1.03, Conflicts Between

Ethics and Organizational Demands).

􀀵 A psychologist in independent practice became aware that his neighbor had begun dating

one of the psychologist’s psychotherapy patients. Although telling the patient about

the social relationship could cause distress, it was likely that the patient would find out

about the relationship during conversations with the neighbor. The psychologist considered

reducing his social exchanges with the neighbor, but this proved infeasible. After

seeking consultation from a colleague, the psychologist decided that he could not ensure

therapeutic objectivity or effectiveness if the situation continued. He decided to explain

the situation to the patient, provide a referral, and assist the transition to a new therapist

during pretermination counseling (see also Standard 10.10, Terminating Therapy).

􀀵 A consulting psychologist developed a company’s sexual harassment policy. After the

policy was approved and implemented, the psychologist took on the position of counseling

employees experiencing sexual harassment. One of the psychologist’s clients

then filed a sexual harassment suit against the company. The psychologist was called

on by the defense to testify as an expert witness for the company’s sexual harassment

policy and by the plaintiff as a fact witness about the stress and anxiety observed during

counseling sessions. The psychologist (a) immediately disclosed to the company and

the employee the nature of the multiple relationship; (b) described to both the problems

that testifying might raise, including the limits of maintaining the confidentiality

of information acquired from either the consulting or counseling roles; and (c) ceased

providing sexual harassment counseling services for employees. Neither party agreed

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**3.06 Conflict of Interest**

Psychologists refrain from taking on a professional role when personal, scientific, professional, legal,

financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity,

competence, or effectiveness in performing their functions as psychologists or (2) expose the

person or organization with whom the professional relationship exists to harm or exploitation.

Psychologists strive to benefit from and establish relationships of trust with those with

whom they work through the exercise of professional and scientific judgments based on

their training and experience and established knowledge of the discipline (Principle A:

Beneficence and Nonmaleficence and Principle B: Fidelity and Responsibility).

Standard 3.06 prohibits psychologists from taking on a professional role when competing

professional, personal, financial, legal, or other interests or relationships could reasonably

be expected to impair their objectivity, competence, or ability to effectively

perform this role. Psychologists, especially those with prescription privileges, should

also be sensitive to the effect of gifts from pharmaceutical or others who might exert

influence on professional decisions (Gold & Applebaum, 2011). Examples of conflicts

of interest sufficient to compromise the psychologist’s judgments include the following:

􀀴 Irrespective of patients’ treatment needs, to save money, a psychologist reduced the

number of sessions for certain patients after he had exceeded his yearly compensation

under a capitated contract with an HMO (see the Hot Topic in Chapter 9, “Managing

the Ethics of Managed Care”).

􀀴 A member of a faculty-hiring committee refused to recuse herself from voting when a

friend applied for the position under the committee’s consideration.

􀀴 A psychologist in private practice agreed to be paid $1,000 for each patient he

referred for participation in a psychopharmaceutical treatment study.

􀀴 A research psychologist agreed to provide expert testimony on a contingent fee basis,

thereby compromising her role as advocate for the scientific data.

􀀴 A psychologist who had just purchased biofeedback equipment for his practice began

to overstate the effectiveness of biofeedback to his clients.

􀀴 A prescribing psychologist failed to disclose to patients her substantial financial

investment in the company that manufactured the medication the psychologist frequently

recommended.

􀀴 A psychologist used his professional website to recommend Internet mental health

services in which he had an undisclosed financial interest.

􀀴 A school psychologist agreed to conduct a record review for the educational placement

of the child of the president of a foundation that contributed heavily to the

private school that employed the psychologist.

to withdraw its request to the judge for the psychologist’s testimony. The psychologist

wrote a letter to the judge explaining the conflicting roles and asked to be recused from

testifying (see Hellkamp & Lewis, 1995, for further discussion of this type of dilemma).

**HMO**

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Conflicts of interest can extend to financial or other gains that accrue to psychologists

indirectly through the effect of their decisions on the interests of their

family members:

􀀴 An educational psychologist encouraged a school system she was consulting to purchase

learning software from a company that employed her husband.

􀀴 An organizational psychologist was hired by a company to provide confidential support

and referral services for employees with substance abuse problems. The psychologist

would refer employees he counseled to a private mental health group

practice in which his wife was a member.

􀀴 A research psychologist on the board of a private foundation encouraged the foundation

to fund a colleague’s proposal from which he would be paid as a statistical

consultant.

􀀴 A psychologist accepted a position on the board of directors from a company for

which she was currently conducting an independent evaluation of employee

productivity.

􀀴 A psychologist took on a psychotherapy client who was a financial analyst at the

brokerage company the psychologist used for his personal investments.

􀀴 A psychologist serving on her university’s IRB gave in to pressure to approve a study

with ethically questionable procedures because it would bring a substantial amount

of funding dollars to the university.

􀀵 A school psychologist refused the district superintendent’s request that she conduct

training sessions for teachers at an overcrowded school that would result in the misapplication

of behavioral principles to keep students docile and quiet.

Psychologists also have a fiduciary responsibility to avoid actions that would create

public distrust in the integrity of psychological science and practice (Principle B:

Fidelity and Responsibility). Accordingly, Standard 3.06 also prohibits taking on a

role that would expose a person or organization with whom a psychologist already

works to harm or exploitation. For example:

Psychologists in administrative positions have a responsibility to resist explicit

or implicit pressure to bias decisions regarding the adequacy of research participant

or patient protections to meet the needs of the institution’s financial interests.

Organizational and consulting psychologists should be wary of situations in

which an employer may request the psychologist to assist with managerial directives

that may be ethically inappropriate and harmful to the wellbeing of employees

(Lefkowitz, 2012).

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**Conflicts of Interest in Forensic Practice**

Psychologists seek to promote accuracy and truthfulness in their work (Principle C:

Integrity). Forensic psychologists hired to provide expert testimony based on forensic

assessment or research relevant to the legal decision need to be aware of potential

conflicts of interest that may impair their objectivity or lead them to distort

their testimony. For example, psychologists providing expert testimony should not

provide such services on the basis of contingent fees (fees adjusted to whether a case

is won or lost) since this can exert pressure on psychologists to intentionally or

unintentionally modify their reports or testimony in favor of the retaining party.

However, if a psychologist is serving as a consultant to a legal team and will not be

testifying in court, a contingency fee may not be unethical as long as it does not lead

psychologists to distort facts in giving their advice (Heilbrun, 2001). Psychologists

should also avoid charging higher fees for testimony since this may motivate writing

a report that is more likely to lead to a request to testify (Heilbrun, 2001). Bush

et al. (2006) suggest psychologists set fixed rates (which may be required in some

states) and bill an hourly rate consistent for all activities.

Forensic psychologists hired by the defense team must also avoid explicit or

subtle pressure to use more or less sensitive symptom validation measures to assess

the mental status of the defendant. Psychologists should not submit to pressure by

a legal team to modify a submitted report. Amendments to the original report may

be added to correct factual errors, and if a report is rewritten, the rationale for the

changes should be given within the report (Bush et al., 2006; Martelli, Bush, &

Sasler, 2003). Interested readers may also refer to the Chapter 8 Hot Topic on

“Avoiding False and Deceptive Statements in Scientific and Clinical Expert

Testimony.”

*Corporate Funding and Conflicts of Interest*

*in Research, Teaching, and Practice*

The APA Task Force on External Funding (http://www.apa.org/pubs/info/reports/

external-funding.aspx) provides a detailed history of conflicts of interest in related

fields and provides specific recommendations for psychology (see also Pachter, Fox,

Zimbardo, & Antonuccio, 2007). Recommendations include the following:

When research is industry sponsored, psychologists should ensure that they

have input into study design, independent access to raw data, and a role in

manuscript submission.

Full public disclosure regarding financial conflicts of interest should be

included in all public statements.

Psychologists should be aware and guard against potential biases inherent in

accepting sponsor-provided inducements that might affect their selection of

textbooks or assessment instruments.

Practitioners should be alert to the influence on clients/patients of sponsorprovided

materials (e.g., mugs, pens, notepads) that might suggest endorsement

of the sponsor’s products.

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Many federal agencies, professional and scientific organizations, and academic

and other institutions have conflict of interest policies of which psychologists

should be aware.

The National Institutes of Health (NIH) Office of Extramural Research

requires every institution receiving Public Health Service (PHS) research

grants to have written guidelines for the avoidance and institutional review

of conflict of interest. These guidelines must reflect state and local laws and

cover financial interests, gifts, gratuities and favors, nepotism, political participation,

and bribery. In addition, employees accepting grants or contracts

are expected to be knowledgeable of the granting and contracting organization’s

conflict-of-interest policy and to abide by it (http://grants.nih.gov/

grants/policy/coi/). In addition, the PHS Regulations 42 CFR Part 50

(Subpart F) and 45 CFR Part 94 provide conflict-of-interest guidelines for

individual investigators (http://grants.nih.gov/grants/guide/notice-files/

not95-179.html).

The APA *Editor’s Handbook: Operating Procedures and Policies for APA*

*Publications* (APA, 2006, Policy 1.03) requires that journal reviewers and editors

avoid either real or apparent conflict of interest by declining to review

submitted manuscripts from recent collaborators, students, or members of

their institutions or work from which they might obtain financial gain. When

such potential conflicts of interest arise or when editors or associate editors

submit their own work to the journal they edit, the *Handbook* recommends

that the editor (a) request a well-qualified individual to serve as ad hoc Action

Editor, (b) set up a process that ensures the Action Editor’s independence, and

(c) identify the Action Editor in the publication of the article. APA also

requires all authors to submit a Full Disclosure of Interests Form that certifies

whether the psychologist or his or her immediate family members have significant

financial or product interests related to information provided in the

manuscript or other sources of negative or positive bias (www.apa.org/pubs/

authors/disclosure\_of\_interests.pdf).

The APA Committee on Accreditation’s Conflict of Interest Policy for Site

Visitors includes prohibitions against even the appearance of a conflict of

interest for committee members and faculty in the program being visited.

Possible conflicts include former employment or enrollment in the program

or a family connection or close friend or professional colleague in the program

(http://www.apa.org/ed/accreditation/visits/conflict.aspx).

The NASP’s *Professional Conduct Manual* requires psychologists to avoid conflicts

of interest by recognizing the importance of ethical standards and the

separation of roles and by taking full responsibility for protecting and informing

the consumer of all potential concerns (NASP, 2010, V.A.1).

According to the SGFP (AP-LS Committee on the Revision of the Specialty

Guidelines for Forensic Psychologists, 2010), psychologists should not provide

services to parties to a legal proceeding on the basis of a contingent fee

(SGFP, IV.B).

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**3.07 Third-Party Requests for Services**

When psychologists agree to provide services to a person or entity at the request of a third party,

psychologists attempt to clarify at the outset of the service the nature of the relationship with all

individuals or organizations involved. This clarification includes the role of the psychologist (e.g.,

therapist, consultant, diagnostician, or expert witness), an identification of who is the client, the

probable uses of the services provided or the information obtained, and the fact that there may

be limits to confidentiality. (See also Standards 3.05, Multiple Relationships, and 4.02, Discussing

the Limits of Confidentiality.)

Psychologists are often asked to conduct an assessment, provide psychotherapy,

or testify in court by third parties who themselves will not be directly involved in

the evaluation, treatment, or testimony.

In all these cases, Standard 3.07 requires psychologists at the outset of services

to explain to both the third party and those individuals who will receive psychological

services the nature of the psychologist’s relationship with all individuals or

organizations involved. This includes providing information about the role of the

psychologist (i.e., therapist, consultant, diagnostician, expert witness), identifying

whether the third party or the individual receiving the services is the client, who

will receive information about the services, and probable uses of information

gained or services provided.

􀀵 A company asked a psychologist to conduct preemployment evaluations of potential

employees. The psychologist informed each applicant evaluated that she was working

for the company, that the company would receive the test results, and that the information

would be used in hiring decisions.

􀀵 A school district hired a psychologist to evaluate students for educational placement.

The psychologist first clarified state and federal laws on parental rights regarding

educational assessments, communicated this information to the school superintendent

and the child’s guardian(s), and explained the nature and use of the assessments

and the confidentiality and reporting procedures the psychologist would use.

􀀵 A legal guardian requested behavioral treatment for her 30-year-old developmentally

disabled adult child because of difficulties he was experiencing at the sheltered workshop

where he worked. At the outset of services, using language compatible with the

client’s/patient’s intellectual level, the psychologist informed the client/patient that

the guardian had requested the treatment, explained the purpose of the treatment,

and indicated the extent to which the guardian would have access to confidential

information and how such information might be used.

􀀵 A defense attorney hired a psychologist to conduct an independent evaluation of a

plaintiff who claimed that the attorney’s client had caused her emotional harm. The

plaintiff agreed to be evaluated. The psychologist first explained to the plaintiff that

the defense attorney was the client and that all information would be shared with the

attorney and possibly used by the attorney to refute the plaintiff’s allegations in court.

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**Legal Representatives Seeking to**

**Retain a Forensic Psychologist**

In many instances, forensic psychologists will be retained by the attorney

representing the legal party’s interests. In such instances, the attorney is the psychologist’s

client. During the initial consultation with a legal representative seeking

the psychologist’s forensic services, psychologists should consider providing

the following information: (a) the fee structure for anticipated services; (b) previous

or current obligations, activities, or relationships that might be perceived as

conflicts of interest; (c) level and limitations of competence to provide forensic

services requested; and (d) any other information that might reasonably be

expected to influence the decision to contract with the psychologist (see AP-LS

Committee on the Revision of the Specialty Guidelines for Forensic Psychologists,

2010; Standard 6.04a, Fees and Financial Arrangements).

**Implications of HIPAA**

Psychologists planning to share information with third parties should also carefully

consider whether such information is included under the HIPAA definition of

Protected Health Information (PHI), whether HIPAA regulations require prior

patient authorization for such release, or whether the authorization requirement

can be waived by the legal prerogatives of the third party (45 CFR 164.508 and

164.512). Psychologists should then clarify beforehand to both the third party and

recipient of services the HIPAA requirements for the release of PHI (see also “A

Word About HIPAA” in the Preface of this book).

**3.08 Exploitative Relationships**

Psychologists do not exploit persons over whom they have supervisory, evaluative, or other

authority such as clients/patients, students, supervisees, research participants, and employees.

(See also Standards 3.05, Multiple Relationships; 6.04, Fees and Financial Arrangements; 6.05,

Barter With Clients/Patients; 7.07, Sexual Relationships With Students and Supervisees; 10.05,

Sexual Intimacies With Current Therapy Clients/Patients; 10.06, Sexual Intimacies With Relatives

Once the evaluation commenced, the psychologist avoided using techniques that

would encourage the plaintiff to respond to the psychologist as a psychotherapist

(Hess, 1998).

􀀵 A judge ordered a convicted sex offender to receive therapy as a condition of parole.

The psychologist assigned to provide the therapy explained to the parolee that all

information revealed during therapy would be provided to the court and might be

used to rescind parole.

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or Significant Others of Current Therapy Clients/Patients; 10.07, Therapy With Former Sexual Partners;

and 10.08, Sexual Intimacies With Former Therapy Clients/Patients.)

Standard 3.08 prohibits psychologists from taking unfair advantage of or manipulating

for their own personal use or satisfaction students, supervisees, clients/

patients, research participants, employees, or others over whom they have authority.

The following are examples of actions that would violate this standard:

􀀴 Repeatedly requiring graduate assistants to work overtime without additional

compensation

􀀴 Requiring employees to run a psychologist’s personal errands

􀀴 Taking advantage of company billing loopholes to inflate rates for consulting services

􀀴 Encouraging expensive gifts from psychotherapy clients/patients

􀀴 Using “bait-and-switch” tactics to lure clients/patients into therapy with initial low

rates that are hiked after a few sessions

Violations of Standard 3.08 often occur in connection with other violations of

the Ethics Code. For example:

􀀴 Psychologists exploit the trust and vulnerability of individuals with whom they work

when they have sexual relationships with current clients/patients or students

(Standards 10.05, Sexual Intimacies With Current Therapy Clients/Patients, and 7.07,

Sexual Relationships With Students and Supervisees).

􀀴 Exploitation occurs when a psychologist accepts nonmonetary remuneration from

clients/patients, the value of which is substantially higher than the psychological services

rendered (Standard 6.05, Barter With Clients/Patients).

􀀴 Psychologists exploit patients with limited resources who they know will require longterm

treatment plans when they provide services until the patients’ money or insurance

runs out and then refer them to low-cost or free alternative treatments.

􀀴 It is exploitative to charge clients/patients for psychological assessments for

which the client/patient had not initially agreed to and that are unnecessary for

the agreed on goals of the psychological evaluation (Standard 6.04a, Fees and

Financial Arrangements).

􀀴 School psychologists exploit their students when, in their private practice, they provide

fee-for-service psychological testing to students who could receive these services

free of charge from the psychologist in the school district in which they work

(Standard 3.05a, Multiple Relationships; see also the Professional Conduct Manual

for School Psychology, National Association of School Psychologists, 2010, http://

www.nasponline.org/standards/ProfessionalCond.pdf).

Standard 3.08 does not prohibit psychologists from having a sliding-fee scale or

different payment plans for different types or amount of services, as long as the fee

practices are fairly and consistently applied.

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**Recruitment for Research Participation**

Institutional populations are particularly susceptible to research exploitation.

Prisoners and youth held for brief periods in detention centers, for example, are

highly vulnerable because of their restricted autonomy and liberty, often compounded

by their low socioeconomic status, poor education, and poor health

(Gostin, 2007). Incarcerated persons have few expectations regarding privacy protections

and may view research participation as a means of seeking favor with or

avoiding punishment from prison guards or detention officials. Inpatients in psychiatric

centers or nursing homes are also vulnerable to exploitive recruitment practices

that touch upon their fears that a participation refusal will result in denial of other

needed services. Investigators should ensure through adequate informed consent

procedures and discussion with institutional staff that research participation is not

coerced (Fisher, 2004; Fisher et al., 2002; Fisher & Vacanti-Shova, 2012; see also

Standards 8.02, Informed Consent to Research, and 8.06, Offering Inducements for

Research Participation).

**3.09 Cooperation With Other Professionals**

When indicated and professionally appropriate, psychologists cooperate with other professionals

in order to serve their clients/patients effectively and appropriately. (See also Standard 4.05,

Disclosures.)

Individuals who come to psychologists for assessment, counseling, or therapy

are often either receiving or in need of collateral medical, legal, educational, or

social services. Collaboration and consultation with, and referral to, other professionals

are thus often necessary to serve the best interests of clients/patients.

Standard 3.09 requires psychologists to cooperate with other professionals when it

is appropriate and will help serve the client/patient most effectively. For example:

􀀵 With permission and written authorization of the parent, a clinical child psychologist

spoke with a child’s teacher to help determine if behaviors suggestive of attention

deficit disorder exhibited at home and in the psychologist’s office were consistent

with the child’s classroom behavior.

􀀵 With consent from the parent, a school psychologist contacted a social worker who

was helping a student’s family apply for public assistance to help determine the availability

of collateral services (e.g., substance abuse counseling).

􀀵 A psychologist with prescribing privileges referred a patient to a physician for diagnosis

of physical symptoms thought by the patient to be the result of a psychological

disorder that was more suggestive of a medical condition.

In schools, hospitals, social service agencies, and other multidisciplinary settings,

a psychologist may have joint responsibilities with other professionals for the

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assessment or treatment of those with whom they work. In such settings, psychologists

should develop a clear agreement with the other professionals regarding overlapping

and distinct role responsibilities and how confidential information should

be handled in the best interests of the students or clients/patients. The nature of

these collaborative arrangements should be shared with the recipients of the services

or their legal guardians.

**Implications of HIPAA**

Psychologists who are covered entities under HIPAA should be familiar with

situations in which regulations requiring patients’ written authorization for

release of PHI apply to communications with other professionals (45 CFR 164.510,

164.512). They should also be aware of rules governing patients’ rights to know

when such disclosures have been made (45 CFR 164.520, Notice of Privacy

Practices, and 45 CFR 164.528, Accounting of Disclosures of Protected Health

Information).

**3.10 Informed Consent**

(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting

services in person or via electronic transmission or other forms of communication, they obtain

the informed consent of the individual or individuals using language that is reasonably understandable

to that person or persons except when conducting such activities without consent is

mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See

also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and

10.01, Informed Consent to Therapy.)

Informed consent is seen by many as the primary means of protecting the selfgoverning

and privacy rights of those with whom psychologists work (Principle E:

Respect for People’s Rights and Dignity). Required elements of informed consent for

specific areas of psychology are detailed in Standards 8.02, Informed Consent to

Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to

Therapy. The obligations described in Standard 3.10 apply to these other consent standards.

**Language**

In research, assessment, and therapy, psychologists must obtain informed consent

using language reasonably understandable by the person asked to consent. For

example, psychologists must use appropriate translations of consent information

for individuals for whom English is not a preferred language or who use sign language

or Braille. Psychologists should also adjust reading and language comprehension

levels of consent procedures to an individual’s developmental or educational

level or reading or learning disability.

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**Culture**

Individuals from recently immigrated or disadvantaged cultural communities

may lack familiarity with assessment, treatment or research procedures, and

terminology typically used in informed consent documents (Fisher, in press).

These individuals may also be unfamiliar with or distrust statements associated

with voluntary choice and other client/patient or research participant rights

described during informed consent. Standard 3.10 requires sensitivity to the

cultural dimensions of individuals’ understanding of and anticipated responses

to consent information and tailor informed consent language to such dimensions.

This may also require psychologists to include educational components

regarding the nature of and individual rights in agreeing to psychological services

or research participation. For individuals not proficient in English, written

informed consent information must be translated in a manner that considers

cultural differences in health care or scientific concepts that present challenges

in a word-for-word translation. When using interpreters to conduct informed

consent procedures, psychologists must follow the requirements of Standard 2.05,

Delegation of Work to Others, in ensuring their competence, training, and

supervision. Readers may also wish to refer to Hot Topic “Multicultural Ethical

Competence” in Chapter 5.

**Consent via Electronic Transmission**

Standard 3.10a requires that informed consent be obtained when research,

assessment, or therapy is conducted via electronic transmission such as the telephone

or the Internet. Psychologists need to take special steps to identify the language

and reading level of those from whom they obtain consent via electronic

media. In addition, psychologists conducting work via e-mail or other electronic

communications should take precautions to ensure that the individual who gave

consent is in fact the individual participating in the research or receiving the psychologist’s

services (i.e., use of a participant/client/patient password).

*Exemptions*

Some activities are exempt from the requirements of Standard 3.10. For example,

psychologists conducting court-ordered assessments or evaluating military

personnel may be prevented from obtaining consent by law or governmental regulation.

In addition, several standards in the Ethics Code detail conditions under

which informed consent may be waived (Standards 8.03, Informed Consent for

Recording Voices and Images in Research; 8.05, Dispensing With Informed Consent

for Research; and 8.07, Deception in Research). HIPAA also permits certain exemptions

from patient authorization requirements relevant to research and practice,

which are discussed in later chapters on standards for research, assessment, and

therapy (see also “A Word About HIPAA” in the Preface of this book).

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(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless

(1) provide an appropriate explanation, (2) seek the individual’s assent, (3) consider such persons’

preferences and best interests, and (4) obtain appropriate permission from a legally authorized

person, if such substitute consent is permitted or required by law. When consent by a legally

authorized person is not permitted or required by law, psychologists take reasonable steps to

protect the individual’s rights and welfare.

Adults who have been declared legally incompetent and most children younger

than 18 years of age do not have the legal right to provide independent consent to

receive psychological services or participate in psychological research. In recognition

of these individuals’ rights as persons, Standard 3.10b requires that psychologists

obtain their affirmative agreement to participate in psychological activities after

providing them with an explanation of the nature and purpose of the activities and

their right to decline or withdraw from participation. The phrase “consider such

persons’ preferences and best interests” indicates that although in most instances,

psychologists respect a person’s right to dissent from participation in psychological

activities, this right can be superseded if failure to participate would deprive persons

of psychological services necessary to protect or promote their welfare.

For individuals who are legally incapable of giving informed consent, psychologists

must also obtain permission from a legally authorized person if such substitute

consent is permitted or required by law. Psychologists working with children

in the foster care system and in juvenile detention centers and those working with

institutionalized adults with identified cognitive or mental disorders leading to

decisional impairment must carefully determine who has legal responsibility for

substitute decision making. Psychologists should be aware that in some instances,

especially for children in foster care, legal guardianship may change over time.

**Informed Consent in Research and Practice**

**Involving Children and Adolescents**

In *law* and ethics, guardian permission is required to protect children from consent

vulnerabilities related to immature cognitive skills, lack of emotional preparedness

and experience in clinical or research settings, and actual or perceived

power differentials between children and adults (Fisher & Vacanti-Shova, 2012;

Koocher & Henderson Daniel, 2012). Despite these limitations, the landmark

“Convention on the Rights of the Child” (United Nations General Assembly, 1989)

established international recognition that children should have a voice in decisions

that affect their well-being. Out of respect for their developing autonomy, the APA

Ethics Code and federal regulations governing research (DHHS, 2009) require the

informed assent of children capable of providing assent. Psychologists working

with children should be familiar with the growing body of empirical data on the

development of children’s understanding of the nature of medical and mental

health treatment and research and with rights-related concepts such as confidentiality

and voluntary assent or dissent (Bruzzese & Fisher, 2003; Condie & Koocher, 2008;

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D. Daniels & Jenkins, 2010; Field & Behrman, 2004; Fisher, 2002a; Gibson, Stasiulis,

Gutfreund, McDonald, & Dade, 2011; Koelch et al., 2009; V. A. Miller, Drotar, &

Kodish, 2004; Unguru, 2011).

**Need to Know: Ethically Appropriate**

**Child and Adolescent Assent Procedures**

When creating the content and language of ethically appropriate assent procedures, psychologists

should be guided by the following (Chenneville, Sibille, & Bendell-Estroff, 2010;

Fisher & Vacanti-Shova, 2012; Masty & Fisher, 2008):

Empirical literature on children’s understanding of the nature and purpose of

mental health treatment or research, confidentiality protections and limitations,

and the voluntary nature of participation (Standard 2.01, Boundaries of

Competence)

Scientific and clinical knowledge of the relationship between specific pediatric

mental health disorders and the cognitive and emotional capacity to assent

(Standard 2.04, Bases for Scientific and Professional Judgments)

Individual evaluation, when relevant, of the child’s appreciation of his or her

mental health status and treatment needs, understanding of the risks and benefits

of assent or dissent, the information he or she may want or need to make an

informed assent decision, and whether an assessment of assent capacity is

required

The child’s experience with his or her own health care decision making and preference

for the degree of involvement the child wishes to have in the treatment or

research participation decision

Children should never be asked to assent or dissent to participation if their choice

will not be respected, that is, in situations in which assessment or intervention is

necessary to identify or alleviate a mental health problem (see also the discussion

of assent to pediatric clinical trials in Chapter 11)

*Emancipated and Mature Minors*

There are instances when guardian permission for treatment or research is not

required or possible for children younger than 18 years of age. For example, *emancipated*

*minor* is a legal status conferred on persons who have not yet attained the

age of legal competency (as defined by state law) but are entitled to treatment as if

they have such status by virtue of assuming adult responsibilities, such as selfsupport,

marriage, or procreation. *Mature minor* is someone who has not reached

adulthood (as defined by state law) but who, according to state law, may be treated

as an adult for certain purposes (e.g., consenting to treatment for venereal disease,

drug abuse, or emotional disorders). Psychologists working with children need to

be familiar with the definition of emancipated and mature minors in the specific

states in which they work. When a child is an emancipated or mature minor,

informed consent procedures should follow Standard 3.10a.

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*Best Interests of the Child*

The requirement for guardian permission may be inappropriate if there is serious

doubt whether the guardian’s interests adequately reflect the child’s interests

(e.g., cases of child abuse or neglect, genetic testing of a healthy child to assist in

understanding the disorder of a sibling) or cannot reasonably be obtained (e.g.,

treatment or research involving runaways). In such cases, the appointment of a

consent advocate can protect the child’s rights and welfare by verifying the minor’s

understanding of assent procedures, supporting the child’s preferences, ensuring

participation is voluntary, and monitoring reactions to psychological procedures.

Psychologists conducting research need to be familiar with federal regulations

regarding waiver of parental permission (45 CFR 46.408c) and have such waivers

approved by an IRB (Standard 8.01, Institutional Approval; Fisher, Hoagwood, &

Jensen, 1996; Fisher & Vacanti-Shova, 2012). Psychologists conducting therapy

need to be familiar with their state laws regarding provision of therapy to children

and adolescents without parental consent (Fisher, Hatashita-Wong, & Isman, 1999;

Koocher & Henderson Daniel, 2012).

**Adults With Cognitive Impairments Who**

**Do Not Have Legal Guardians**

There may be adults, such as those with Alzheimer’s disease or developmental

disabilities, who do not have a legal guardian but whose ability to fully understand

consent-relevant information is impaired (APA, 2012b). For example, clinical geropsychologists

frequently work with older persons with progressive dementia living

in nursing homes and assisted-living and residential care facilities where substitute

decision making is typically handled informally by family members or others. In

addition to obtaining consent from the individual, psychologists can seek additional

protections for the individual by encouraging a shared decision-making

process with or seeking additional permission from these informal caretakers

(Fisher, 1999, 2002b, 2003b; Fisher, Cea, Davidson, & Fried, 2006; see also the Hot

Topic, “Goodness-of-Fit Ethics for Informed Consent Involving Adults With

Impaired Decisional Capacity,” at the end of this chapter).

**HIPAA Notice of Privacy Practices**

HIPAA requires that if, under applicable law, a person has authority to act on

behalf of an individual who is an adult or minor in making decisions related to

health care, a covered entity must treat such a person (called a personal representative)

as the individual. Exceptions are permitted if there is reason to believe that the

patient has been abused or is endangered by the personal representative or that

treating the individual as a personal representative would not be in the best interests

of the client/patient (45 CFR 164.502g). This requirement refers to courtappointed

guardians or holders of relevant power of attorney of adults with

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impaired capacities, parents who are generally recognized as personal representatives

of their minor children, and individuals designated as a representative by the

patient. To comply with both Standard 3.10b and the HIPAA Notice of Privacy

Practices (see “A Word About HIPAA” in the Preface of this book), psychologists

should provide the Notice of Privacy Practices to both the individual’s legal guardian

or personal representative and the client/patient.

(c) When psychological services are court ordered or otherwise mandated, psychologists inform

the individual of the nature of the anticipated services, including whether the services are court

ordered or mandated and any limits of confidentiality, before proceeding.

When informed consent is prohibited by law or other governing authority, psychologists

must nonetheless respect an individual’s right to know the nature of

anticipated services, whether the services were court ordered or mandated by

another governing authority, and the limits of confidentiality before proceeding.

**Military Psychologists**

When regulations permit, military psychologists should inform active-duty personnel

of the psychologist’s duty to report information revealed during assessment

or therapy to appropriate military agencies violations of the Uniform Code of

Military Justice.

**Court-Ordered Assessments**

Psychologists conducting a court-ordered forensic assessment must inform the

individual tested (a) why the assessment is being conducted, (b) that the findings

may be entered into evidence in court, and (c) if known to the psychologist, the

extent to which the individual and his or her attorney will have access to the information.

The psychologist should not assume the role of legal adviser but can advise

the individual to speak with his or her attorney when a testee asks about potential

legal consequences of noncooperation.

(d) Psychologists appropriately document written or oral consent, permission, and assent. (See

also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and

10.01, Informed Consent to Therapy.)

Standard 3.10d requires psychologists conducting research or providing health

or forensic services to document that they have obtained consent or assent from an

individual and permission by a legal guardian or substitute decision maker. In most

instances, individuals will sign a consent, assent, or permission form. Sometimes,

oral consent is appropriate, such as when obtaining a young child’s assent, when

working with illiterate populations, when there is concern that confidentiality may

be at risk (i.e., in war-torn countries where consent documents may be confiscated

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by local authorities), or when a signature would risk identification in anonymous

surveys. In these situations, documentation can be provided by a note in the psychologist’s

records, or, in the case of anonymous, web-based or mail surveys, by the

participants’ checking a box to indicate that they have read the consent information

and agree to participate.

**Implications of HIPAA**

Appropriate documentation can also be related to legal requirements. For

example, HIPAA requires that all valid client/patient authorizations for the use and

disclosure of PHI be signed and dated by the individual or the individual’s personal

representative (45 CFR 164.508[c][1][vi]).

**3.11 Psychological Services Delivered**

**To or Through Organizations**

(a) Psychologists delivering services to or through organizations provide information beforehand

to clients and when appropriate those directly affected by the services about (1) the nature and

objectives of the services, (2) the intended recipients, (3) which of the individuals are clients,

(4) the relationship the psychologist will have with each person and the organization, (5) the

probable uses of services provided and information obtained, (6) who will have access to the

information, and (7) limits of confidentiality. As soon as feasible, they provide information about

the results and conclusions of such services to appropriate persons.

The informed consent procedures described in Standard 3.10, Informed Consent,

are often not appropriate or sufficient for consulting, program evaluation, job effectiveness,

or other psychological services delivered to or through organizations. In

such contexts, Standard 3.11 requires that organizational clients, employees, staff, or

others who may be involved in the psychologists’ activities be provided information

about (a) the nature, objectives, and intended recipients of the services; (b) which

individuals are clients and the relationship the psychologist will have with those

involved; (c) the probable uses of and who will have access to information gained;

and (d) the limits of confidentiality. Psychologists must provide results and conclusions

of the services to appropriate persons as early as is feasible.

􀀵 An industrial–organizational psychologist was hired to evaluate whether a company’s

flexible-shift policy had lowered employee absentee rates. In addition to a review of

employee records, the evaluation would include interviews with supervisors and employees

on the value and limits of the policy. The psychologist prepared a document for all

supervisors and employees explaining (a) the purpose of the evaluation, (b) the nature of

and reason for employee record review and the interviews, (c) that the evaluation would

be used to help the company decide if it should maintain or modify its current flexible-shift

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(b) If psychologists will be precluded by law or by organizational roles from providing such information

to particular individuals or groups, they so inform those individuals or groups at the outset of the service.

Standard 3.11b pertains to situations in which psychological services not requiring

informed consent are mandated by law or governmental regulations, and the law or

regulations restrict those affected by the services from receiving any aspect of the

information listed in Standard 3.11a.

policy, (d) that no one in the company would have access to the identities of the individuals

interviewed, and (e) that the results and conclusions would be presented to the

company’s board of directors in a manner that protected confidentiality.

􀀵 A psychologist was hired by a school district to observe teacher management of student

behavior during lunch and recess to help the district determine how many teachers were

required for such activities and whether additional staff training was needed for these

responsibilities. The psychologist held a meeting for all teaching staff who would be

involved in the observations. At the meeting, the psychologist explained why the school

district was conducting the research, how long it would last, the ways in which notes and

summaries of observations would be written to protect the identities of individual teachers,

that a detailed summary of findings would be presented to the school superintendent,

and that, with the district’s permission, teachers would receive a summary report.

􀀵 A psychologist providing court-ordered therapy to a convicted pedophile submitted a

report to the court regarding the therapy client’s attendance and responsiveness to treatment.

The therapist was prohibited from releasing the report to the client. At the beginning

of therapy, the psychologist had informed the client that such a report would be

written and that the client would not have access to the report through the psychologist.

􀀵 A company stipulated that the results of a personality inventory conducted as part of an

employee application and screening process would not be available to applicants.

Psychologists informed applicants about these restrictions prior to administering the tests.

􀀵 An inmate of a correctional institution was required to see the staff psychologist after

repeatedly engaging in disruptive and violent behaviors that were jeopardizing the

safety of the staff and other prisoners. The psychologist explained to the inmate that

in this situation, she was acting on the request of prison officials to help the inmate

control his behaviors. She also informed the inmate that she would be submitting

formal reports on the sessions that might be used by prison officials to determine if

the inmate would be assigned to a more restrictive facility.

**Implications of HIPAA**

Standard 3.11b may also apply to health care settings in which institutional

policy dictates that testing results are sent to another professional responsible for

interpreting and communicating the results to the client/patient. However, the

nature of such institutional policies may be changing in light of HIPAA regulations

providing greater client/patient access to PHI and control of disclosures of PHI.

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**3.12 Interruption of Psychological Services**

Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating

services in the event that psychological services are interrupted by factors such as the psychologist’s

illness, death, unavailability, relocation, or retirement or by the client’s/patient’s

relocation or financial limitations. (See also Standard 6.02c, Maintenance, Dissemination, and

Disposal of Confidential Records of Professional and Scientific Work.)

Planned and unplanned interruptions of psychological services often occur. For

example, a psychologist can leave a job at a mental health care facility for a new

position, take parental or family leave, interrupt services for a planned medical

procedure, or retire from private practice. Clients/patients may move out of state or

have a limited number of sessions covered by insurance.

When interruption of services can be anticipated, Standard 3.12 requires psychologists

to make reasonable efforts to ensure that needed service is continued. Such efforts

can include (a) discussing the interruption of services with the clients/patients and

responding to their concerns, (b) conducting pretermination counseling, (c)referring

the client/patient to another mental health practitioner, and, if feasible and clinically

appropriate, (d) working with the professional who will be responsible for the client’s/

patient’s case (see also Standard 10.10, Terminating Therapy).

􀀵 A psychologist providing Internet-mediated psychological services to clients in a distant

rural community included in her informed consent information the address of a

website she created providing continuously updated information on the names, credentials,

and contact information of local and electronically accessible backup professionals

available to assist clients if the psychologist was not immediately available

during an emergency.

Standard 3.12 also requires psychologists to prepare for unplanned interruptions

such as sudden illness or death. In most cases, it would suffice to have a

trusted professional colleague prepared to contact clients/patients if such a

situation arises. Pope and Vasquez (2007) recommend that psychologists create

a professional will, including directives on the person designated to assume

primary responsibility, backup personnel, coordinated planning, office security

and access, easy to locate schedule, avenues of communication, client records

and contact information, client notification, colleague notification, professional

liability coverage, attorney for professional issues, and billing records

and procedures.

The phrase “reasonable efforts” reflects awareness that some events are unpredictable

and even the best-laid plans may not be adequate when services are interrupted.

The phrase “unless otherwise covered by contract” recognizes that there may be

some instances when psychologists are prohibited by contract with a commercial or

health care organization from following through on plans to facilitate services.

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**HOT TOPIC**

Goodness-of-Fit Ethics for Informed Consent

to Research and Treatment Involving Adults

With Impaired Decisional Capacity

An outgrowth of the person-centered care movement has been growing recognition that adults with cognitive

disorders have rights, including the right to make decisions related to their own health care, independent living,

financial management, and participation in research (McKeown, Clarke, Ingleton, & Repper, 2010). The process of

obtaining informed consent presents unique ethical challenges for mental health treatment and research involving

adults with schizophrenia, developmental disabilities, Alzheimer’s disease, and other disorders characterized

by fluctuating, declining, or long-term impairments in decisional capacity. The heterogeneity of cognitive strengths

and deficits within each of these diagnostic groups means that judgments about each individual’s decisional

capacity cannot be based solely on his or her diagnosis (Kaup, Dunn, Saks, Jeste, & Palmer, 2011; Pierce, 2010).

Obtaining informed consent from these populations raises a fundamental ethical question: How can psychologists

balance their ethical obligation to respect the dignity and autonomy of persons with mental disorders to make

their own decisions with the obligation to ensure that ill-informed or incompetent choices do not jeopardize their

welfare or leave them open to exploitation (Fisher, 1999)?

**Legal Status, Diagnostic Labels, and Consent Capacity**

Some adults with serious mental disorders have been declared legally incompetent to consent. Removal of a

person’s legal status as a consenting adult does not, however, deprive him or her of the moral right to be

involved in treatment or research participation decisions. For these adults, APA Ethics Code Standard 3.10b

requires that psychologists obtain the appropriate permission from a legally authorized person and provide an

appropriate explanation to the prospective client/patient or research participant, consider such person’s preferences

and best interests, and seek the individual’s assent.

The implementation of ethically appropriate consent procedures is more complex for the many situations

in which individuals diagnosed with neurological or other mental health disorders retain the legal status of a

consenting adult, though their capacity for making informed, rational, and voluntary decisions may be compromised.

Each person with a serious mental disorder is unique. Sole reliance on a diagnostic label to determine

a client’s/patient’s capacity to make treatment or research participation decisions risks depriving persons

with mental disorders of equal opportunities for autonomous choice.

**Fitting Consent Procedures**

**to Enhance Decisional Capacities and Protections**

Thomas Grisso and Paul Appelbaum (Appelbaum & Grisso, 2001; Grisso & Appelbaum, 1998) have developed

the most well-known model of consent capacity for clinical research and treatment. Based on a psycho-legal

perspective, it consists of four increasingly complex consent components: choice, understanding, appreciation,

and reasoning. This model has given rise to several empirically validated instruments (Dunn, Nowrangi, Palmer,

Jeste, & Saks, 2006). However, in the case of Alzheimer’s Disease for example, practitioners do not agree on

the salience of these components for deciding a client’s/patient’s consent capacity (Volicer & Ganzine, 2003).

From an ethical perspective, assessing capacity is a necessary but insufficient basis for determining whether

an individual should be granted or deprived of the right to autonomously consent to treatment, assessment,

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or research. In her Goodness-of-Fit Ethics (GFE) for informed consent, Fisher argues that the burden of consent

capacity must be shared by psychologists and the individuals from whom consent is sought (Fisher, 2002a,

2002b, 2003). According to GFE, just and respectful informed consent processes require psychologists not only

to identify the consent strengths and vulnerabilities of the specific individuals or groups with whom they will

work, but also to take responsibility to create consent procedures that can minimize vulnerabilities, enhance

consent strengths, and provide consent supports when feasible (Fisher, 2005b; Fisher & Masty, 2006; Fisher &

Ragsdale, 2006; Fisher & Vacanti-Shova, 2012).

**Goodness-of-Fit and Components of Consent**

This section describes the four components of Grisso and Appelbaum’s model and discusses how the informed

consent process can be enhanced through goodness-of-fit procedures.

**Choice**

Evidencing a choice reflects the ability to actively indicate consent or dissent. For example, some adults

suffering from catatonia or Parkinson’s dementia may be unable to communicate a choice verbally or nonverbally.

While these individuals may understand some of the consent information presented and may have a

participation preference, their inability to communicate agreement or dissent will require stringent safeguards

against harmful or exploitative consent procedures.

In such settings, creating a goodness of fit between person and consent context often requires respectful

inclusion of a consent surrogate who has familiarity with the patient’s preference history. The proxy can help

ensure that the consent decision reflects, to the extent feasible, the patient’s attitudes, hopes, and concerns.

Once proxy consent has been obtained, respect for personhood and protection of individual welfare requires

psychologists to be alert to patient expressions of anxiety, fatigue, or distress that indicate an individual’s dissent

or desire to withdraw from participation.

**Understanding**

Understanding reflects comprehension of factual information about the nature, risks, and benefits of treatment

or research. When understanding is hampered by problems of attention or retention, psychologists can

incorporate consent enhancement techniques into their procedures such as incorporating pictorial representations

of treatment or research procedures, presenting information in brief segments, or using repetition. Person–

consent context fit also requires identifying which information is and is not critical to helping an individual

make an informed choice. For example, when seeking consent for a behavioral intervention for aggressive

disorders in a residence for adults with developmental disabilities, it may be important for clients to understand

the specific types of behaviors targeted (e.g., hitting other residents), the reward system that will be used

(e.g., points toward going to movies or other special activities), and who will be responsible for monitoring the

behavior, for example, residential staff (Cea & Fisher, 2003; Fisher et al., 2006). Although individuals should be

informed about the confidentiality and privacy of their records, psychologists should consider whether it is

important to limit the right to make autonomous decisions to only those individuals who understand details

of residential policies regarding the protection of residents’ health records, especially if the confidentiality

protections do not differ from those that are a natural and ongoing part of the residential experience.

**Appreciation**

Appreciation refers to the capacity to comprehend the personal consequences of consenting or dissenting

to treatment or research. For example, an adult with a dual diagnosis may understand that treatment will require

limiting aggressive behavior but not appreciate the difficulties he or she may have in adhering to the behavioral

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rules. An individual suffering from schizophrenia may understand that clinical research is testing treatment

effectiveness but may not appreciate that he or she has a disorder that requires treatment.

A sliding-scale approach based on the seriousness of personal consequences of the consent decision can

be helpful in evaluating the ethical weight that should be given to the client’s/patient’s or prospective research

participant’s capacity for appreciation. For example, understanding may be sufficient for consent decisions to

standard or experimental interventions that present minimal risk and are supplemental to current treatment

programs. On the other hand, appreciation may be essential when the treatment or experimental intervention

may expose the individual to the risk of serious side effects or offer an opportunity to receive needed services

not otherwise available.

**Reasoning**

Reasoning reflects the ability to weigh the risks and benefits of consent or dissent. For example, an adult

with schizophrenia with paranoid features may understand the nature of a treatment and appreciate its potential

for reducing his anxiety but may reason that the risks outweigh the potential benefits because the psychologist

offering the treatment is part of a government conspiracy to undermine his freedom. There is also

preliminary evidence that severe empathic deficits may confound reasoning about research participation even

when other cognitive skills are preserved (Supady, Voelkel, Witzel, Gubka, & Northoff, 2011). At the same time,

psychologists should be cautious about the legal consequences of erroneously assuming that paper-and-pencil

assessments of reasoning associated with decisional capacity are sufficient to evaluate “performative capacity”

defined as the ability of individuals to perform particular tasks (Appelbaum, 2009).

Asking individuals with questionable reasoning capacity to select a family member, friend, or other trusted

person to be present during an informed consent discussion can be empowering and avoid the risk of triggering a

legal competency review solely for the purposes of a single mental health treatment or research participation decision

(Fisher, 2002a; Fisher et al., 2006; Roeher Institute, 1996).

**Consent and Empowerment**

People with long-standing, declining, or transient disorders related to decisional capacities may be accustomed

to other people making decisions for them and may not understand or have experience applying the concept

of autonomy. In institutional contexts, individuals with mental disorders may fear disapproval from doctors or

residence supervisors or feel that they must be compliant in deference to the authority of the requesting psychologist.

Some may have little experience in exercising their rights or, if they are living in a community residence,

may be fearful of discontinuation of other services. Baeroe (2010) has described current approaches to

competency evaluations and surrogate consent in health care settings as arbitrary and inconsistently applied.

She questions whether the capacity decision of a single practitioner and the health care decision of a single

guardian are sufficient means of respecting patient autonomy, particularly for individuals with borderline

decision-making capacity. While recognizing the potential strain on institutional resources, she recommends a

“collective deliberation” for hospitalized patients with ambiguous capacity that would include the patient, his

or her guardian, health care workers with specific knowledge about the patient, and patient advocates.

To empower and respect the autonomy of patients or prospective research participants, psychologists can

study the nature of consent misconception among diagnostic groups and use this knowledge to develop brief

interventions to enhance consent capacity (Cea & Fisher, 2003; Fisher et al., 2006; Kaup et al., 2011; Mittal et al.,

2007). Modifying the consent setting to reduce the perception of power inequities, providing opportunities to

practice decision making, demonstrating that other services will not be compromised, and drawing on the

support of trusted family members and peers can strengthen the goodness of fit between person and consent

setting and ensure that informed consent is obtained within a context of justice and care.