CHAPTER 12

Chp 12 Standards on Assessment

*9. Assessment*

**9.01 Bases for Assessments**

(a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic

or evaluative statements, including forensic testimony, on information and techniques sufficient

to substantiate their findings. (See also Standard 2.04, Bases for Scientific and

Professional Judgments.)

Psychological assessment serves the public good by providing information to

guide decisions affecting the well-being of individuals, families, groups, organizations,

and institutions. Psychologists who draw their conclusions on information

and techniques based on the scientific and professional knowledge of the discipline

are uniquely qualified to interpret the results of psychological assessments in ways

that merit the public trust. However, the public and the profession are harmed

when psychologists provide opinions unsubstantiated by information obtained or

drawn from data gathered through improper assessment techniques (Principle A:

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

Standard 9.01a of the APA Ethics Code (APA, 2010c) prohibits psychologists from

providing written or oral opinions that cannot be sufficiently substantiated by the

information obtained or the techniques employed.

The standard is broadly worded to apply to all written and oral professional

opinions irrespective of information recipient, setting, or type of assessment.

**Information Recipient**

The standard prohibits unfounded professional opinions offered to, among others,

(a) individual clients/patients or their representatives; (b) other professionals;

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(c) third-party payors; (d) administrative and professional staff at schools, hospitals,

and other institutions; (e) businesses, agencies, and other organizations; (f) the

courts; (g) the military or other governing legal authorities; and (h) callers to talk

radio programs or those interacting with psychologists via the Internet or through

other media.

**Setting**

Standard 9.01a applies to (a) diagnostic opinions offered orally in the office of a

private practitioner; (b) written reports provided to clients/patients, other practitioners,

or third-party payors through the mail, the Internet, or other forms of

electronic transmission; (c) testimony provided in the courts; and (d) opinions

about an individual’s mental health offered over the Internet, radio, television, or

other electronic media.

**Types of Assessment**

The standard pertains to all unfounded opinions claiming to be based on any

form of evaluation, including but not limited to (a) standardized psychological,

educational, or neuropsychological tests; (b) diagnostic information gained

through clinical interviews; (c) collateral data obtained through discussions with

family members, teachers, employee supervisors, or other informants; (d) observational

techniques; or (e) brief discussion or correspondence with an individual via

radio, television, telephone, or the Internet.

Violations of this standard are often related to failure to comply with other standards,

including Standards 2.04, Bases for Scientific and Professional Judgments;

9.01b, Bases for Assessments; and 9.02b, Use of Assessments. The following are

examples of opinions based on insufficient information or techniques that would

be considered violations under this standard:

􀀴 Testifying on the validity of a child abuse allegation based on the results of an idiosyncratic,

improperly constructed parent checklist of child behaviors

􀀴 Diagnosing an adult with impaired decisional capacity as developmentally disabled

without taking a developmental history

􀀴 Providing preemployment recommendations on the basis of a personality test with no

proven relationship to job performance

􀀴 Submitting a diagnosis of neurological impairment to a health insurance company

based solely on information derived during therapy sessions

􀀴 Informing parents that their preschooler is autistic on the basis of a single observational

session

􀀴 Recommending a child for special education placement solely on the basis of scores

on a standardized intelligence test

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Psychologists who knowingly provide unsubstantiated opinions in forensic,

school, or insurance reports fail to live up to the ideals of Principle C: Integrity

and may also find themselves in violation of Standard 5.01, Avoidance of False

or Deceptive Statements (see Hot Topic “Avoiding False and Deceptive Statements

in Scientific and Clinical Expert Testimony,” Chapter 8). However, psychologists

should also be alert to personal and professional biases that may affect their

choice and interpretation of instruments. For example, in a survey of forensic

experts testifying in cases of child sexual abuse allegations, Everson and Sandoval

(2011) found that evaluator disagreements could be explained, in part, by individual

differences in three forensic decision-making attitudes: (1) emphasis on

sensitivity, (2) emphasis on specificity, and (3) skepticism toward child reports

of abuse.

(b) Except as noted in 9.01c, psychologists provide opinions of the psychological characteristics

of individuals only after they have conducted an examination of the individuals adequate

to support their statements or conclusions. When, despite reasonable efforts, such an examination

is not practical, psychologists document the efforts they made and the result of those

efforts, clarify the probable impact of their limited information on the reliability and validity

of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations.

(See also Standards 2.01, Boundaries of Competence, and 9.06, Interpreting

Assessment Results.)

Standard 9.01b specifically addresses the importance of in-person evaluations

of individuals about whom psychologists will offer a professional opinion.

Under this standard, with few exceptions, psychologists must conduct individual

examinations sufficient to obtain personal verification of information on which

to base their professional opinions and refrain from providing opinions about

the psychological characteristics of an individual if they themselves have not

conducted an examination of the individual adequate to support their statements

or conclusions. As video conferencing and other electronically mediated

sources of video communication become increasingly common, appropriately

conducted assessments via these media may meet the requirements of this standard

if the psychologist has had the appropriate preparatory training and the

validity of the video methods of assessment has been scientifically and clinically

established for use with members of the population tested (Standards 2.01e,

Boundaries of Competence; 2.04, Bases for Scientific and Professional Judgment;

9.02, Use of Assessments).

􀀴 Offering a diagnosis of PTSD based on a 5-minute discussion with a listener to a radio

program hosted by the psychologist

􀀴 Offering a diagnosis of bipolar disorder based on an individual’s comments on the

psychologist’s blog

􀀴 Prescribing a psychotropic medication to an elderly patient complaining of memory

lapses without conducting a neuropsychological assessment

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Standard 9.01b also recognizes that in some cases, a personal examination may

not be possible. For example, an individual involved in a child custody suit, a disability

claim, or performance evaluation may refuse or, because of relocation or

other reasons, be unavailable for a personal examination. The standard requires

that psychologists make “reasonable efforts” to conduct a personal examination.

Efforts that would not be considered reasonable in the prevailing professional judgment

of psychologists engaged in similar activities would be considered a violation

of this standard. Consider the following two examples of potential violations:

􀀴 A psychologist testified about a parent’s psychological fitness for visitation rights,

drawing his opinion solely from comments made by the child and divorced spouse in

the absence of an individual examination of the parent.

􀀴 A psychologist contracted by an insurance company to evaluate an individual’s mental

health as part of a current disability claim provided an opinion based solely on

job performance evaluations written by the insured’s immediate supervisors and

diagnostic information collected by another psychologist prior to the incident cited

in the claim.

􀀴 A psychologist working in a correctional facility who was asked to recommend

whether a prison guard’s mental status was a risk to prisoner protections did not

personally examine the guard but instead gave an opinion based on reports by facility

administrators, staff, and prisoners.

􀀴 A psychologist was contracted by a prison to evaluate the job potential of guards

hired for a probationary period. Without conducting an individual interview, the psychologist

wrote a report concluding that emotional instability of one job candidate

made him ineligible for full-time employment. The psychologist justified the lack of a

personal examination on the fact that several coworkers claimed the guard was too

dangerous to interview.

􀀴 A psychologist hired by the attorney of a husband engaged in a custody suit provided

court testimony on the wife’s parenting inadequacies without having interviewed her

personally. The psychologist claimed that the wife did not respond to the psychologist’s

letter requesting the interview. On cross-examination, it was revealed that the

letter written by the psychologist included the following language seemingly designed

to discourage agreement to be examined: “I have reason to believe from interviews

with your spouse and an examination of your children that you are responsible for the

children’s current mental health problems and would like to conduct an examination

to confirm or dispute these assumptions.”

When, despite reasonable efforts, a personal interview is not feasible, under

Standard 9.01b, psychologists in their written or oral opinions must document and

explain the results of their efforts, clarify the probable impact that the failure to

personally examine an individual may have on the reliability and validity of their

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opinions, and appropriately limit their conclusions or recommendations to information

they can personally verify. For example:

(c) When psychologists conduct a record review or provide consultation or supervision and an

individual examination is not warranted or necessary for the opinion, psychologists explain this

and the sources of information on which they based their conclusions and recommendations.

This standard applies to those assessment-related activities for which an individual

examination is not warranted or necessary for the psychological opinion.

Such activities include record or file reviews where psychologists are called on to

review preexisting records and reports to assist or evaluate decisions made by

schools, courts, health insurance companies, organizations, or other psychologists

they supervise or with whom they consult. Record reviews can be performed to (a)

determine whether a previously conducted assessment was appropriate or sufficient;

(b) evaluate the appropriateness of treatment, placement, employment, or

the continuation of benefits based on the previously gathered information and

reports; (c) adjudicate a disability or professional liability claim based on existing

records; or (d) resolve conflicts over the applicability of records to interpretations

of federal and state laws in administrative law or due process hearings

(Hadjistavropoulos & Bieling, 2001; Krivacska & Margolis, 1995).

Reviewers provide a monitoring function for the court or a function of forensic

quality control so the court will not be misled by *expert testimony* of evaluators that

is based on flawed data collection and/or analysis (Austin, Kirkpatrick, & Flens,

2011). According to Standard 9.01c, psychologists who provide such services must

clarify to the appropriate parties the source of the information on which the opinion

is based and why an individual interview conducted by the psychologist is not

necessary for the opinion.

Simply complying with this standard may not be sufficient for psychologists who

are in supervisory roles that carry legal responsibility for the conduct of assessments

by unlicensed supervisees or employees. In many of those instances, psychologists may

be directly responsible for ensuring that individuals are qualified to conduct the assessments

and do so competently (see Standard 2.05, Delegation of Work to Others).

􀀵 A court-appointed psychologist attempted to contact the biological parent of a child

currently in foster care to make recommendations regarding parental visitation. The

parent was no longer at the last known residence and had not left a forwarding

address. In testimony, the psychologist described the current mental health status of

the child, the child’s statements regarding the biological parent, and the observed

relationship between the child and foster parents. In referring to the biological parent,

the psychologist informed the court of efforts to contact the parent, described how

failure to interview the parent limited any conclusions that could be drawn regarding

the parent’s psychological characteristics and parenting competence, and clarified

that recommendations regarding visitation were based on the child’s attitudes, mental

health, and foster care arrangements.

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**Review of Data From Surreptitious**

**Investigative Recording**

There are instances when forensic psychologists may be asked to evaluate past

mental states from audio or video recordings of a defendant’s behavior at the time

of the alleged offense or surreptitious recordings of a plaintiff ’s behavior in a personal

injury, insurance disability, or divorce case (Denney & Wynkoop, 2000).

Before agreeing to review such recordings, psychologists should make sure that the

surveillance information was obtained legally at the time it was recorded, that the

party requesting the psychologist’s evaluation has the legal right to share such

information, and that inadmissibility of such information will not compromise the

psychologist’s findings. Psychologists should also take reasonable steps to ascertain

that they have been provided with all legally available recordings and other available

information relevant to the forensic opinion. The psychologist’s oral testimony or

written report should clarify the source of the information and why an individual

examination is not warranted or necessary for the type of evaluation requested.

**9.02 Use of Assessments**

(a) Psychologists administer, adapt, score, interpret, or use assessment techniques, interviews,

tests, or instruments in a manner and for purposes that are appropriate in light of the research

on or evidence of the usefulness and proper application of the techniques.

The appropriate use of psychological assessments can benefit individuals, families,

organizations, and society by providing information on which educational

placements, mental health treatments, health insurance coverage, employee selection,

job placement, workers’ compensation, program development, legal decisions,

and government policies can be based. The inappropriate use of assessments can

lead to harmful diagnostic, educational, institutional, legal, and social policy decisions

based on inaccurate and misleading information.

Standard 9.02a is concerned with the proper selection, interpretation, scoring,

and administration of assessments. It refers to the full range of assessment techniques

used by psychologists, including interviews and standardized tests administered

in person, through the Internet, or through other media. According to this

standard, ethical justification for the use of assessments is determined by research on

or evidence supporting the purpose for which the test is administered, the method

of administration, and interpretation of scores. To comply with the standard, psychologists

should be familiar with the data and other information provided in test

manuals detailing (a) theoretical and empirical support for test use for specific purposes

and populations, (b) administration procedures, and (c) how test scores are to

be calculated and interpreted. Psychologists should also keep themselves apprised of

ongoing research or evidence of a test’s usefulness or obsolescence over time (see

also Standards 2.03, Maintaining Competence; 2.04, Bases for Scientific and

Professional Judgments; and 9.08b, Obsolete Tests and Outdated Test Results).

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**Internet-Mediated Assessments**

Psychologists administering assessments via the Internet need to remain up-todate

on research demonstrating their validity or lack thereof for use in this media

(Standard 2.03, Maintaining Competence). Verification of the examinee’s age, gender,

and honesty of disclosures is important to the assessment’s validity and reliability

(Alleman, 2002). Some assessments developed for in-person administration

require verbal, auditory, or kinesthetic clues for accurate diagnosis (Barak &

English, 2002). When assessments have not been validated for use of the Internet,

psychologists should make every effort to conduct an in-person evaluation. When

this is not possible, psychologists should select instruments that research or other

evidence indicates are most appropriate for this medium, implement when possible

information-gathering techniques that can best approximate in-person settings (e.g.,

video and auditory interactive technology), and acknowledge limitations of the assessment

in interpretations of the data (Standard 9.06, Interpreting Assessment Results).

Violations of Standard 9.02a occur when psychologists use assessments in a

manner or for a purpose that is not supported by evidence in the field (see also this

chapter’s Hot Topic on “The Use of Assessments in Expert Testimony: Implications

of Case Law and the Federal Rules of Evidence”).

􀀴 A psychologist contracted to conduct employment testing for an organization administered

a series of personality inventories with little or no validity evidence supporting

the link between scores on the inventories and actual job performance.

􀀴 A counseling psychologist working with an isolated rural community administered a

series of tests over the Internet without previously establishing whether the Internetmediated

scores measure the same construct as scores from the paper-and-pencil

version (Buchanan, 2002).

􀀴 A school psychologist working under pressure to meet the school system’s quotas for

weekly testing gave the same battery of tests to all students irrespective of their grade

level or presenting problem.

􀀴 A neuropsychologist conducted a forensic examination of a prisoner in a room occupied

by other prisoners, thereby compromising the validity of score interpretation

based on norms established under standardized distraction-free testing environments.

Test administration for individuals with disabilities may require modifications

and adaptations in testing administration to minimize the effect of test taker characteristics

incidental to the purpose of the assessment. Standard 9.02a permits

departure from a standard administration protocol if the method of test adaptation

can be justified by research or other evidence. For example, converting a written test

to Braille for a blind individual, physically assisting a client with cerebral palsy to

circle items on a written test, or providing breaks for an individual with a disability

associated with frequent fatigue is acceptable if the particular disability is not associated

with the construct to be measured by the test and there are professional or

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scientific reasons to assume that such modifications will not affect the validity of

the test (American Educational Research Association [AERA], APA, & National

Council on Measurement in Education [NCME], 1999). Such accommodations are

not appropriate if the disability is directly related to the abilities or characteristics

that the test is designed to measure. Federal regulations relevant to the assessment

of individuals with disabilities include IDEA (http://idea.ed.gov/), Section 5.04 of

the Rehabilitation Act of 1973 (http://www.hhs.gov/ocr/504.html), and ADA

(www.ada.gov).

**Need to Know: Assessment of Dementia**

The APA Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change

(APA, 2012b) stress the importance of using age-normed standardized psychological and

neurological tests, being aware of the limitations of brief mental status examinations, and

estimating premorbid abilities. The Guidelines also describe the following key elements

that should be obtained to assure accurate diagnosis of conditions associated with cognitive

decline (p. 5):

The onset and course of changes in cognitive functioning

Preexisting disabilities

Educational and cultural background that could affect testing variability

General medical and psychiatric history

Past neurological history, including prior head injuries or other central nervous

system insults (strokes, tumors, infections, etc.)

Current psychiatric symptoms and significant life stressors

Current prescription and over-the-counter medication use

Current and past use and abuse of alcohol and drugs

Family history of dementia

**Presence of Third Parties to Assessments**

Standard 9.02a requires that psychologists administer tests in a manner consistent

with procedures and testing contexts used in the development and validation

of the instruments. Many psychological assessment instruments and procedures are

validated under administration conditions limited to the presence of the psychologist

and testee. In rare instances, psychologists may judge it necessary to include

third parties to control the behavior of difficult examinees (e.g., parents of young

children, hospital staff for psychiatric patients with a recent history of violence). In

such situations, psychologists should select assessment instruments that are least

likely to lend themselves to distortion based on the presence of a third party and

include in their interpretations of test results the implications of such violations of

standardized testing conditions.

Psychologists providing expert forensic consultations in relation to a criminal

case, tort litigation, insurance benefits, or workers’ compensation claims may find

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that state law, institutional policy, or a judge’s ruling mandating the presence of a

third party during forensic assessment can compromise the assessment validity of

tests when third parties are present. For example, in neuropsychological assessments

related to workers’ compensation cases, the presence of the plaintiff ’s legal counsel,

family members, or company representatives may distort the testing process or render

test scores and interpretations invalid if the third party influences the test taker’s

motivation, behavior, or psychologist–testee rapport (American Academy of Clinical

Neuropsychology, 2001). The use of data from such assessments may be unfair to

individuals if it leads to invalid test administration or misleading interpretations of

the testee’s responses (Principle D: Justice and Standards 1.01, Misuse of Psychologists’

Work; 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing

Legal Authority; and 9.06, Interpreting Assessment Results). When there is no legal

flexibility in denying third-party presence during an assessment, psychologists

should select tests and procedures found to be least susceptible to distortion under

these conditions and ensure that their written reports highlight the unique circumstances

of the assessment and the limitations in interpretation.

*Trainees and Interpreters as Third Parties*

Third parties may observe evaluations for training purposes or serve as interpreters

when translation is necessary to ensure accuracy and fairness of assessments

(Standard 9.02c, Use of Assessments). In such instances, psychologists must select

procedures that, research or other evidence has demonstrated, can be applied

appropriately under these circumstances, ensure that trainees and interpreters are

trained adequately to minimize threats to the proper test administration, and

include in their reports any limitations on conclusions presented by the presence of

the third parties (Standards 2.05, Delegation of Work to Others, and 9.06,

Interpreting Assessment Results).

(b) Psychologists use assessment instruments whose validity and reliability have been established

for use with members of the population tested. When such validity or reliability has not been

established, psychologists describe the strengths and limitations of test results and interpretation.

The proper use of tests can further principles of fairness and justice by ensuring

that all persons benefit from equal quality of assessment measures, procedures, and

interpretation (Principle D: Justice and Standard 3.01, Unfair Discrimination). Fair

applicability of test results rests on assumptions that the validity and reliability of a

test are equivalent for different populations tested. *Validity* refers to the extent to

which empirical evidence and psychological theory support the interpretation of

test data; that is, whether the test measures the psychological construct it purports

to measure. *Reliability* refers to the consistency of test scores when a test is repeated

for an individual or for a given population (see AERA, APA, & NCME, 1999).

A test that is a valid and reliable measure of a psychological construct in one

population may not adequately measure the same construct in members of a different

population, especially if members of the population were represented inadequately

in the normative sample or if test validity information has not been

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established specifically for that group. Standard 9.02b requires psychologists to

select assessment instruments whose validity and reliability have been established

for use with members of the population tested. This standard applies to psychological

assessment of any population, including clients/patients, students, job candidates,

legal defendants, and research participants.

To comply with this standard, psychologists, when selecting a test, must be

familiar with the specific populations included in the standardization sample and

the test’s validity and reliability estimates. At minimum, psychologists should determine

the applicability of a test to an individual’s age group, ethnicity/culture,

language, and gender and, where applicable, disability or other population characteristics

for which there is scientific or professional evidence to suggest that test

scores may not be psychometrically, functionally, or theoretically comparable to the

reference groups on which the test was normed (Landwher & Llorente, 2012).

Psychologists should also be familiar with relevant federal laws on the selection

and administration of nondiscriminatory assessment and evaluation procedures

(e.g., IDEA, 34 CFR 300.30[c][1][i]).

􀀴 A school psychologist was asked to evaluate a bilingual child whose family recently

moved to New York from Puerto Rico. The psychologist used the English version of

a well-known intelligence test without considering whether the standardized

Spanish version of the test was or was not most appropriate for the child’s particular

needs.

􀀴 A psychologist working in a nursing home always used the Beck Depression Inventory

(Beck, Steer, & Brown, 1996) to assess patient depression without considering the

appropriateness of other measures specifically standardized on elderly populations or

populations with chronic illnesses.

􀀴 A consulting psychologist was hired to evaluate the job performance of a factory supervisor

who had a visual disability. The psychologist limited her assessment to tests that

were validated on individuals without vision impairment and neglected to assess

unique ways in which the supervisor might successfully compensate for his disability.

The dynamic and evolving nature of this country’s cultural, political, and economic

landscape creates situations in which population-valid and reliable tests of a

psychological construct may not be available for the individual or group tested.

Psychologists asked to evaluate individuals from such groups should select tests

validated on other populations with caution because they may produce results that

do not adequately assess the qualities or competencies intended to be measured

(AERA, APA, & NCME, 1999). Recommendations based on these assessments in

turn may lead to unfair denial of educational or employment opportunities, health

coverage, legal rights, or necessary services (Principle D: Justice). According to

Standard 9.02b, psychologists who use tests without established norms for the individual

or population assessed must describe in their reports the strengths of using

the specific test results as well as the limitations the use of such tests places on

psychologists’ interpretations and recommendations.

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**Selection of “Culture-Free” Tests**

School psychologists and neuropsychologists conducting assessments of intellectual,

educational, and cognitive abilities may attempt to be culturally sensitive by

“stacking” their test batteries with nonverbal visuoperceptual and motor tests when

assessing patients who speak languages in which more traditional language-based

tests are not available. The use of such tests requires ethical caution since nonverbal

tests of cognitive ability can be just as culturally biased as verbal tests (Wong,

Strickland, Fletcher-Janzen, Ardila, & Reynolds, 2000).

􀀵 A forensic psychologist was asked to evaluate the competence to stand trial of a

prisoner who recently immigrated to the United States from Botswana. The prisoner’s

English was poor, but there were no tests for competence standardized for individuals

from the prisoner’s cultural or language group. The psychologist selected the best

culturally sensitive techniques and assessments available and in written conclusions

to the court explained the limitations of the tests used.

􀀴 A neuropsychologist was hired by an insurance company to assess a recent Nigerian

immigrant who claimed he had suffered brain damage falling on the premises of a

store insured by the company. Because the man had such limited English skills, and no

test was available in his primary language, the neuropsychologist decided that the

most culturally sensitive approach would be to assess the man’s cognitive capacity

with an assessment battery composed entirely of visuospatial, perceptual, and motor

tasks. The psychologist’s report did not describe the limitations of test results based

on the absence of language-based assessments of reasoning and other cognitive

abilities, nor did the report acknowledge the absence of pre-injury cognitive tests

necessary to help determine whether behavioral and cognitive functioning had

declined after the fall (adapted from Wong, 2000).

(c) Psychologists use assessment methods that are appropriate to an individual’s language preference

and competence, unless the use of an alternative language is relevant to the assessment issues.

Language differences are part of the cultural diversity, rich immigration history,

and individual differences in hearing and other linguistically relevant disabilities

that make up the demographic mosaic of the United States. The validity and applicability

of assessment data can be severely compromised when testing is conducted

in a language the testee is relatively unfamiliar with or uncomfortable using. Under

Standard 9.02c, prior to selecting, administering, or interpreting tests, psychologists

must consider both the language preference and language competence of the testee.

Whereas the inappropriateness of English-only-based psychological testing is

obvious when testees speak little or no English, the hazards of English-only testing

for bilingual persons or oral-language-only assessment of persons with hearing

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disabilities who can read lips and communicate in sign language are often overlooked.

The linguistic competencies of individuals who are bilingual often vary

with the mode of communication (e.g., oral vs. written language), language function

(e.g., social, educational, or job related), and topical domain (e.g., science,

mathematics, interpersonal relationships, self-evaluations). In addition, individuals’

language preferences do not always reflect their language competence.

Individuals may be embarrassed to reveal that their English, hearing, or oral language

is poor; believe non-English or nonhearing testing will negatively affect

their evaluations; or misjudge their language proficiency.

The *Standards for Educational and Psychological Testing* (AERA, APA, & NCME,

1999) recommends a number of steps that can help psychologists comply with

Standard 9.02c:

Psychologists can use language tests that assess multiple language domains to

determine language dominance and proficiency relevant to different modes of

assessment (e.g., written, oral) and topics (e.g., academic, interpersonal).

Whenever possible, psychologists should use test translations that have been

developed according to accepted methods of test construction (see Standard

9.05, Test Construction). For example, the *Standards for Educational and*

*Psychological Testing* recommends the use of an iterative process more akin to

test construction and validation rather than sole reliance on back translation

(translating the translation of the test back into the original language).

Additional testing or observation may be necessary to determine whether

what appears to be eccentric behavior (e.g., short phrases or reticence in

response to test questions) reflects differences in cultural communication

styles or an individual characteristic.

To the extent feasible, psychologists must ensure the language competence of

the test administrator (see also Standards 2.05, Delegation of Work to Others,

and 9.03c, Informed Consent in Assessments).

When interpreting assessment results, test norms for native speakers of

English should not be used for individuals for whom English is a second

language or should be interpreted in part as reflecting a level of English

proficiency.

**When English or Other Language**

**Proficiency Is Essential**

There are instances when proficiency in English or another language is essential

to the goal of the assessment. For example, the ability to communicate with

English-speaking employees may be a necessary qualification for a successful

applicant for a personnel position. Evaluating a student’s English proficiency may

be necessary to determine appropriate educational placement. The ability to read

and speak English may be important to certain service positions responsible for

protecting public health, safety, and welfare (AERA, APA, & NCME, 1999).

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Inclusion of the phrase “unless the use of an alternative language is relevant to the

assessment issues” indicates that Standard 9.02c permits psychologists to use tests

in a language in which the testee may not be proficient, if effective job performance,

school placement, or other goals of assessment require the ability to communicate

in that language.

**9.03 Informed Consent in Assessments**

(a) Psychologists obtain informed consent for assessments, evaluations, or diagnostic services, as

described in Standard 3.10, Informed Consent, except when (1) testing is mandated by law or

governmental regulations; (2) informed consent is implied because testing is conducted as a

routine educational, institutional, or organizational activity (e.g., when participants voluntarily

agree to assessment when applying for a job); or (3) one purpose of the testing is to evaluate

decisional capacity. Informed consent includes an explanation of the nature and purpose of the

assessment, fees, involvement of third parties, and limits of confidentiality and sufficient opportunity

for the client/patient to ask questions and receive answers.

To comply with this standard, psychologists must obtain and document, with

few exceptions, written or oral consent in the manner set forth in Standard 3.10,

Informed Consent. Psychologists must provide individuals who will be assessed

and, when appropriate, their legal representative a clear explanation of the

nature and purpose of the assessment, fees, involvement of third parties, and the

limits of confidentiality. Psychologists should also be attuned to consent vulnerabilities

related to transient disorders, such as depression (Ghormley, Basso,

Candlis, & Combs, 2011), and develop appropriate measures to ensure consent

comprehension.

**Core Elements of Informed Consent in Assessment**

*Nature of the Assessment*

The *nature* of an assessment refers to (a) the general category of the assessment

(e.g., personality, psychopathology, competency, parenting skills, neuropsychological

abilities and deficits, employment skills, developmental disabilities), (b) procedures

and testing format (e.g., oral interviews, written self-report checklists,

behavioral observation, skills assessment), and (c) duration of the assessment (e.g.,

hours or multiple assessments).

*Purpose of the Assessment*

The *purpose* of the assessment refers to its potential use, for example, in employment

decisions, school placement, custody decisions, disability benefits, treatment

decisions, and plans for or evaluation of rehabilitation of criminal offenders.

**HMO**

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*Fees*

Discussion of *fees* must include the cost of the assessment and payment schedule

and should be consistent with requirements of Standard 6.04, Fees and Financial

Arrangements. When applicable and to the extent feasible, psychologists must also

discuss with relevant parties the extent to which their services will be covered by the

individual’s health plan, school district, employer, or others (see Standard 6.04a and d,

Fees and Financial Arrangements).

*Third Parties*

Involvement of *third parties* refers to other individuals (e.g., legal guardians),

HMOs, employers, organizations, or legal or other governing authorities that have

requested the assessment and to whom the results of the assessments will be provided.

Psychologists should be familiar with ethical standards, state law, and federal

regulations relevant to the appropriate role of third parties and the release and

documentation of release of such information to others (see Standard 4.05,

Disclosures). Psychologists asked to evaluate a child by one parent should clarify

custody issues to determine if another parent must give permission.

*Confidentiality*

Informed consent to assessments must provide a clear explanation of the extent

and limits of *confidentiality*, including (a) when the psychologist must comply with

reporting requirements such as mandated child abuse reporting or duty-to-warn

laws and (b) in the case of assessments involving minors, guardian access to records

(see discussion of parental access involving HIPAA, FERPA, and other regulations

in Standards 3.10, Informed Consent; 4.01, Maintaining Confidentiality; and 4.02,

Discussing the Limits of Confidentiality). Psychologists who administer assessments

over the Internet must inform clients/patients, research participants, or others

about the procedures that will be used to protect confidentiality and the threats

to confidentiality unique to this form of electronic transmission of information

(see also Standard 4.02c, Discussing the Limits of Confidentiality).

**Implications of HIPAA for**

**Confidentiality-Relevant Information**

The HIPAA regulation most relevant to informed consent in assessments is the

Notice of Privacy Practices. At the beginning of the professional relationship, covered

entities must provide clients/patients a written document detailing routine

uses and disclosures of PHI and the individual’s rights and the covered entities’

legal duties with respect to PHI (45 CFR 164.520). Psychologists conducting

assessments should also be familiar with HIPAA-compliant authorization forms

for use and release of PHI and HIPAA requirements for Accounting of Disclosures.

These regulations are described in greater detail in the section “A Word About

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HIPAA” in the Preface of this book and in discussions of Standard 3.10, Informed

Consent, in Chapter 6; Standards 4.01, Maintaining Confidentiality, and 4.05,

Disclosures, in Chapter 7; Standard 6.01, Documentation of Professional and

Scientific Work and Maintenance of Records, in Chapter 9; and Standard 9.04,

Release of Test Data, in this chapter.

**Dispensing With Informed Consent**

Under Standard 9.03a, informed consent may be waived when consent is

implied because testing is conducted as (a) a routine educational activity, such as

end-of-term reading or math achievement testing in elementary and high schools;

(b) regular institutional activities, such as student and teaching evaluations in academic

institutions or consumer satisfaction questionnaires in hospitals or social

service agencies; or (c) organizational activity, such as when individuals voluntarily

agree to preemployment testing when applying for a job.

Standard 9.03a permits psychologists to dispense with informed consent in

assessment when testing is mandated by law or other governing legal authority or

when one purpose of testing is to determine the capacity of the individual to give

consent. Ethical steps that must be taken in these contexts are discussed next under

Standard 9.03b (Moberg & Kniele, 2006).

(b) Psychologists inform persons with questionable capacity to consent or for whom testing is

mandated by law or governmental regulations about the nature and purpose of the proposed

assessment services, using language that is reasonably understandable to the person being

assessed.

Under Standards 3.10b, Informed Consent, and 9.03a, Informed Consent in

Assessments, informed consent in assessment is not required when an individual

has been determined to be legally incapable of giving informed consent, when testing

is mandated by law or other governing legal authority, or when one purpose of

testing is to determine consent capacity. These waivers reflect the fact that the term

*consent* refers to a person’s legal status to make autonomous decisions based on age,

mental capacity, or the legal decision under consideration. Consistent with the

moral value of respect for the dignity and worth of all persons articulated in

Principle E: Respect for People’s Rights and Dignity, under Standard 9.03c, psychologists

must provide all individuals irrespective of their legal status appropriate

explanations of the nature and purpose of the proposed assessment. Readers may

also refer to the Hot Topic in Chapter 6, titled “Goodness-of-Fit Ethics for Informed

Consent Involving Adults With Impaired Decisional Capacity.”

Standard 9.03a often applies in situations where assessment is requested by parents

of children younger than age 18 years or family members of adults with suspected

cognitive impairments. In some contexts the affirmative agreement of the

testee is not required. In these situations, the psychologist must provide information

in a language and at a language level that is reasonably understandable to

the child or adult being assessed. When both guardian permission and child or

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cognitively impaired adult assent are sought, psychologists working with populations

for whom English is not a first language should be alert to situations in which

prospective clients/patients and their legal guardians may have different language

preferences and proficiencies.

**Mandated Assessments**

Psychologists conducting forensic, military, or other assessments that have been

legally mandated should provide *notification of purpose*, which explains to the person

being tested the nature and purpose of the testing, who has requested the testing,

and who will receive copies of the report. If the examinee is unwilling to

proceed following a thorough explanation, according to the Specialty Guidelines

for Forensic Psychologists, “The forensic practitioner may attempt to conduct the

examination, postpone the examination, advise the examinee to contact his or her

attorney, or notify the retaining attorney about the examinee’s unwillingness to

proceed” (AP-LS Committee on the Revision of the Specialty Guidelines for

Forensic Psychologists, 2010). The APAIT provides a useful sample of a Forensic

Informed Consent Contract developed by Jeffrey Younggren, Eric Harris, and Bruce

Bennett (http://www.apait.org/apait/).

Defendants who are entering a plea of insanity may not be able to act on their

Fifth Amendment right to silence and avoidance of self-incrimination. To avoid

compromising the admissibility of a comprehensive forensic evaluation, Bush et al.

(2006) suggest that psychologists first assess competency, then sanity, and separate

the reports given to the court to provide the court the opportunity to first determine

the competence question.

**Informed Consent for the Assessment of Malingering**

Malingering refers to the intentional production of false symptoms to attain an

identifiable external benefit (Iverson, 2006; National Academy of Neuropsychology

Policy and Planning Committee, 2000). Assessment of malingering is one of the

most challenging tasks facing forensic psychologists (Kocsis, 2011). Some have

argued that assessment of malingering is the number one priority of forensic

assessment, preceding any professional conclusions in forensic evaluations (Brodsky

& Galloway, 2003). Malingering can be manifested through intentional under- or

overperformance during psychological assessment. Accurate assessment of malingering

is ethically important because errors in diagnosis can impede justice when

undetected in forensic procedures or obscure adequate treatment for psychopathology

(Principle A: Beneficence and Nonmaleficence; Kocsis, 2011).

Some have questioned whether describing the purposes of tests for malingering

during informed consent compromises the validity of the assessment or whether

failing to include such information during informed consent violates testees’

autonomy rights (Principle E: Respect for People’s Rights and Dignity and Standard

9.03, Informed Consent in Assessments). Current standards of practice support

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communicating to testees during informed consent or notification of purpose that

measures will be used to assess the examinee’s honesty and efforts to do well (Bush

et al., 2006). Psychologists conducting assessments for Social Security Disability

benefits should take extra steps to craft language and procedures that ensure testees

understand that honesty and effort are required (Chafetz, 2010).

*Research on Coached Malingering*

A practical concern in the forensic assessment of defendants or plaintiffs is

whether existing tests of malingering can detect over- or underexaggeration of

symptoms when the examinee has been coached by individuals familiar with the

tests (Jelicic, Cuenen, Peters, & Merckelbach, 2011). When researchers attempt to

study the extent to which commonly used tests are vulnerable to coached faking,

there is a risk that the information provided to research participants or disseminated

through publication will be used to improve the success of coached malingers

(Berry, Lamb, Wetter, Baier, & Widiger, 1994). Ben-Porath (1994) suggests that to

protect against these risks, investigators can (a) coach research participants on

items similar but not identical to those on the test under investigation, (b) provide

only a brief synopsis of coaching instructions in published articles, and (c) release

information on verbatim instructions only to those bound by the APA Ethics Code

to protect the integrity of tests (see also Standard 9.11, Maintaining Test Security).

(c) Psychologists using the services of an interpreter obtain informed consent from the client/

patient to use that interpreter, ensure that confidentiality of test results and test security are maintained,

and include in their recommendations, reports, and diagnostic or evaluative statements,

including forensic testimony, discussion of any limitations on the data obtained. (See also Standards

2.05, Delegation of Work to Others; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments;

9.06, Interpreting Assessment Results; and 9.07, Assessment by Unqualified Persons.)

Compliance with the consent requirements outlined in Standard 3.10 obligates

psychologists to provide information in a language and at a language level that is

reasonably understandable to the client/patient and, where applicable, his or her

legally authorized representative. Psychologists may use the services of an interpreter

when they do not possess the skills to obtain consent in the language in

which the client/patient is proficient.

When delegating informed consent responsibilities to an interpreter, psychologists

must ensure not only that the interpreter is competent in the consent-relevant

language (see Standard 2.05, Delegation of Work to Others) but that the interpreter

also understands and complies with procedures necessary to protect the confidentiality

of test results and test security. An interpreter who revealed the identity of a

client/patient or the nature of specific test items used during the assessment would

place the psychologist who hired the interpreter in potential violation of this standard.

Because test validity and reliability may be vulnerable to errors in interpretation,

Standard 9.03c also requires that the involvement of the interpreter and any

related limitations on the data obtained be clearly indicated and discussed in any

assessment-based report, recommendation, diagnostic or evaluative statement, or

forensic testimony.

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**9.04 Release of Test Data**

(a) The term test data refers to raw and scaled scores, client/patient responses to test questions

or stimuli, and psychologists’ notes and recordings concerning client/patient statements and

behavior during an examination. Those portions of test materials that include client/patient

responses are included in the definition of test data. Pursuant to a client/patient release, psychologists

provide test data to the client/patient or other persons identified in the release.

Psychologists may refrain from releasing test data to protect a client/patient or others from substantial

harm or misuse or misrepresentation of the data or the test, recognizing that in many

instances release of confidential information under these circumstances is regulated by law. (See

also Standard 9.11, Maintaining Test Security.)

**Definition of Test Data**

In Standard 9.04a, the term *test data* refers to the client’s/patient’s actual

responses to test items, the raw or scaled scores such responses receive, and a psychologist’s

written notes or recordings of the client’s/patient’s specific responses or

behaviors during the testing. The term *notes* in this standard is limited to the assessment

context and does not include psychotherapy (or process) notes documenting

or analyzing the contents of conversation during a private counseling session.

*Test Data and Test Materials*

Recognizing that availability of test questions and scoring criteria may compromise

the validity of a test for future use with a client/patient or other individuals

exposed to the information, Standard 9.04a distinguishes *test data*, which under

most circumstances must be provided upon a client/patient release, from *test materials*,

which under most circumstances should not (see Standard 9.11, Maintaining

Test Security). The definition of *test data* does *not* include test manuals, protocols

for administering or scoring responses, or test items *unless* these materials include

the client’s/patient’s responses or scores or the psychologist’s contemporaneous

notes on the client’s/patient’s testing responses or behaviors. If testing protocols

allow, it is good practice for psychologists to record client/patient responses on a

form separated from the test items themselves to ensure that upon client/patient

request, only the test data and not the test material itself need be released.

**The Affirmative Duty to Provide Test Data**

**to Clients/Patients and Others Identified**

**in a Client’s/Patient’s Release**

*Release to Clients/Patients*

Under Standard 9.04a, psychologists have an affirmative duty to provide test data

as defined above to the client/patient or other persons identified in a client/patient

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release. The obligation set forth by Standard 9.04a to respect clients’/patients’ right

to their test data is consistent with legal trends toward greater patient autonomy and

the self-determination rights of clients/patients as set forth in Principle E: Respect

for People’s Rights and Dignity. Although not explicitly stated in the standard, it is

always good practice for psychologists to have a signed release or authorization from

the client/patient even if the data are to be given directly to the client/patient. This

standard does not preclude psychologists from discussing with a client/patient the

potential for misuse of the information by individuals unqualified to interpret it.

*Release to Others*

A fundamental tension exists between the desire of psychologists to respect

clients’/patients’ right to determine who will have access to their assessment results

and the desire to ensure that the data are not reviewed by unqualified individuals

who might misinterpret or misuse the data or violate contractual agreements

designed to protect a test publisher’s proprietary interests (Principle A: Beneficence

and Nonmaleficence, Principle D: Justice, and Principle E: Respect for People’s

Rights and Dignity). The language of Standard 9.04 reflects this tension by providing

exceptions to the release of test data under conditions in which the release

might lead to substantial harm or misuse of the test.

There are several reasons why the standard supports release of test data to

clients/patients and those whom they authorize to receive the data. First, whether a

person designated by the client/patient is qualified to use test data is determined by

the context of the proposed use. For example, restricting release of test data to

individuals with advanced degrees or licensure in professional psychology would

preclude other qualified health care professionals from using the information.

Broadening but limiting the definition of *qualified* person to health professionals

might jeopardize appropriate judicial scrutiny of psychological tests and a client’s/

patient’s right to the discovery process to challenge their use in court. Second, even

if a consensus of “qualified” person could be achieved, requiring a psychologist to

confirm the education, training, degrees, or certifications of other professionals

would pose burdens that might not be possible or feasible to meet. Third, as

described below, with few exceptions, HIPAA regulations require that covered entities

provide clients/patients and their personal representatives access to PHI.

**Withholding Test Data**

Standard 9.04a permits psychologists to withhold test data to protect the client/

patient or another individual from substantial harm. The standard also permits

withholding test data to protect misuse or misrepresentation of the data or the test.

Before refusing to release test data under this clause, psychologists should carefully

consider the proviso in the standard “that such decisions may be regulated by law.”

For example, when refusing a client’s/patient’s request to release test data based on

the psychologist’s judgment that the data will be misused, psychologists should

document in each specific case their rationale for assuming that the data will be

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misused and refrain from behaviors that may be in violation of other standards

(e.g., Standard 6.03, Withholding Records for Nonpayment).

**Implications of HIPAA**

Requiring psychologists to release test data to the client/patient or others pursuant

to a client/patient release reflects a sea change in the legal landscape from paternalistic

to autonomy-based rules governing access to health records. In particular,

HIPAA establishes the right of access of individuals to inspect and receive copies of

medical and billing records maintained and used by the provider for decisions

about the client/patient (45 CFR 524). This requirement does not include psychotherapy

notes or information compiled in reasonable anticipation of or use in civil,

criminal, or administrative actions or proceedings. In addition, psychologists who

are covered entities under HIPAA must also provide such access to a client’s/

patient’s personal representative (45 CFR 164.502[g][1]).

HIPAA severely limits the ability of covered entities to use professional judgment

to determine the appropriateness of releasing test data to clients/patients and

their personal representatives. For example, the right of clients/patients to obtain

their own test data under HIPAA regulations means in practice that they can pass

it on to other individuals of their choice.

*Harm*

Under HIPAA, psychologists who are covered entities can deny client/patient

access to test data if it is reasonably likely to endanger the life or physical safety of

the individual or another person or, in some cases, likely to cause equally substantial

harm (Principle A: Beneficence and Nonmaleficence). In addition, psychologists

must allow clients/patients the right to have the denial reviewed by a

designated licensed health care professional. HIPAA regulations thus severely limit

psychologists’ ability to exercise their professional judgment as to what constitutes

substantial harm to clients/patients.

*Misuse or Misrepresentation of the Test*

Release of “test data” that include client/patient responses recorded on the test

protocol itself can raise issues of copyright protection and fair use by test development

companies (Principle B: Fidelity and Responsibility). If testing protocols

allow, psychologists may wish to record client/patient responses on a form separated

from the test items themselves to comply with contractual agreements with

test developers and to maintain test security (Standard 9.11, Maintaining Test

Security). When test data cannot be separated from test materials that are protected

by copyright law, psychologists’ decision to withhold release of test data

would be consistent with HIPAA regulations and Standard 9.04a. According to

Richard Campanelli, director of the Office for Civil Rights at the U.S. DHHS,

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under Section 1172 (e), withholding PHI would not be in violation of HIPAA if to do

so would violate trade secret laws (http://aspe.hhs.gov/admnsimp/pl104191.htm).

􀀴 To protect against the misuse of test data in possible instances when they would be

released to clients/patients or another identified person, a psychologist used an idiosyncratic

code to record testees’ responses. When a client/patient requested the test

data be released to another licensed practitioner, it was clear that the test data were

undecipherable to others, and the psychologist refused to provide the code. The psychologist

was in violation of Standard 9.04a and HIPAA regulations, because in this

particular case there was no reason to assume misuse of test data. The psychologist’s

failure to appropriately create and store records also violated Standard 6.01,

Documentation of Professional and Scientific Work and Maintenance of Records.

*Withholding Data in Anticipation of Its*

*Use for Legal Purposes*

There are instances, however, when HIPAA constraints are not at issue. For example,

HIPAA does not require release of PHI to clients in situations in which information

is compiled in reasonable anticipation of, or for use in, civil, criminal, or

administrative actions or proceedings. In other instances, such as certain educational

evaluations, test data may not come under the PHI classification, and thus the HIPAA

Privacy Rule would not apply (see Standard 4.01, Maintaining Confidentiality).

**Organizations, Courts, and**

**Government Agencies**

The use of the term *client/patient* in this standard refers to the individual

testee and not to an organizational client. This standard does not require industrial–

organizational or consulting psychologists to release test data to either an organizational

client or an employee when testing is conducted to evaluate job candidacy or

employee or organization effectiveness and does not assess factors directly related

to medical or mental health conditions or services. Psychologists working in these

contexts would not be required to provide the test data to the employees themselves

under this standard because the organization, not the employee, is the client (see

also Standards 3.07, Third-Party Requests for Services; 3.11, Psychological

Services Delivered To or Through Organizations; and 9.03, Informed Consent in

Assessments). Similarly, forensic psychologists, military psychologists, and others

working under governing legal authority are permitted by the Ethics Code to withhold

release of test data from a testee when the client is an attorney, the court, or

other governing legal authority. Finally, all psychologists are permitted by the Ethics

Code to withhold release of test data when required by law (Standard 1.02, Conflicts

Between Ethics and Law, Regulations, or Other Governing Legal Authority).

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(b) In the absence of a client/patient release, psychologists provide test data only as required by

law or court order.

Standard 9.04b recognizes the clients’/patients’ right to expect that in the

absence of their release or authorization, psychologists will protect the confidentiality

of test data. The standard does permit psychologists to disclose test data without

the consent of the client/patient in response to a court order (including

subpoenas that are court ordered) or in other situations required by law (e.g., an

order from an administrative tribunal). In such instances, psychologists are wise to

seek legal counsel to determine their legal responsibility to respond to the request

(see also Standard 4.05b, Disclosures). Psychologists may also ask the court or other

legal authority for a protective order to prevent the inappropriate disclosure of

confidential information or suggest that the information be submitted to another

psychologist for qualified review (see also Standard 1.02, Conflicts Between Ethics

and Law, Regulations, and Other Governing Legal Authority).

**Implications of HIPAA**

Standard 9.04b provides stricter protection of confidential test data than HIPAA.

Under the HIPAA Privacy Rule, PHI may be disclosed in response to a subpoena,

discovery request, or other lawful process that is not accompanied by an order of a

court or administrative tribunal, if the covered entity receives satisfactory assurance

from the party seeking the information either that reasonable efforts have been

made to ensure that the client/patient has been notified of the request or reasonable

efforts have been made to secure a qualified protective order (45 CFR 164.512[e][1]).

Psychologists who disclosed information in such an instance would be in violation

of 9.04b. The greater protection provided by 9.04b is consistent with most states’

more stringent psychotherapist–patient privilege communication statutes.

**9.05 Test Construction**

Psychologists who develop tests and other assessment techniques use appropriate psychometric

procedures and current scientific or professional knowledge for test design, standardization, validation,

reduction or elimination of bias, and recommendations for use.

Test development is the foundation of good psychological assessment.

Psychologists who construct assessment techniques must be familiar with and

apply psychometric methods for establishing the validity and reliability of tests,

developing standardized administration instructions, selecting items that reduce or

eliminate bias, and drawing on current scientific or professional knowledge for

recommendations about the use of test results (see also Standard 2.01, Boundaries

of Competence; Turchik, Karpenko, Hammers, & McNamara, 2007).

Standard 9.05 applies to all test development activities, not just those implemented

in professional testing services or research settings. Psychologists who

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develop tests or other assessment techniques to serve private practice clients/

patients, organizational clients, or the courts can violate this standard if they fail to

use proper psychometric methods for test construction.

**Psychometric Procedures**

To be in compliance with Standard 9.05, psychologists must be familiar with and

competent to implement appropriate psychometric procedures to establish the

usefulness of the test (Standard 2.01, Boundaries of Competence). A good resource

for complying with this standard in the Ethics Code is the *Standards for Educational*

*and Psychological Testing* (AERA, APA, & NCME, 1999). The following are brief

definitions of psychometric procedures presented in greater detail by the AERA,

APA, and NCME (1999).

*Validity, Reliability, and Standardization*

*Validity* is the degree to which theory and empirical evidence support specific

interpretations of test scores. Methods for establishing test validity include content,

concurrent, construct, and predictive validity as well as evidence-based

response processes, internal structure of a test, and consequences of testing.

*Reliability* is the degree to which test scores for a group of test takers are consistent

over repeated administrations of a test or for items within a test. Methods for

establishing test reliability include internal consistency coefficients, analysis of the

standard error of measure, test–retest, split-half, or alternative form comparisons.

*Standardization* refers to the establishment of scoring norms based on the test

performance of a representative sample of individuals from populations for which

the test is intended.

Validity and reliability must be assessed appropriately for each total score, subscore,

or combination of scores that will be interpreted. Where relevant, descriptions

of the test to users, school personnel, organizational clients, and the courts

should include a description of the psychometric procedures used during test

development.

􀀴 An industrial–organizational psychologist was hired by a firm to develop a selection

system for promotion of line workers to supervisors. The psychologists used appropriate

sampling and validation procedures to construct a 20-item measure. When he

presented the final measure to the firm’s board of trustees, the board president

expressed concern that items on attitudes toward the firm were not included. The

psychologist agreed to add a few of these to the test without further validation (see

Lowman, 2006, Case 3).

􀀴 Over the years, a school psychologist had observed that students who had been

removed from their homes because of child abuse or neglect frequently gave a set of

common and unique narrative responses to items on the Wechsler Intelligence Scale

for Children Comprehension subtest (WISC; Wechsler, 1991). Cognizant of school

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**Recommendations for Use**

In their recommendations for use, test developers must provide adequate guidance

to allow users to administer tests in a standardized fashion and score and interpret

responses according to established criteria. Psychologists who develop tests or

assessment techniques must provide explanations of the meaning and intended

interpretation of reported scores by users, school personnel, organizational clients,

the courts, and others as appropriate. For example, a test manual might explain how

score interpretation can be facilitated through norm- or criterion-referenced scoring,

scaling, or cut scores.

*Reduction or Elimination of Test Bias*

*Test bias* may refer to systematic errors in test scoring. The term is associated

more frequently with test fairness and refers to assessment norms applied to persons

from different populations that fail to establish measurement equivalence: The

degree to which reliability and validity coefficients associated with a measure are

similar across populations. Depending on the purpose and nature of testing, failure

to determine item, functional, scalar, or predictive measurement equivalence when

developing a test can lead to over- or underdiagnosis, faulty personnel recommendations,

inappropriate educational placements, and misinformation to the courts

(AERA, APA, & NCME, 1999; Knight & Hill, 1998).

􀀴 An industrial–organizational psychologist developed a prescreening employment test

for a large personnel department. After demonstrating high levels of interitem and

test–retest reliability, the scale was touted as a culture-free measure of employment

preparedness. However, the psychologist did not examine whether the factor structure,

predictive validity of the test for job performance, or other psychometric factors

were equivalent across the members of major ethnic/cultural groups in the city who

applied for positions in the company.

psychologists’ legal duty to report suspected child abuse, she constructed a test

composed of 10 narrative statements that she believed were typical of abused and

neglected children. She developed a scoring system where 0 to 1 indicated that the

child was probably not abused or neglected, 2 to 3 suggested that the child should

be further observed, and 4 to 10 supported a suspicion of child abuse or neglect that

should be reported to child protective services. She began to use the scale to decide

whether to make a report of child abuse. When she became district supervisor of

psychological and social services, she required all school psychologists and social

workers to administer the scale to children with whom they worked despite the lack

of evidence of its reliability or validity.

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􀀴 A psychologist working for a test company was responsible for developing a test for

premorbid speech and language predictors of childhood-onset schizophrenia. Child

inpatients who had already been diagnosed with schizophrenia were the only population

available for test development. The test yielded good test–retest reliability and

was validated on correlations with practitioner diagnoses of childhood schizophrenia.

In writing the test manual, the psychologist described the test as useful for identifying

children at risk for the disorder. The manual did not indicate that test norms were

applicable only to inpatients who had already manifested the disorder.

Psychologists’ validity reports should accurately reflect the soundness of the test

validation research supporting the use of an assessment procedure. Psychologists

should include in their reports limitations of methodological or statistical weaknesses

that would limit the usefulness of the test.

􀀴 A psychologist was hired by a company to develop a work climate questionnaire to

help in their restructuring plans. In her lengthy validity report to the company, the

psychologist buried information that indicated problems with sample representativeness

and low validity coefficients and failed to include this information in the executive

summary (see Lowman, 2006, Case 8; Principle C: Integrity).

**Test Revisions**

Once tests have been developed, test developers are responsible for monitoring

conditions that might warrant test revision, modifications in recommendations for

test interpretation, or limitations or withdrawal of test use. According to the

*Standards for Educational and Psychological Testing*, tests “should be amended or

revised when new research data, significant changes in the domain represented, or

newly recommended conditions of test use may lower the validity of test score

interpretations” (AERA, APA, & NCME, 1999, Standard 3.25, p. 48). The scope of

test revision will depend on the conditions warranting change and may include

revisions in test stimuli, administration procedures, scales or units of measure,

norms or psychometric features, or applications (Butcher, 2000). Bersoff, DeMatteo,

and Foster (2012) emphasize psychologists’ responsibility to keep up-to-date on

society-wide improvements or shifts in test performance known as the Flynn effect

(Flynn, 1984).

􀀴 A test company sold a popular test to help determine cognitive decline in newly

admitted nursing home patients. The test had been used for more than 15 years.

During the past 5 years, the psychologist directing the geropsychological test

department of the company had been getting complaints that patients were being

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**9.06 Interpreting Assessment Results**

When interpreting assessment results, including automated interpretations, psychologists take

into account the purpose of the assessment as well as the various test factors, test-taking abilities,

and other characteristics of the person being assessed, such as situational, personal, linguistic,

and cultural differences, that might affect psychologists’ judgments or reduce the accuracy of

their interpretations. They indicate any significant limitations of their interpretations. (See also

Standards 2.01b and c, Boundaries of Competence, and 3.01, Unfair Discrimination.)

Accurate interpretations of assessment results are critical to ensure that appropriate

decisions are made regarding an individual’s diagnosis, treatment plan, legal

status, educational placement, or employment and promotion opportunities. It is

ethically imperative that when providing interpretations, psychologists take into

account the purpose of the test and testee characteristics and indicate any significant

limitations of their interpretations.

**The Purpose of the Test**

As required by Standard 9.06, the *purpose* of the assessment must be considered

carefully in the interpretation of test scores. At the same time, psychologists must

also resist allowing test interpretations to be biased by pressures from school personnel,

parents, employers, attorneys, managed care companies, or others with a

vested interest in a particular interpretation (AERA, APA, & NCME, 1999).

When offering recommendations, drawing conclusions, or making predictions

from test scores, psychologists should refer to test manuals prepared by the test developer

as well as relevant research to understand the extent to which tests, in isolation

or within the context of other tests, are directly related to the purpose of testing.

underdiagnosed. The psychologist reasoned that the test norms established 15 years

ago might not be applicable to a better-educated cohort of elderly persons.

However, the company’s current 5-year plan focused on the development of new

depression inventories and had no budget for revisions of current tests. The psychologists

decided not to rock the boat and to wait for the next 5-year plan to

recommend a revision of the test (see also Standard 1.03, Conflicts Between Ethics

and Organizational Demands).

􀀴 A neuropsychologist was hired by an insurance claims company to evaluate whether

an individual insured by the company had sustained neurological damage following a

car accident or whether the individual was feigning symptoms. Following administration

of a battery of tests, the psychologist determined that the individual’s test scores

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*Test Factors and Examinee Characteristics*

With the exception of perhaps some employment-related screenings, interpretations

should never be based solely on test scores. Standard 9.06 requires psychologists

to consider factors associated with the testing context, the examinee’s test-taking abilities,

and other characteristics that may affect or inappropriately bias interpretations.

When relevant, psychologists should take into account observations of test-taking

styles, fatigue, perceptual and motor impairments, illness, limited fluency in the language

of the test, or lack of cultural familiarity with test items that would introduce

construct-irrelevant variability into a test score (AERA, APA, & NCME, 1999).

In addition to familiarity with the test itself, psychologists should have the specialized

knowledge necessary to formulate professional judgments about the meaning

of test scores as they relate to the individual examinee (see Standard 2.01b and c,

Boundaries of Competence).

Test takers’ scores should not be interpreted in isolation of other information

about the characteristics of the person being assessed. Such information may be

gained from interviews, additional testing, or collateral information from teachers,

employers, supervisors, parents, or school or employment records. Such information

may lead to alternative explanations for examinees’ test performance.

were at the lower boundaries of normal functioning. Although the psychologist made

no effort to obtain information regarding the patient’s neurological functioning before

the accident, he concluded in his report that there was no evidence to support an

injury claim.

􀀴 A psychologist conducting employment assessment for law enforcement personnel

interpreted candidates’ scores using norms from a broad range of reference groups

rather than police normative data (Gallo & Haglin, 2011).

􀀴 An inpatient at a psychiatric hospital had a Monday appointment with a psychologist

to help determine whether he was well enough to go home for the weekend. When

he arrived for the appointment, he was obviously distressed and told the psychologist

that the patient he shared his room with had threatened to kill him. The psychologist

confirmed this story with one of the orderlies. Rather than reschedule the appointment,

the psychologist decided to conduct the required standardized assessment and

clinical interview. In his report, the psychologist noted that the patient had high scores

on the Minnesota Multiphasic Personality Inventory (MMPI; Butcher, Dahlstrom,

Graham, Tellegen, & Kaemmer, 2002) indicating paranoid tendencies and high levels

of stress that might be interpreted as a lack of readiness to go home. The psychologist’s

report did not address how the events surrounding the roommate’s threats

might have influenced MMPI scores and responses to interview questions.

􀀵 An industrial–organizational psychologist was responsible for administering and

interpreting standardized group tests for employee promotion. During one testing

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*Limitations*

Under Standard 9.06, psychologists must indicate any significant limitations of

their interpretations. In general, interpretive remarks that are not supported by

validity and reliability information should be presented as hypotheses. When test

batteries are used, interpretations of patterns of relationships among different test

scores should be based on identifiable evidence. If none are available, this must be

stated in the report. Interpretations of test results often include recommendations

for placement, treatment, employment, or legal status based on validity evidence

and professional experience. Psychologists should refrain from implying that

empirical relationships exist between test results and recommendations when they

do not, as well as distinguish between recommendations based on empirical evidence

and those based on professional judgment.

*Automated Interpretations*

Computer-generated interpretations are based on accumulated empirical data

and expert judgment but cannot take into account the special characteristics of the

examinee (AERA, APA, & NCME, 1999). Psychologists should use interpretations

provided by automated and other types of services with caution and indicate their

relevant limitations.

**9.07 Assessment by Unqualified Persons**

Psychologists do not promote the use of psychological assessment techniques by unqualified

persons, except when such use is conducted for training purposes with appropriate supervision.

(See also Standard 2.05, Delegation of Work to Others.)

Psychologists’ professional and scientific responsibilities to society and those with

whom they work (Principle B: Fidelity and Responsibility) include helping ensure that

the administration, scoring, interpretation, and use of psychological tests are conducted

only by those who are competent to do so by virtue of their education, training, or experience.

Standard 9.07 prohibits psychologists from promoting the use of psychological

assessment techniques by unqualified persons. For example, psychologists should not

employ persons who have not received formal graduate-level training in psychological

assessments to administer, score, or interpret psychological tests that will be used to

determine an individual’s educational placement, psychological characteristics for

session, two employees got into a shouting match that threatened but did not become

a physical fight. In his reporting of the test results to managers, the psychologist

mentioned there was a disturbance that could have had a significant detrimental

effect on testees’ performance and recommended that those who requested should

be permitted to retake the tests.

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employment or promotion, competence to stand trial, parenting skills relevant to child

custody, mental health status or diagnosis, or treatment plan.

**Psychological Assessments Conducted by Trainees**

Standard 9.07 does not prohibit psychologists from supervising trainees in the

administration, scoring, and interpretation of tests. However, (a) the trainees must

be qualified on the basis of their enrollment in a graduate or postdoctoral psychology

program or externship or internship and (b) supervision must be appropriate

to their level of training. For example, psychologists teaching a first-year graduatelevel

personality assessment course that requires students to submit scored protocols

of individuals they have independently assessed must ensure that (a) the course

adequately prepares students for initial testing situations and (b) students inform

persons tested or their legal guardians that the testing is for training purposes only

and not for individual assessment.

When students registered in advanced practica, externships, or internships have

had a sequence of courses in an assessment program, faculty and site supervisors

must nonetheless provide a level of supervision appropriate to the trainees’ previous

education and experience and see that trainees administer, score, and interpret

tests competently (see also Standard 2.05, Delegation of Work to Others).

􀀴 A group practice of consulting psychologists was hired to conduct psychological assessments

of applicants for promotion to management positions in a large national company.

After a month, the managing psychologists realized they had not negotiated a

contractual fee large enough to employ the number of advanced-degree psychologists

required to conduct all of the assessments. To stay within budget, they set up an internship

program for business school seniors and trained them to administer the tests.

􀀵 A psychologist served as an on-site supervisor for externships of third-year school

psychology graduate students in a large school district. All students had taken a series

of advanced courses in educational assessment. In addition to reviewing their transcripts,

during the first weeks of the externship, the psychologist observed each student

administer tests and carefully reviewed and provided feedback on their scoring

and interpretation of the standard battery of tests they were expected to use. She held

weekly supervision meetings with the students and continued to review their reports

throughout the year.

􀀴 Members of a group practice composed of educational, school, and clinical psychologists

specializing in learning disabilities and school-related disorders were finding it

difficult to keep up with the hours required to provide individualized treatment, family

therapy, and psychological assessment. To meet their needs and keep costs down, they

decided to hire and train recent college graduates who had majored in psychology or

education to independently administer some of the assessments.

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**9.08 Obsolete Tests and Outdated Test Results**

(a) Psychologists do not base their assessment or intervention decisions or recommendations on

data or test results that are outdated for the current purpose.

Standard 9.08a prohibits psychologists from making evaluative, intervention, or

treatment decisions or recommendations based on outdated data or test results,

unless such information is specifically relevant to the diagnostic or placement decision.

The standard applies to psychologists who administer, score, and interpret the

test as well as to psychologists who use test results for intervention decisions or

recommendations. Whether test data or results are outdated for the current purpose

may be determined by whether the test from which scores were derived is itself

obsolete (see Standard 9.08b, below).

Standard 9.08a is addressed to the use of test scores that may have been

derived from currently used tests but are obsolete for the purposes of the evaluation.

Previous scores derived from an up-to-date version of a test may be obsolete

if individuals might be expected to score differently or require a different

test based on (a) the amount of time between the previous administration and

the current need for assessment, (b) maturational and other developmental

changes, (c) educational advancement, (d) job training or employment experiences,

(e) change in health status, (f) new symptomatology, (g) change in work

or family status, or (h) an accident or traumatic experience.

In some instances, it may be appropriate to use outdated test scores as a basis of

comparison with new test results to evaluate the long-term effectiveness of an educational

program or intervention or to help identify cognitive decline or a sudden

change in mental health or adaptive functioning relevant to treatment, placement

in an appropriate educational or health care environment, disability claims, competency

hearings, or custody suits. When outdated data or results are used, psychologists’

reports and recommendations should include explanations for their use

and their limitations (see Standard 9.06, Interpreting Assessment Results).

􀀵 A neuropsychologist was asked to evaluate cognitive and personality factors that might

be responsible for a sudden change in adaptive functioning of an 80-year-old nursing

home resident. The resident had been given a battery of intelligence and personality

tests 5 years previously upon admission to the nursing home. Advances in geropsychology

in the past 5 years had resulted in more developmentally appropriate and sensitive

assessment instruments for this age group. The psychologist conducted a new evaluation

using the more valid instruments. In her summary, she compared the results of the

assessment with the results of the earlier evaluation, accompanied by a discussion of

the limitations of comparing current performance with the older test results.

Psychologists should resist pressures to use obsolete test results from schools,

health care delivery systems, or other agencies or organizations that seek to cut

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expenses by using outdated test results for employment, promotion, educational

placement, or services (see Standard 1.03, Conflicts Between Ethics and

Organizational Demands).

(b) Psychologists do not base such decisions or recommendations on tests and measures that are

obsolete and not useful for the current purpose.

Test developers often construct new versions of a test to reflect significant

(a) advances in the theoretical constructs underlying the psychological characteristic

assessed; (b) transformations in cultural, educational, linguistic, or societal influences

that challenge the extent to which current test items validly reflect content

domains; or (c) changes in the demographic characteristics of the population to

be tested affecting interpretations that can be drawn from standardized scores.

Standard 9.08b prohibits psychologists from using outdated versions of tests for

assessment or intervention decisions when interpretations drawn from the test are

of questionable validity or otherwise not useful for the purpose of testing.

The expense of purchasing the most up-to-date version of a test is not an ethical

justification for using obsolete tests when the validity of interpretations drawn

from such tests is compromised. Psychologists working with schools, businesses,

government agencies, courts, HMOs, and health care delivery systems that resist

purchasing updated tests because of costs or ease of record keeping should clarify

the nature of the problem, urge organizational reconsideration, and, if such recommendations

are not heeded, strive to the extent feasible to limit harms that will arise

from misapplication of the test results, ensuring that their actions do not justify or

defend violating testees’ human rights (see Standards 1.02, Conflicts Between Ethics

and Law, Regulations, or Other Governing Legal Authority; and 1.03, Conflicts

Between Ethics and Organizational Demands).

The standard does permit psychologists to use obsolete versions of a test when

there is a valid purpose for doing so. In most cases, the purpose will be to compare

past and current test performance. When use of an obsolete test is appropriate to

the purpose of assessment, psychologists should clarify to schools, courts, or others

that will use the test results which version of the test was used, why that version

was selected, and the test norms used to interpret the results.

􀀵 A psychologist asked to evaluate an employee’s claim that an industrial accident was

responsible for a current disabling psychological disorder learned that the employee

had been administered a battery of cognitive and personality tests several years earlier

during preemployment screening. The psychologist decided it would be useful and

appropriate to compare the complainant’s current performance with his performance

on test scores obtained prior to the accident. One of the previous scores was derived

from an older version of a test that had been updated and revised recently. The psychologist

decided to administer the older version of the test to better determine

whether functioning had been affected by the accident. The psychologist’s report

included a rationale for the use of the older version of the test.

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**9.09 Test Scoring and Interpretation Services**

(a) Psychologists who offer assessment or scoring services to other professionals accurately

describe the purpose, norms, validity, reliability, and applications of the procedures and any special

qualifications applicable to their use.

Standard 9.09 applies to psychologists who develop or sell computerized,

automated, web-linked, or other test scoring and interpretation services to

other professionals. Psychologists offering these services must provide in

manuals, instructions, brochures, and advertisements accurate statements

about the purpose, basis and method of scoring, validity and reliability of

scores derived from the service, the professional contexts in which the scores

can be applied, and any special user qualifications necessary to competently

use the service.

When test interpretations, in addition to scores, will be provided to users

of the services, psychologists providing the services must document the sources,

theoretical rationale, and psychometric evidence for the validity and reliability

of the particular interpretation method employed. The *Standards for Educational*

*and Psychological Testing* recommends that scoring services provide a summary of

the evidence supporting the interpretations that includes the nature, rationale,

and formulas for cutoff scores or configural scoring rules (rules for scoring test

items or subtests that depend on a pattern of responses; AERA, APA, & NCME,

1999). If algorithms or other rules for scoring jeopardize proprietary interests,

copyrights, or other intellectual property rights issues, owners of the intellectual

property are nevertheless responsible for documenting in some way evidence in

support of the validity of score interpretations (AERA, APA, & NCME, 1999;

Bersoff & Hofer, 1991).

**Need to Know:**

**When to Use Obsolete Tests**

The Ethics Code does not prescribe a specific time period in which psychologists should

adopt a new version of a test. Such decisions depend on which version is best suited for

an examinee within the context of the specific purpose of testing. Psychologists should

be cautious about adopting a test publisher’s recommendations for when they should

purchase and transition to a revision, since such recommendations do not have legal

standing and test developers have a financial stake in encouraging the purchase of new

versions (Bush, 2010). Bush (2010) recommends that psychologists should be guided by

whether independent research on the new or revised measure supports its use for a

particular purpose or patient population; use of the prior version of the test may be

preferable and may include the rationale for selecting a specific edition in the written

assessment report.

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Descriptions of the application of test scoring and interpretation procedures

must include a discussion of their limitations. For example, computer-generated or

automated systems may not be able to take into account specific features of the

examinee that are relevant to test interpretation such as medical history, gender,

age, ethnicity, employment history, education, or competence in the language of the

test; motor problems that might interfere with test taking; current life stressors; or

special conditions of the testing environment.

(b) Psychologists select scoring and interpretation services (including automated services) on the

basis of evidence of the validity of the program and procedures as well as on other appropriate

considerations. (See also Standard 2.01b and c, Boundaries of Competence.)

Standard 9.09b applies to psychologists who use computerized, automated, weblinked,

or other test scoring and interpretation services developed by other professionals

or test vendors. Psychologists should select only test scoring and

interpretation services that provide evidence of the validity of the program and

procedures for the types of evaluation or treatment decisions that are to be

informed by the assessment and that are appropriate for the individual case under

consideration. Psychologists should not use scoring and interpretation services if

the psychometric information provided by the test scoring or interpretation services

is inadequate or fails to support the applicability of the scoring and interpretation

methods to the goals of the particular assessment.

**Implications of HIPAA**

When the test data to be scored and interpreted by the service come under the

HIPAA definition of PHI, the Notice of Privacy Practices must list the name of the

service or the psychologist must obtain a valid authorization from the client/patient

to transmit the information to the service (see more detailed discussion on core

requirements for valid HIPAA authorizations under Standard 4.05a, Disclosures).

Psychologists must also ensure that the service receives, stores, transmits, and discloses

client/patient information in a manner that is HIPAA compliant. In most

instances, psychologists will enter into a business associate agreement with the testing

service (45 CFR 160.103 and 164.504[e]). As part of the business associate

contract, the service must provide assurances to the psychologist that information

will be safeguarded appropriately. If a psychologist discovers that the service has

violated HIPAA regulations in some way, the psychologist must correct the error or

terminate the business associate contract.

(c) Psychologists retain responsibility for the appropriate application, interpretation, and use of

assessment instruments, whether they score and interpret such tests themselves or use automated

or other services.

Irrespective of whether psychologists use a service or score and interpret test

data themselves, the psychologist is ultimately responsible for the appropriate

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selection, administration, scoring, interpretation, and use of the test. Under

Standard 9.09c, psychologists must acknowledge this responsibility and take

appropriate steps to ensure that tests were properly scored and interpreted.

To be in compliance with Standard 9.09c, psychologists must avoid simplified

interpretations of test scores that can lead to misdiagnosis, inadequate or

iatrogenic treatment plans, or unfair or invalid personnel decisions or that

can mislead the trier of fact in judicial and government hearings (AERA, APA,

& NCME, 1999) and possess the following competencies (Standard 2.01,

Boundaries of Competence):

Sufficient familiarity with scoring and interpretation techniques to adequately

perform these tasks themselves, detect errors in test scores provided

by a service, and critically evaluate canned interpretations.

Training and experience necessary to identify the limitations of test service

interpretations and know when collateral test scores and other relevant information

are necessary to adequately interpret and apply test results. Such

information might include an examinee’s health status, culture, gender, age,

employment history, educational experiences, language competencies, physical

disabilities, symptoms of or empirical evidence to assume comorbid disorders,

current life stressors, and special conditions of the testing environment.

**Need to Know: Security and**

**Interpretation of Online Testing**

The use of online preemployment testing is becoming increasingly popular because of the

convenience, lower cost, and expansion of the pool of national and international applicants

that can be screened. Organizational and consulting psychologists utilizing these

systems need to be aware of the serious security risks associated with this new technology.

As detailed by Foster (2010), these tests are often offered without security to enable easy

administration and worldwide reach. This poses a threat to test interpretation since there

is usually no way to authenticate who actually took the test, and test theft and cheating

are easily accomplished.

**9.10 Explaining Assessment Results**

Regardless of whether the scoring and interpretation are done by psychologists, by employees or

assistants, or by automated or other outside services, psychologists take reasonable steps to

ensure that explanations of results are given to the individual or designated representative unless

the nature of the relationship precludes provision of an explanation of results (such as in some

organizational consulting, preemployment or security screenings, and forensic evaluations), and

this fact has been clearly explained to the person being assessed in advance.

Psychologists who administer, supervise, or otherwise are responsible for test

administration are also responsible for ensuring that the individuals tested, their

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guardians, or personal representative receive an explanation of the assessment results.

The purpose of an explanation is to enable a client/patient to understand the meaning

of a test score or test score interpretation as it relates to its purpose, implications,

and potential consequences. According to the *Standards for Educational and*

*Psychological Testing*, an appropriate explanation “should describe in simple language

what the test covers, what scores mean, the precision of the scores, common misinterpretations

of the test scores, and how scores will be used” (AERA, APA, & NCME, 1999,

Standard 5.10, p. 65). Whenever possible and clinically appropriate, psychologists

assessing children and adolescents should provide feedback to the child as well as his

or her guardian; the feedback should be appropriate to the child’s developmental level.

**Employees and Trainees**

According to Standard 9.10, the responsibility for appropriate test explanation

lies with the psychologist. It takes into account whether he or she personally scored

or interpreted the test, assigned the scoring or interpretation to an employee or

assistant, or used an outside service (Standard 2.05, Delegation of Work to Others).

The standard does not require that psychologists provide the explanation but that

they take reasonable steps to ensure that one is given. The term *reasonable steps* is

used to acknowledge situations in which the examinee may not wish to or is unable

to meet for an explanation of results or an employee has misinformed the psychologist

about an explanation taking place. If, however, a psychologist is aware that

appropriate staff is unavailable or unable to provide the explanation, the psychologist

should do so personally.

􀀴 A psychologist supervised several interns at an outpatient unit of a veterans hospital.

The interns were responsible for administering a battery of psychological tests to new

patients. Weekly supervision meetings with the interns included discussion of test

selection, administration, scoring, and interpretation. The psychologist paid only cursory

attention to instructing the supervisees on how to explain test results to patients.

The clinic director received several complaints that interns’ explanations of test results

were confusing and distressing to patients (see also Standard 2.05, Delegation of

Work to Others).

**Use of Automated Scoring Services**

A psychologist who asks a scoring service to send a computerized interpretation

to a client/patient should take reasonable steps to ensure that the computerized

interpretation provides an explanation adequate for conveying test performance

information to examinees. As discussed under Standard 9.09b, psychologists who

are covered entities under HIPAA who use scoring services must include this information

in the Notice of Privacy Practices or obtain a specific client/patient authorization

to use such services and ensure that the service transmits information and

protects client/patient privacy in a HIPAA-compliant manner.

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􀀵 A psychologist decided to use a popular scoring service for some frequently administered

tests after examination of the company’s materials indicated that the scoring

system was reliable and valid. An added benefit of the service was that it would send

test interpretations directly to the client. For the first set of test data the psychologist

sent to the service, she asked the service to send her the test interpretation that is

usually mailed directly to the client. The psychologist reviewed the interpretive materials

and believed that the information was too sparse to adequately inform clients and

might create confusion. She therefore decided to continue using the service for scoring

but did not permit the service to send explanations directly to the client.

**Exceptions**

Standard 9.10 permits exceptions to this requirement when an explanation of

the results is precluded by the psychologist–examinee relationship, such as instances

when an organization or legal counsel has retained the psychologist’s services or

assessment has been ordered by a judicial referral. For example, it is usually inappropriate

for psychologists to provide an explanation of test results directly to the

examinee when testing is court ordered, when it involves employment testing, or

when it involves eligibility for security clearances for government work. Rather,

reports are released to the court or retaining party and cannot be released to examinees

and their family members, doctors, lawyers, or other representatives without

the permission of the retaining party or the court (Bush et al., 2006; National

Academy of Neuropsychology Policy and Planning Committee, 2003). In such situations,

prior to administering assessments, psychologists are required to inform

examinees that the psychologist will not be providing them with an explanation of

the test results. If legally permissible, the psychologist should provide the reason

why an explanation will not be given (see Standards 3.10c, Informed Consent; 3.11,

Psychological Services Delivered To or Through Organizations; and 9.03, Informed

Consent in Assessments).

**9.11 Maintaining Test Security**

The term test materials refers to manuals, instruments, protocols, and test questions or stimuli and

does not include test data as defined in Standard 9.04, Release of Test Data. Psychologists make

reasonable efforts to maintain the integrity and security of test materials and other assessment

techniques consistent with law and contractual obligations, and in a manner that permits adherence

to this Ethics Code.

An assumption of test validity is that individuals take the test under prescribed

standardized conditions. For many tests, a critical aspect of standardization is that

testees are equally unfamiliar with the test items. When some testees have access to

test items prior to the administration of the test, the test norms and thus interpretations

based on scaled scores may not be psychometrically defensible. Duplicating

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test materials or making video or audio recordings of an assessment session that

subsequently enters the public domain also threatens the ongoing validity of tests.

Individuals who have had uncontrolled access to test content can manipulate or

coach others to manipulate test results that harm the public by enabling individuals

to malinger or to obtain positions for which they are unqualified. Many tests consist

of a static number of items that are costly to develop, take years to construct, and

are not easily replaced. Thus, release of test materials can compromise the validity

and usefulness of a test and jeopardize the intellectual property rights of test

authors and publishers.

**Definition of Test Materials and Test Security**

Under Standard 9.11, *test materials* are manuals, instruments, protocols, and test

questions or stimuli that do not come under the definition of *test data*, as defined

in Standard 9.04a, Release of Test Data. Under Standard 9.11, psychologists have a

duty to make reasonable efforts to protect the integrity and security of test materials

and other assessment techniques. With few exceptions, test materials that do not

include client/patient responses should never be released to clients/patients or others

unqualified to use the instruments. Unless specifically recommended by the test

developer, self-administered tests should not be given to clients/patients to take

home. Additional security precautions need to be taken for tests administered

through the Internet. Psychologists should consult test developers and, if necessary,

seek legal consultation before distributing copyrighted tests over the Internet

(Bersoff et al., 2012).

This standard does not prohibit psychologists from discussing individual test

items with clients/patients if it assists in explaining test results (Standard 9.10,

Explaining Assessment Results). Psychologists may also send test materials to other

qualified health professionals bound by their ethical guidelines to protect the security

of the instruments, taking appropriate steps not to violate copyright laws.

􀀴 A patient of a psychologist in independent practice was discussing her anxiety about

an upcoming psychological evaluation for a job promotion that required security clearance.

To reduce the patient’s anxiety, the psychologist took out from his files several

of the standardized tests that are usually administered for such purposes and went

over them with the patient.

**Laws Governing Release of Records**

*Implications of HIPAA*

As a matter of practice, psychologists should keep test materials separated from

a client’s/patient’s mental health records so the materials do not come under the

HIPAA-defined “designated record set,” which may not be withheld pursuant to

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client/patient release under federal law. Test materials do not have to be included in

the patient’s record if *test data*, as defined by Standard 9.04, Release of Test Data, are

not recorded on the test material itself. *Separated* does not necessarily mean that the

test data and test material must be kept in a separate file cabinet, but it does require

that they are separated by a folder or binding unit so they are not confused or commingled

with the test data records. Psychologists should seek legal advice before

making such a determination and be mindful that removing clients’/patients’

responses from the test protocol after they have been recorded on the material can

constitute unlawful alteration of the patient’s record.

*Implications of FERPA*

School psychologists may also find that laws governing the release of school

records supersede the requirements of Standard 9.11. FERPA establishes the right

of parents to obtain copies of their children’s school records where failure to provide

the copies would effectively prevent a parent or eligible student from exercising

his or her right to inspect and review the education records (20 U.S.C. § 1232G[a]

[1][A]; 34 CFR § 99.11b; www.ed.gov/offices/OM/fpco/ferpa/index.html). Schools

are not required to provide copies of the records unless, because of distance or

other considerations, it is impossible for the parent or student to review the records.

Psychologists working in schools may also release test materials to attorneys or

other nonprofessionals in response to a court order. In these situations, psychologists

can request that the court issue a protective order requiring that test items not

be duplicated or made available to the public as part of the court record and

returned to the psychologist at the end of the proceedings.

*Copyright Protection Laws*

Release of “test data” that include client/patient responses recorded on the test

protocol itself can raise issues of copyright protection and fair use by test development

companies. If testing protocols allow, psychologists may wish to record client/

patient responses on a form separated from the test items themselves to comply

with contractual agreements with test developers and to maintain test security

(Standard 9.11, Maintaining Test Security).

When test data consisting of PHI cannot be separated from test materials that are

protected by copyright law, psychologists’ decision to withhold the release of test

data would be consistent with HIPAA regulations and Standard 9.04a. According to

Richard Campanelli, director of the Office for Civil Rights at the U.S. DHHS, under

Section 1172 (e), withholding PHI would not be in violation of HIPAA if to do so

would violate trade secret laws (http://aspe.hhs.gov/admnsimp/pl104191.htm).

In school contexts, reproduction of a test without permission may also be a

violation of copyright law, although providing a single copy of a used protocol to

parents under FERPA regulations may fall under the “fair use doctrine” provisions

of copyright law (S. Jacob & Hartshorne, 2007; *Newport-Mesa Unified School*

*District v. State of California Department of Education,* 2005).

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The increase in use of listservs, social media, and websites authored by psychologists

has also given rise to an increase in threats to test security. Psychologists

need to monitor their online communications to ensure that they do not divulge

sensitive information about the content or interpretation of frequently used psychological

tests (Schultz & Loving, 2012).

**HOT TOPIC**

The Use of Assessments in Expert Testimony:

Implications of Case Law and the

Federal Rules of Evidence

In 1988, testimony by mental health professionals accepted as experts by the court played a key role in the conviction

of Kelly Michaels on 115 counts of sexual offenses involving 20 nursery school children. The “experts”

claimed that the responses of children to assessment questions fit the profiles of abuse “documented” by Roland

Summit (1983) and Suzanne Sgroi (1982). However, these profiles, drawn from clinical work with sexually abused

children, were largely theoretical and had never been subjected to tests of validity or reliability in or out of a

forensic context (Fisher, 1995). Five years after Ms. Michael’s conviction, the Appellate Division ruled that the data

on which the experts’ testimonies were based were unreliable, invalid, and not probative of sexual abuse and

therefore could not be used as evidence of guilt (State of New Jersey v. Margaret Kelly Michaels, 1993).

The Kelly Michaels case served as a wake-up call for psychologists on the ethical and legal consequences

of providing expert testimony based on assessment instruments and procedures that have not gained general

acceptance within the field and do not have established relevance to the legal question at hand (Faller &

Everson, 2012; Everson & Faller, 2012; Klee & Friedman, 2001; Olafson, 2012; Standards 2.04, Bases for

Scientific and Professional Judgments, and 9.01, Bases for Assessments). This Hot Topic highlights ethical and

legal challenges in selecting forensically valid assessment instruments for expert testimony.

**Relevant Case and Federal Law**

Mental health professionals are not alone in receiving increased scrutiny of expert opinion in criminal and civil

cases. In recent years, there has been an increase in federal and case law requiring judges to determine evidentiary

admissibility of expert testimony based on the general acceptance of methods and procedures within

the expert’s field (Klee & Friedman, 2001; Sales & Shuman, 2007).

The “General Acceptance” Standard. The “general acceptance” standard for admissibility of expert testimony

was first established by the Supreme Court in Frye v. United States (1923). In Daubert v. Merrell Dow

Pharmaceuticals, Inc. (1993), the standard was expanded to require specific relevance to the legal question at

hand and demonstrated scientific reliability and validity. In General Electric Co. v. Joiner (1997), the Court held

that judges should exclude from evidence expert testimony when the gap between the data (and the methodology

used to substantiate the data) is too great (Grove & Barden, 1999). The “general acceptance” standard

was explicitly extended to practitioners in Kumho Tire Co., Ltd. v. Carmichael (1999).

As of 2004, the Federal Rules of Evidence (70 FED. R. EVID. 702) require judges to permit expert testimony

only if it is derived from reliable principles and methods in the expert’s field and these principles and methods

have been applied reliably to the facts of the case.

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In light of case and federal law, appropriate selection of psychological assessment methods for forensic use

should be determined by the legal question at hand, the psychometric properties of the instruments and procedures,

and admissibility standards established by the court (Bush et al., 2006; Standards 2.01f, Boundaries

of Competence; 9.01a, Bases for Assessments; and 9.02, Use of Assessments).

**Challenges of the “General Acceptance” Standard to Selection**

**and Use of Assessments in Forensic Contexts**

The integration of Daubert, Kumho, and Joiner into the courts’ standard for admissibility of expert testimony

has led to ethical and legal debate regarding whether assessments used in clinical settings should be included

in forensic opinions if they have not been validated for application to issues before the court. For example,

Grove and Barden (1999) argue that diagnostic categories derived from the text revision of the DSM, fourth

edition, text revision (DSM-IV-TR; American Psychiatric Association, 2000), while useful in increasing the reliability

of practitioners’ agreement on a patient’s diagnosis, may not be acceptable under the Daubert–Kumho–

Joiner evidentiary criteria because they are derived from a process of consensus among a small group of

professionals that sometimes draws upon available research but does not require scientific data to validate

the existence or etiology of the disorder.

Similar arguments have been made against the use of tests such as the Rorschach Comprehensive System

as data for expert testimony regarding psychopathology, based on the fact, among others, that its validity and

reliability in and outside of forensic settings continue to be the subject of intense scientific debate (Grove,

Barden, Garb, & Lilienfeld, 2002; Ritzler, Erard, & Pettigrew, 2002). Others have challenged whether assessments

for neurological injury claims meet the Daubert–Kumho–Joiner standard for evidentiary admissibility in

the absence of premorbid baselines or empirically established ecological validity of the tests to predict functioning

in everyday life (Stern, 2001).

Kaufman (2011) has identified four recurring challenges to the admissibility of neuropsychological evidence

that include (1) battery selection (fixed vs. flexible), (2) symptom validity measures, (3) causation opinions, and

(4) nonpsychologists exerting neuropsychological opinions.

The Limits of Psychological Assessments for Child Custody Disputes. In recent years, courts have begun

using the ambiguous standard “best interests of the child” as a means of resolving custody decisions (APA,

2010d; Elrod & Spector, 2004). Currently, there are no reliable legal criteria or any validated mental health or

behavioral criteria on which a psychologist can provide an expert opinion on “best interest” (Krauss & Sales,

2000). Forensic psychologists hired to evaluate the mental health of one or more family members can provide

expert opinion on the interpretation of data based on assessment instruments found to be reliable and valid

indicators of children’s or parents’ emotional and cognitive status and their interpersonal interactions with one

another. However, unless there is established scientific evidence that these instruments can reliably determine

whether joint custody or the number of visitations permitted for a noncustodial parent would be in the best

interests of the child, expert opinion that implies a direct empirical link between the data collected to specific

recommendations regarding custody decisions before the court may be inadmissible under the Daubert–

Kumho–Joiner standard and in violation of Standard 9.01a, Bases for Assessments (Ellis, 2012; Otto &

Martindale, 2007).

Forensic Assessment Relevant to Violent or Abusive Crimes. In criminal cases, forensic psychologists are

often called upon to provide expert testimony based on a defendant’s response to assessment instruments

designed to measure inclinations toward violence or psychopathologies associated with abusive or other

criminal behaviors (Nedopil, 2002; Tolman & Rotzien, 2007). Psychometric techniques for evaluating the validity

of such assessment instruments most often depend on probability evidence and comparisons of within- and

between-group responses to determine a test’s reliability and validity. By contrast, the ultimate decision before

the court in such cases is categorical: A defendant is either guilty or innocent. The opinions of psychologists

testifying as expert witnesses must therefore reflect the limitations of the methods in which data were

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Chapter 12 Standards on Assessment——**307**

obtained (Vitacco, Gonsalvas, Tomony, Smith, & Lishner, 2012). The clinical forensic evaluator can testify as to

the degree to which a defendant’s test scores reach criteria for psychological characteristics associated with

different criminal behaviors but cannot form an opinion as to whether those scores indicate the defendant’s

behavioral guilt or innocence in the legal case at hand (Fisher, 1995; Krauss & Lieberman, 2007).

**Ethical and Legal Considerations in the Selection and Use**

**of Assessment Instruments for Expert Testimony**

Psychologists providing expert testimony based on psychological assessments with established relevance to the

legal question at hand assist the courts in making fair determinations by illuminating data on the legal issue.

However, neither justice nor the legal rights of plaintiffs or defendants are well served when psychologists

declaring “expert” status present forensic opinions based on assessment instruments and techniques insufficient

to substantiate their findings (Principle B: Fidelity and Responsibility; Principle D: Justice; Standards 2.04,

Bases for Scientific and Professional Judgments, and 9.01, Bases for Assessments). The following are points that

psychologists should consider when expert testimony will be based on psychological assessment:

Select assessment instruments and procedures with established psychometric validity and reliability for

the legal question at hand (Standards 9.01a, Bases for Assessments, and 9.02a, Use of Assessments).

Ensure that established principles of test interpretation have been applied reliably to the facts of the

case (Standard 9.06, Interpreting Assessment Results).

Prepare testimony that reflects awareness of and meets legal criteria for the admissibility of expert

testimony based on the reliability of the scientific foundation on which an opinion is based and the

established validity and reliability in providing data relevant to the legal question for which their opinion

is sought (Bush et al., 2006; Daubert–Kumho–Joiner; Standards 2.01f, Boundaries of Competence,

and 2.04, Bases for Scientific and Professional Judgments).

Take full responsibility for ensuring testimony is not flawed by the use of unorthodox assessment procedures

and provide the court with reasoning that led from the data to the expert opinion (Grisso, 2003;

Heilbrun, 2001).

Acknowledge limitations in the applicability of the test data to the legal issue (Standard 9.06, Interpreting

Assessment Results).

Avoid omission of relevant data or overemphasis on minor facts to support an opinion (Bush et al., 2006).

Avoid offering testimony beyond the data collected. Remember, “An expert opinion that answers the

ultimate legal question is not an ‘expert’ opinion, but a personal value judgment” (Grisso, 2003, p. 477).

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CHAPTER 143

Chapter 13 Standards on Therapy

*10. Therapy*

**10.01 Informed Consent to Therapy**

(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent,

psychologists inform clients/patients as early as is feasible in the therapeutic relationship about

the nature and anticipated course of therapy, fees, involvement of third parties, and limits of

confidentiality and provide sufficient opportunity for the client/patient to ask questions and

receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality, and 6.04, Fees

and Financial Arrangements.)

To comply with this standard of the APA Ethics Code (APA, 2002b), psychologists

must obtain and document written or oral consent in the manner set forth in

Standard 3.10, Informed Consent. They must also provide prospective therapy

clients/patients and, when appropriate, their legal guardians a clear explanation of

the nature and anticipated course of therapy, fees, involvement of third parties, and

the limits of confidentiality. This information must be presented in a language

reasonably understandable to the client/patient, and the consent process must provide

sufficient opportunity for questions and answers.

**As Early as Feasible**

Standard 10.01 explicitly uses the phrase “as early as is feasible” to indicate that in

some cases, obtaining informed consent during the first therapy session may not be

possible or clinically appropriate. Psychologists may need to wait for feedback from a

client’s/patient’s HMO before consent discussions regarding fees can be completed.

Informed consent during the first session may be clinically contraindicated if a new

client/patient is suicidal or experiencing some other crisis needing immediate therapeutic

attention. In such situations, consent is obtained as soon as all information is available

or the crisis has subsided (see also Standard 6.04a, Fees and Financial Arrangements).

**HMO**

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􀀵 At the beginning of the first session, it became apparent that a new client was having

difficulty communicating in a coherent fashion. With probing, the psychologist learned

that the client had a history of schizophrenia and had recently gone off his medications

because of its intolerable side effects. The psychologist postponed discussion

relevant to informed consent and spent the rest of the session working with the client

to determine the best course of action to deal with the immediate situation.

**Nature of the Therapy**

The *nature* of the therapy refers to information about the therapeutic process

that would reasonably be expected to affect clients’/patients’ decisions to enter into

therapy with the psychologist. Informed consent should include discussion of the

duration of each session (e.g., 50 minutes), appointment schedule (e.g., weekly),

and the general objectives of treatment (e.g., crisis management, symptom reduction).

Depending on the treatment modality, the consent process might inform

clients/patients that therapy entails participating in biofeedback sessions, relaxation

exercises, behavioral contracts, homework assignments, discussion of dreams and

developmental history, collateral treatments, or other aspects of the therapeutic

process relevant to an informed consent decision. Psychologists should not assume

that all clients/patients are familiar with the nature of psychotherapy.

􀀵 A new patient who had recently immigrated to the United States from West Africa told

a psychologist that his general practitioner had recommended that he see the psychologist

because of headaches that had not responded to traditional medications.

The psychologist explained her cognitive therapy approach to working with such

problems, standard confidentiality procedures, and issues relevant to the patient’s

health plan and then turned to a discussion of issues relevant to the patient’s presenting

problem. Toward the end of the session, the psychologist asked the patient if he

had any additional questions. The patient asked the psychologist if she was ready to

give him a prescription for a medication that would cure his headaches. The psychologist

then carefully explained in great detail the nature of cognitive therapy and the

difference between such therapy and psychopharmacological approaches.

**Anticipated Course of the Therapy**

The *anticipated course* of therapy refers to the number of sessions expected,

given the psychologist’s current knowledge of the client’s/patient’s presenting problem

and, when applicable, the company, institutional, or health plan policies that

may affect the number of sessions. Depending on the treatment modality, consent

discussions would also include expectable modifications such as the evolving

nature of systematic desensitization or exposure therapy, the uncovering of as yet

unidentified treatment issues, or, if the practitioner is a prescribing psychologist,

adjustments in dosage levels of psychopharmacological medications.

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**310**——PART II ENFORCEABLE STANDARDS

**Need to Know: Informed**

**Consent With Suicidal Patients**

For certain disorders and treatment contexts, informed consent will include discussion

of empirically documented risks inherent in psychotherapy. Following a review of the

literature, Rudd, Joiner, et al. (2009) concluded that given the available data on

increased suicide risk during treatment involving multiple attempters, there is a need

to include potential risks of death or suicide in the informed consent process. As a

comparison, they note the recent FDA black box warning label for antidepressant use

with adolescents (Rudd, Cordero, & Bryan, 2009). According to the authors, frank discussions

about suicide risk during informed consent offer the following benefits:

(a) assists clients/patients and their families to understand the true nature of suicide

risk during the treatment process and to recognize shared responsibility to reduce its

likelihood, (b) helps clarify the importance of treatment compliance and crises management

to treatment effectiveness, (c) provides an opportunity to emphasize the need for

effective self-management during outpatient care, (d) helps psychologist identify and

target for treatment skill deficits that might limit patient’s willingness or ability to

access emergency services, and (e) facilitates a frank exchange about the responsibilities

of provider and client/patient.

In many instances, informed consent to therapy will be an ongoing process

determined, for example, by the extent to which the nature of a client’s/patient’s

treatment needs are immediately diagnosed or gradually identified over a series of

sessions, cognitive and social maturation in child clients/patients, or functional

declines in clients/patients with progressive disorders. Providing clients/patients with

an honest evaluation of the anticipated and unanticipated factors that may determine

the course of therapy demonstrates respect for their right to self-determination and

can promote trust in the therapeutic alliance (Pomerantz, 2005; Principle C:

Integrity; Principle E: Respect for People’s Rights and Dignity).

􀀴 A psychologist saw a new client whose presenting problems appeared to be related

to a debilitating social phobia. The client was to pay privately for treatment because

her health plan did not cover psychotherapy. The client asked the psychologist how

long she might have to be in therapy before she saw some relief from her symptoms.

The psychologist responded, “We’ll just see how it goes.”

􀀵 A psychologist saw a new patient who appeared to be suffering from a mild form of

agoraphobia. The psychologist explained his cognitive-behavioral approach to this

type of problem and the average number of sessions after which patients often feel

some relief from their symptoms. The psychologist stressed that each individual

responds differently and that together they would reassess the patient’s progress after

a specific number of sessions.

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**Fees**

Discussion of *fees* must include the cost of the therapy, the types of reimbursement

accepted (e.g., checks, credit card payments, direct payment from insurance companies),

the payment schedule (e.g., weekly, monthly), when fees are reevaluated (e.g.,

annual raise in rates), and policies regarding late payments and missed appointments.

When appropriate and as soon as such information can be verified, psychologists

should also discuss with clients/patients the percentage of therapy costs reimbursed

under the client’s/patient’s health plan and limitations on the number of sessions

that can be anticipated because of limitations in insurance or other sources of client/

patient financing (see also Standard 6.04, Fees and Financial Arrangements).

Psychologists directly contracted with HMOs may have capitated or other types of

business agreements that provide financial incentives to limit the number of treatment

sessions. When permitted by law and contractual agreement, psychologists

should inform clients/patients about such arrangements (Acuff et al., 1999; see also

Standard 3.06, Conflict of Interest and the Hot Topic in Chapter 9, “Managing the

Ethics of Managed Care”).

􀀴 On the initial visit, a psychologist told a client her fee for each session and mentioned

that she was an approved provider for some HMOs. At the end of the first month in

treatment when the client asked the psychologist to fill out an insurance form for

treatment, he was shocked to learn that the psychologist was not an approved provider

for his HMO plan, that she had not called the HMO to inquire about her eligibility,

and that she had not informed him of this possibility during the first session.

􀀵 A psychologist was assigned to see a couple for court-ordered therapy following a finding

of child abuse and neglect resulting in the removal of the children from their home. The

psychologist informed the couple that the treatment was mandatory, that it was paid for

by a court-affiliated child protective services agency, and that the psychologist would be

providing to the court a summary of the couple’s compliance with and progress in therapy.

**Involvement of Third Parties**

The term *third parties*, as used in this standard, refers to legal guardians, health

insurance companies, employers, organizations, or legal or other governing authorities

that may be involved in the therapy. Psychologists should inform clients/

patients if such parties have requested or ordered mental health treatment, are paying

for the therapy, and are entitled to receive diagnostic information or details of

the therapy based on law or contractual agreement—and to whom information

may be provided—contingent on the client’s/patient’s appropriate written release

or authorization (see section below on implications of HIPAA). Psychologists asked

to evaluate a child by one parent should clarify, when appropriate, custody issues to

determine if the other parent must also give permission.

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**312**——PART II ENFORCEABLE STANDARDS

**Confidentiality**

Informed consent to therapy must provide a clear explanation of the extent and

limits of *confidentiality*, including (a) when the psychologist must comply with

reporting requirements such as mandated child abuse reporting or duty-to-warn

laws and (b) guardian access to records in the case of therapy involving minors or

individuals with impaired consent capacities. Psychologists who provide therapy

over the Internet must inform clients/patients about the procedures that will be

used to protect confidentiality and the threats to confidentiality unique to this form

of electronic transmission of information (see also Standard 4.02c, Discussing the

Limits of Confidentiality). Clients/patients enrolled in health plans must be

informed about the extent to which treatment plans, diagnosis, or other sensitive

information must be disclosed to case managers for precertification or continuing

authorization for treatment (Acuff et al., 1999). When appropriate, psychologists

providing treatment in forensic settings should inform clients/patients of the possibility

that the psychologist may be obligated to disclose statements made in

therapy in court testimony.

􀀵 A psychologist had an initial appointment with an adolescent and his parents to discuss

the 14-year-old’s entry into individual psychotherapy for depression. The psychologist

discussed with both the prospective patient and his parents what

information concerning the adolescent’s treatment would and would not be shared

with the parents, including her confidentiality and disclosure policies regarding adolescent

risk behaviors such as sexual activity and use of illegal drugs. She also

informed them about her legal obligations to report suspected child abuse or neglect

and her own policy regarding disclosure of information pertaining to client/patient

imminent self-harm or harm to others. In addition, she described the parents’ right to

access the adolescent’s health records under HIPAA (see also the Hot Topic on

“Confidentiality and Involvement of Parents in Mental Health Services for Children

and Adolescents” in Chapter 7).

􀀴 A psychologist began therapy with a client over the Internet. The psychologist failed

to inform the client of the need of a password to protect the home computer from

which the client would be interacting with the psychologist. The client’s spouse

opened the files in which therapeutic communications had been saved and printed

them out to use against the client in petitioning for divorce.

*Implications of HIPAA*

Psychologists who are *covered entities* under HIPAA must inform clients/patients

about their rights regarding the use and disclosures of their PHI*.* This includes

providing clients/patients with a Notice of Privacy Practices that explains the uses

and disclosures of PHI that may be made by the covered entity, as well as the individual’s

rights and covered entity’s legal duties with respect to PHI (45 CFR

164.502[g]; see discussions regard HIPAA under Standard 3.01, Informed Consent,

and in “A Word About HIPAA” in the Preface of this book for definitions and

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discussion of these terms). Remember, the designation of “covered entity” is not

specific to an individual client/patient but to the psychologist’s practice (45 CFR

160.102[a][3] and 160.103). Thus, even if a psychologist is not electronically transmitting

health information about a particular client/patient, HIPAA is triggered if

the psychologist or business associate (including clients’/patients’ health insurer)

has conducted any such transactions for others who are the psychologist’s clients/

patients. Readers may also wish to review HIPAA regulations governing the protection

of psychotherapy notes discussed in Chapter 12.

**Need to Know: Setting an Internet**

**Search and Social Media Policy**

**During Informed Consent**

As discussed in Chapter 6, the continued growth, popularity, and accessibility of personal

information online raises issues regarding appropriate privacy protections and personal/

professional boundary setting in psychotherapy (Standards 3.05, Multiple Relationships;

4.01, Maintaining Confidentiality; and 4.02, Discussing the Limits of Confidentiality). For

example, situations may arise when it is ethically responsible to search online for client/

patient information, for example, for an emergency contact or in rare instances to corroborate

client/patient clinically relevant statements (Lehavot et al., 2010). As Internet searches

become even more ubiquitous in personal and professional life, discussing the psychologist’s

policy for such web-based searches during informed consent may become another important

contributor to the therapeutic alliance. The psychologist’s restrictions on interaction with the

client/patient through social networks or other online outlets should also be a part of the

consent process. APAIT provides a sample statement of social media policy for private practice

developed by Keely Kolmes (http://www.apait.org/apait/download.aspx). The statement

provides explanations for policies against “friending” and “fanning” by clients/patients on

the psychologist’s professional Facebook page, security concerns for clients/patients who

might choose to follow the psychologist’s professional twitter posts or blogs, policies on

client/patient testimonials, and restriction of e-mails for appointment purposes only.

**Informed Consent Involving Children**

**and Adolescent Clients/Patients**

Psychologists providing therapy and counseling to children and adolescents face

unique informed consent challenges tied to (a) state and federal laws governing the

rights of minors to autonomous health care decisions, (b) laws related to the rights

and obligations of minors’ legal guardians, and (c) developmental changes in children’s

ability to understand their rights, the nature of their disorder, and the purpose

of treatment (Standard 3.10b, Informed Consent). When working with children and

adolescents, psychologists must constantly balance ethical obligations to protect

client/patient welfare and respect client/patient developing autonomy and privacy

(Principle A: Beneficence and Nonmaleficence; Principle E: Respect for People’s

Rights and Dignity).

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**314**——PART II ENFORCEABLE STANDARDS

*When Guardian Consent Is Required by Law*

According to Standard 3.10b, Informed Consent, for persons who are legally

ineligible to provide informed consent, psychologists must obtain guardian permission,

provide the client/patient with an appropriate explanation, seek the client’s/

patient’s assent, and consider such person’s preferences and best interests. This

standard respects the developing autonomy needs and rights of minor children by

requiring that they receive developmentally appropriate information regarding the

reason for and nature of the treatment and, with some exceptions, are given the

right to refuse treatment.

Exceptions to the requirement for child assent arise when children are too young

or too impaired at the time treatment is initiated to appreciate their disorder or

understand the nature of therapy, especially when treatment is necessary for their

well-being. When children’s mental health needs indicate that their dissent will not

determine whether they will receive treatment, psychologists should provide them

with an appropriate explanation but not seek their assent (Fisher & Masty, 2006;

Masty & Fisher, 2008).

*When Guardian Consent Is Not Permitted or Required by Law*

Parents are given significant responsibilities and rights to consent to health care

treatments for their children who are below 18 years of age (*Parham v. J.R.*, 1979;

Weithorn, 2006; *Wisconsin v. Yoder*, 1972). Psychologists should be familiar with

relevant state and federal laws before they consider treating a minor client/patient

without guardian permission (for a review of state laws, see English & Kenney,

2003). Psychologists providing counseling services in schools should also be

aware of district rules and state and federal laws restricting services to children

without parental consent (S. Jacob & Hartshorne, 2007). As outlined in Chapter 6,

Standard 3.10b, Informed Consent, exceptions to requirements for parental permission

to treatment include state laws defining (a) *emancipated minors*, (b) *mature*

*minors*, and (c) minors for whom there is evidence that their guardians’ decisions

may not be in their best interests.

According to Standard 3.10b, Informed Consent, when consent by a legally

authorized person is not permitted or required by law, psychologists must take

reasonable steps to protect the child’s rights and welfare. A first step in complying

with this standard is to be familiar with research on developmental differences in

children’s understanding of consent information and clinical methods to evaluate

the consent capacity of individual clients/patients. For example, research suggests

that by age 14, many children understand consent information as well as adults,

although their relative lack of experience with independent health care decision

making may place them at a consent disadvantage (Belter & Grisso, 1984;

Bluebond-Langner, DiCicco, & Belasco, 2005; Broome, Kodish, Geller, & Siminoff,

2003; Bruzzese & Fisher, 2003; Kaser-Boyd, Adelman, & Taylor, 1985; Masty &

Fisher, 2008; Szajnberg & Weiner, 1995; Weithorn & Campbell, 1982).

The next step is to tailor the consent information to the child’s level of understanding

of both the nature of treatment and their rights under law and ethics. This

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may include educating clients/patients about treatment terminology, the nature of

treatment, and their right to refuse or withdraw from treatment. Finally, as detailed

in the Hot Topic in Chapter 7, even when adolescents have the legal right to consent

to their own treatment, parents may have legal access to their child’s psychotherapy

records. For example, in many instances, if parents are responsible for paying their

child’s health care costs directly or through insurers, they will have access to the

records irrespective of whether a child has been designated a mature or emancipated

minor. Psychologists working with adolescents in the absence of parental

consent need to be familiar with state and federal laws governing parental access to

records and include this information during informed consent (see “A Word

About HIPAA” in the Preface of this book).

**Need to Know: Child Assent and Parental**

**Permission for Online Therapies**

As discussed throughout this book, the Internet has increased the availability of psychological

services as well as the ethical issues that must be addressed. Since minors constitute

a substantial portion of web users (Kaiser Family Foundation, 2001), psychologists need to

have a method for verifying client/patient age and obtaining guardian permission if

required by state law. Since state laws vary in these requirements, psychologists also need

to verify the state in which the minor resides. When feasible, some practitioners choose to

have an initial face-to-face meeting with clients/patients before initiating web-based treatments.

When this is not feasible, an initial videoconference, phone call, or exchange of

identifying documents may be useful. Compliance with law and ethics protecting minors’

participation in treatment requires documenting the validity of parental permission when it

is required. An initial in-person visit if feasible, a web-based video consent conference, or

telephone discussion with the client’s/patient’s legal guardian can ensure that appropriate

permission has been obtained, provide an opportunity to discuss with guardians specific

confidentiality and disclosure policies, and initiate a collaborative relationship that will be

beneficial to the child’s treatment. Psychologists also need to verify to the best of their

ability that the individual they are corresponding with is the same person from whom

consent was obtained. Some psychologists have used personalized code names that clients/

patients include in their exchanges to address this potential problem.

(b) When obtaining informed consent for treatment for which generally recognized techniques

and procedures have not been established, psychologists inform their clients/patients of the

developing nature of the treatment, the potential risks involved, alternative treatments that may

be available, and the voluntary nature of their participation. (See also Standards 2.01e, Boundaries

of Competence, and 3.10, Informed Consent.)

Most techniques that are now accepted practice in the profession of psychology

emerged from treatment needs unmet by existing therapies. Standard 10.01b recognizes

that innovation in mental health services is critical if a profession is to

continue to adequately serve a diverse and dynamic public. The standard also

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recognizes that during the development and refinement of new therapeutic techniques,

the risks and benefits to clients/patients are unknown. Consequently,

respect for a client’s/patient’s right to informed, rational, and voluntary consent

requires that when the treatment needs of a client/patient call for innovative techniques,

during informed consent, psychologists have the obligation to explain the

relatively new and untried nature of the therapy. Furthermore, they must clearly

describe alternative established treatments and clarify the client’s/patient’s right to

dissent in favor of more established treatments whether they are offered by the

psychologist obtaining the consent or other mental health professionals.

**E-therapy**

Web-based or e-therapy has been described as a new modality for helping

people resolve life and relationship issues using the power and convenience of the

Internet to allow synchronous (simultaneous) and asynchronous (time-delayed)

communication between client/patient and therapist (APA, 2011b; Grohol, 2001;

Maheu & Gordon, 2000). A primary advantage of e-therapy is that through remote

communication, it can provide clients/patients access to qualified mental health

professionals regardless of geographical proximity.

To date, e-therapy does not represent a new theoretical approach to psychotherapy

in the same vein as cognitive, psychodynamic, behavioral, or other theoretically

driven approaches to treatment. Rather, it represents a new modality or

process in which these forms of therapy can be provided. While great strides

have been made, in many contexts in which web-based therapies are conducted

(i.e., e-mail, chat rooms, videoconferencing), they have yet to emerge as

“established” treatments (Pietrzak, Pullman, Campbell, & Cotea, 2010). This is due

in part to continuously changing technology, use of different web-based modes of

treatment, variability in treatment techniques viewed as compatible with webbased

approaches, the range of disorders treated, and difficulty in obtaining empirical

data on the demographics and other characteristics of individuals using

web-based therapies (Heinlen et al., 2003). For these reasons, psychologists providing

web-based services should carefully consider the extent to which their services

are considered “established” within the profession and whether their informed

consent procedures need to comply with Standard 10.01b.

􀀵 A psychologist working in a large, underserved rural community found that a number

of his clients could not afford to make the 100-mile trip to his office on a weekly

basis. After attending an intensive workshop on e-mail therapy and developing a

network of colleagues to consult with on behavioral telehealth techniques, the

psychologist decided to use this form of therapy. He adopted the procedure of having

an initial in-person meeting with each client who might be appropriate for

e-mail therapy. During the informed consent provided at this session, he explained

the following: (a) e-mail therapy is a new and still-developing form of therapy;

(b) although there was reason to believe this form of therapy would serve the client’s

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mental health needs, the extent of such benefits was still largely unknown; (c) current

risks associated with e-mail therapy include confidentiality concerns and lack of

immediacy; (d) there are traditional treatments available for the client’s presenting

problem; and (e) if the client preferred to receive a more traditional therapy, the

psychologist would try to work out a schedule that could accommodate the client’s

travel difficulties.

**Need to Know: State Laws Regulating**

**Use of Telehealth Services**

In the most recent survey of state licensing laws, only a few states currently regulate

the use of telehealth-related services by licensed psychologists (American Psychological

Association Practice Organization, 2010). States that have begun to regulate electronically

communicated health care services require certain information to be disclosed

during informed consent, largely focused on risks inherent in providing services

via the Internet or other electronic media, including how records are stored and protected

and communication alternatives in the event of technology failure (Baker &

Bufka, 2011).

**The Ongoing Nature of Consent**

Informed consent should be conceptualized as a continuing process in which the

clinically determined need to shift to treatment strategies distinctly different from

those that were originally agreed upon during informed consent are discussed with

the client/patient at appropriate points during the course of psychotherapy. If, after

several sessions, a client’s/patient’s treatment needs call for a shift to innovative

techniques that have not been widely used or accepted by practitioners in the field,

psychologists should follow the requirements of Standard 10.01b. The following

case illustrates a potential violation of this standard.

􀀴 A psychologist had just returned from a professional meeting where she heard several

other practitioners discuss a new technique for anxiety disorders that involved viewing

video clips of people reacting to natural or human-made catastrophes. She

decided to try this untested technique with one of her patients who had not been

responding to traditional interpersonal approaches to anxiety. At the next session,

rather than discussing with the patient the option of trying this new type of approach,

she told the patient that as part of his ongoing treatment, they would look at a video

together. The patient experienced an anxiety attack following exposure to the video

and apologized to the therapist for failing to improve after so many sessions.

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**10.02 Therapy Involving Couples or Families**

(a) When psychologists agree to provide services to several persons who have a relationship (such

as spouses, significant others, or parents and children), they take reasonable steps to clarify at the

outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist

(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides

with the supervisor, the client/patient, as part of the informed consent procedure, is informed

that the therapist is in training and is being supervised and is given the name of the supervisor.

Standard 10.01c applies to therapy conducted and supervised as part of practice,

internships, or other training experiences in which the legal responsibility for treatment

resides with the supervisor. In these contexts, clients/patients must be informed

that the therapist is a trainee and that the therapy is supervised and is given the name

and contact information of the supervisor. Both the trainee and the supervisor would

be in potential violation of this standard if the supervisee failed to include this information

during informed consent. This standard does not apply to therapy conducted

by licensed psychologists obtaining postdoctoral training and supervision because in

such contexts, the legal responsibility most often resides with the psychologist.

**Need to Know: Expanded Informed**

**Consent for Psychologists With**

**Prescriptive Authority**

Guideline 12 of the APA Practice Guidelines regarding Psychologists’ Involvement in

Pharmacological Issues (APA, 2011a, pp. 844–845) encourages psychologists with prescriptive

authority to use an expanded informed consent process to incorporate additional

issues specific to prescribing, including the following:

The agent to be used

Symptoms it is intended to address

Potential adverse side-effects, potential contraindications if the patient is taking

other medications, and risks associated with sudden unilateral discontinuation

Rationale for treatment relative to other treatments, including other medications, and,

when appropriate, why psychotherapy and psychopharmacology are used together

The estimated duration and cost of treatment, including any indicated physical or

laboratory examinations and therapeutic monitoring of drug levels

The potential reasons for reducing dosage or discontinuing medication

􀀴 A student interning at a veterans hospital was concerned that her ability to help

patients would be compromised if she told them that she was a trainee. When she

discussed this with her supervisor, the supervisor told her the decision was up to her.

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will have with each person. This clarification includes the psychologist’s role and the probable

uses of the services provided or the information obtained. (See also Standard 4.02, Discussing the

Limits of Confidentiality.)

Steps required to inform prospective clients/patients in couples or family therapy

about the nature of treatment go beyond those described in Standards 3.10,

Informed Consent, and 10.01, Informed Consent to Therapy. In some couples or

family treatment modalities, the client/patient is the multiperson unit, and the primary

obligation of the psychologist is to the parties as a whole. Under Standard 10.02,

psychologists must identify and explain which members of the couple or family are

the primary client/patient. They should also discuss issues related to termination,

including whether treatment will continue if a member of the couple or family

decides to discontinue (Knauss & Knauss, 2012). In other family or couple therapy

modalities, the primary client/patient is a single individual, with family members

involved only to provide collateral support for the client’s/patient’s treatment.

While the psychologist does not have the same legal obligations to these individuals

(they are not clients/patients, Younggren, 2009), they should be told how the information

will be used and the therapist’s confidentiality policy, including mandated

reporting requirements.

􀀵 A divorced couple with joint custody of their children began family therapy to help

their 10-year-old son, who had been having problems in school and in adjusting to

living in two different homes. The father indicated that he was just attending sessions

to support his son’s therapy. The psychologist explained to the father, mother, and

child that she offered family therapy in which all members are clients and their feelings

and behaviors equally explored during the treatment sessions. She also told them

that if there were some indication that the son needed individual therapy, she would

recommend an appropriate practitioner specializing in childhood disorders (see also

Standard 2.01, Boundaries of Competence).

During informed consent, psychologists also need to ensure that all family

members understand the nature of psychotherapy and are voluntarily agreeing to

participate. If a family member joins the process at a later time, the informed consent

process should be repeated (Knauss & Knauss, 2012).

􀀵 A 40-year-old woman sought family therapy for herself and her elderly mother. At the

initial session, the psychologist learned that the daughter had given up her job to care

for her mother and was frustrated by her mother’s refusal to do simple chores around

the house and their constant arguments. During the informed consent process, the

mother appeared anxious. When the psychologist asked her whether she had any

questions, she burst into tears and said she found it humiliating to speak to a stranger

about family problems. The psychologist explained his role and his obligation to keep

whatever he learned in therapy confidential. As the consent discussion continued, the

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**Clarifying the Psychologist’s Role and Goals of Therapy**

In addition to identifying who is the client/patient, discussions at the outset of

couple or family therapy must clarify (a) the psychologist’s responsibilities in balancing

the interests of different individuals, (b) whether the psychologist will conduct

individual or conjoint sessions, and (c) how often the psychologist will meet

with each party (Principle B: Fidelity and Responsibility). The modifier *reasonable*

indicates that a violation of this standard is limited to instances when psychologists

do not take steps to clarify information in a manner that would be considered

appropriate in the prevailing judgment of other similarly engaged psychologists.

Clients’/patients’ failure to understand the full implications of this information is

not in itself sufficient evidence of violation.

􀀵 An elderly couple entered therapy to help them address feelings and conflicts arising

from the husband’s terminal illness. Upon initial assessment of their situation,

the psychologist determined that the wife’s and husband’s emotional reactions to the

illness should be explored in individual sessions before it would be helpful for

the couple to meet with the therapist together. The therapist outlined a treatment

plan that included scheduling of individual and joint sessions.

􀀵 An interfaith couple began premarital counseling to help resolve conflicts regarding

issues such as which clergy should perform their wedding ceremony and the religious

upbringing of their children. In the first 10 minutes of the initial session, it became

clear that one member of the couple believed the purpose of counseling was to convince

his fiancée to agree to have the wedding ceremony performed and their children

raised in his faith. During the process of informed consent and in subsequent sessions,

the psychologist continued to clarify that involvement in premarital counseling could

not promise the direction the couple’s relationship would take.

In many instances, the goals of treatment may be different for the individuals

involved. For example, one member of a couple may see therapy as a means of

strengthening the relationship, whereas the other sees it as a means of ending the

relationship. Psychologists must take reasonable steps to correct such misimpressions.

mother became increasingly more agitated about sharing her personal thoughts and

feelings. The psychologist concluded that her participation in the therapy would not

be voluntary. He discussed his observations with the mother and daughter and recommended

they consider seeing a pastoral counselor affiliated with their church as an

alternative that might be more acceptable to the mother. He also let them know that

he would be available if the mother changed her mind.

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**Confidentiality**

Psychologists working with couples and families must take reasonable steps to

clarify how confidential information will be handled. Will the psychologist keep

information received from one party secret from the other? Or will all information

be shared (see Margolin, 1982; Snyder & Doss, 2005)? Psychologists must also clearly

articulate their legal obligations and policies regarding confidentiality and disclosure

of information about child abuse, domestic abuse, HIV notification, high-risk

behaviors of adolescent clients/patients, and other instances of potential harm.

􀀴 A gay couple had been in couples counseling for several sessions. One member of the

couple called the psychologist and revealed that, without the knowledge of his significant

other, he had begun seeing his former wife in what was progressing toward

a renewal of their sexual relationship. The client asked the psychologist to keep the

information secret. Although the psychologist had communicated a general confidentiality

policy to the couple at the outset of therapy, she had not specifically discussed

with them her policy regarding secrets between her and one member of the couple.

She now felt in a terrible bind. If she refused to keep the information secret, she would

violate the presumption of confidentiality held by the client who had called. If she

respected the request for secrecy, she might be violating the other client’s trust and

expectation of openness.

(b) If it becomes apparent that psychologists may be called on to perform potentially conflicting

roles (such as family therapist and then witness for one party in divorce proceedings), psychologists

take reasonable steps to clarify and modify, or withdraw from, roles appropriately. (See also

Standard 3.05c, Multiple Relationships.)

It is not unusual for individuals who have sought couples or family therapy to

become involved in litigation involving divorce, child custody, child abuse allegations,

petitions for child or family services, or mental competency hearings. In

such situations, psychologists may be asked by one party to testify on his or her

behalf or receive a court order to serve as a fact witness for the legal matter at issue.

When such situations arise, under Standard 10.02b, psychologists must first take

steps to clarify to clients/patients the nature of the two roles and the potential

effect on each party involved in the therapy. To comply with this standard, psychologists

will need to be aware of and communicate to their patients/clients the

extent to which state law defines as public or private the information revealed in

couples or family therapy and whether one or all parties must agree to disclosure

of information in court.

As with other forms of multiple relationships, sometimes the request to serve in

a dual capacity risks impairing performance of one or both professional roles. In

such cases, psychologists are required to take reasonable steps to modify or withdraw

from one of the roles to ensure that services continue to be objective and

effective and to avoid exploitation or harm to parties involved (Standard 3.05b and c,

Multiple Relationships).

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􀀵 A psychologist providing therapy for a family with a terminally ill child received a

court order to serve as a fact witness for a case against the couple alleging child

neglect. The psychologist informed the parents of the court’s request and took steps

to clarify the nature of this role to them. The psychologist was concerned that testifying

in court would harm the therapeutic relationship achieved with this family and

informed the judge in writing of these concerns. The judge refused to comply with the

psychologist’s request not to testify. The psychologist discussed the situation further

with the family, and they mutually agreed to a referral to another therapist (see also

Standard 1.02, Conflicts Between Ethics and Law, Regulations, and Other Governing

Legal Authority).

**10.03 Group Therapy**

When psychologists provide services to several persons in a group setting, they describe at the

outset the roles and responsibilities of all parties and the limits of confidentiality.

In addition to responsibilities described in Standards 3.10, Informed Consent,

and 10.01, Informed Consent to Therapy, psychologists conducting group therapy

must describe at the outset of treatment the unique roles and responsibilities of

both therapist and clients/patients in multiperson therapies. Such information may

include discussion of (a) differences between the exclusivity of the therapist’s attention

in individual therapy compared with attention to group dynamics in multiperson

treatments; (b) group member responsibilities, including turn taking and

prohibitions against group members socializing outside sessions; and (c) policies

regarding such client/patient responsibilities as acceptance of diverse opinions,

abusive language, coercive or aggressive behaviors, or member scapegoating. As in

couple and family therapy, informed consent regarding termination policies is

critical (e.g., disruptive group members; Knauss & Knauss, 2012). Group members

need to know their right to voluntarily withdraw from the group as well as the

consequences of member drop outs to the continuation of the group as a whole.

**Confidentiality**

A frequently misunderstood aspect of group therapy concerns the limits of confidentiality.

Although psychologists are professionally obligated to maintain the

confidentiality of most statements made during group therapy sessions, decisions

by members of a therapy group to disclose confidential information are neither

bound by professional codes nor subject to legal liability. At the outset of group

therapy, and each time a new member enters an ongoing group, psychologists must

take reasonable steps to clarify that they can request, but not guarantee, that all

group members maintain the confidentiality of statements made during sessions.

Psychologists should also be familiar with and inform group members about state

laws protecting or denying client/patient privilege (the right to limit the psychologist’s

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disclosures to courts) for information shared during group therapy. When group

therapy is conducted in response to court-ordered counseling, psychologists must

also clarify to group members the parties in the justice system who will receive

information learned during group therapy and how such information may be used.

**Clients/Patients in Concurrent**

**Single and Group Therapy**

Psychologists who see clients/patients concurrently in individual and group

therapy must take special precautions to ensure that they do not inadvertently

reveal during a group session confidential information gained about a client/

patient during an individual session. Psychologists must also clarify in advance to

such clients differences between the goals, processes, and therapist–client relationships

in single versus group therapy. When recommending that a client/patient seen

in individual therapy also participate in group therapy conducted by the psychologist,

steps should be taken to ensure that clients/patients understand that such a

decision is voluntary and that reluctance to participate in the group will not compromise

the current therapeutic relationship. This does not prohibit psychologists

from having a policy of only accepting individuals as clients/patients if they participate

in group therapy if (a) such multimodal treatment is clinically indicated

and (b) clients/patients are informed of this requirement prior to or at the outset

of therapy. For additional discussion, see Standards 3.05, Multiple Relationships,

and 3.06, Conflict of Interest.

**10.04 Providing Therapy to Those Served by Others**

In deciding whether to offer or provide services to those already receiving mental health services

elsewhere, psychologists carefully consider the treatment issues and the potential client’s/

patient’s welfare. Psychologists discuss these issues with the client/patient or another legally

authorized person on behalf of the client/patient in order to minimize the risk of confusion and

conflict, consult with the other service providers when appropriate, and proceed with caution and

sensitivity to the therapeutic issues.

There may be instances when psychologists professionally encounter an individual

already receiving mental health services from another professional who

might benefit from or is requesting additional therapy with the psychologist.

Standard 10.04 recognizes the rights of clients/patients to seek additional services

and the potential benefits of collateral therapy, as well as the potential harm that

can result from client/patient involvement in concurrent therapies.

Under this standard, careful consideration of the client’s/patient’s welfare and

treatment needs determines the ethical appropriateness of providing therapy to

those served by others. In some instances, clients/patients may benefit from consultation

with a psychologist when they are uncertain about the effectiveness of their

current therapy or uncomfortable with what they perceive as their current provider’s

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boundary violations. In other instances, the expertise of the psychologist may provide

needed collateral treatment, for example, when a client/patient who is under

the care of a psychiatrist for psychopharmacological treatment of depression would

also benefit from psychosocial or behavioral treatment. On the other hand, provision

of concurrent services may be harmful if clients/patients consciously or

unconsciously seek to use a second therapist as a means of triangulating issues arising

in their current therapy, if they begin to receive conflicting therapeutic messages

from two different service providers, or if the psychologist’s choice to see the

patient is governed by the psychologist’s own financial interests rather than client/

patient welfare (see also Standards 3.04, Avoiding Harm; 3.06, Conflict of Interest; 3.08,

Exploitative Relationships; and 5.06, In-Person Solicitation).

􀀵 A psychologist had an initial consultation with an individual who was currently in treatment

with another provider. During the consultation, the patient frequently asked

questions about the appropriateness of certain therapeutic styles. The psychologist

asked the patient why he sought the consultation. He stated that he liked his current

therapist but thought he would benefit from two different perspectives on his problems.

During further discussions, there was no evidence that the patient’s current treatment

was inadequate or that the psychologist could provide collateral therapy that

would be helpful. The psychologist explained this to the patient and told him that under

such circumstances, it would not be appropriate for her to see him as a regular patient.

􀀵 An individual met with a psychologist to discuss joining one of the psychologist’s

therapy groups. The client was currently in individual psychotherapy with another

practitioner and informed the psychologist that her current therapist suggested that

concurrent participation in group therapy might be helpful in addressing some of the

social anxiety issues they had been discussing in treatment. The psychologist

explained the differences in goals and modalities of group and single therapy and

received written authorization from the client to discuss the treatment recommendation

with her current therapist. After a conversation with the current therapist, the

psychologist agreed that the client could be further helped through participation in

group therapy.

In addition to careful consideration of the treatment issues and client/patient

harm, under Standard 10.04, psychologists should take steps to minimize the risk

that providing therapy to an individual already receiving mental health services

will lead to confusion and conflicts that could jeopardize client/patient welfare.

Such steps include discussing with the client/patient or his or her legally authorized

representative the potential consequences of entering into a second therapeutic

relationship and obtaining authorization from the client/patient to consult

with the other service provider about the appropriateness and effectiveness of

conjoint services.

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Because conflicts and issues associated with providing therapy to those served

by others may continue to emerge over the course of treatment, Standard 10.04

also requires that psychologists who decide to offer such services continue to

monitor and proceed cautiously and sensitively in response to therapeutic issues

that may arise.

**10.05 Sexual Intimacies With**

**Current Therapy Clients/Patients**

Psychologists do not engage in sexual intimacies with current therapy clients/patients.

Sexual intimacies of any kind with a current therapy client/patient are harmful

and prohibited by Standard 10.05. Sexual intimacies are broadly interpreted and

include fondling, intercourse, kissing, masturbation in front of a client, telephone

sex, touching of genitals, erotic hugging, verbal invitations to engage in sexual relationships,

or communications (in person or via electronic transmission) intended

to erotically arouse the patient. The ethical obligation to avoid sexual intimacies

with clients/patients lies solely with the therapist, not with the client/patient. Any

sexual intimacy between psychologists and clients/patients represents a violation of

this standard regardless of whether clients/patients initiated sexual contact or voluntarily

or involuntarily responded to therapists’ overtures.

Sexual intimacies with current clients/patients exploit the explicit power differential

and influence that psychologists have over those they treat in therapy and the

vulnerabilities that led clients/patients to treatment in the first place. Sexual intimacies

further harm clients/patients by impairing the provider’s ability to objectively

evaluate treatment issues and the client’s/patient’s ability to trust and respond to

the psychologist in his or her professional role. In many cases, therapist–client sex

exacerbates the client’s/patient’s symptoms or leads to more serious mental disorders

(Sonne & Pope, 1991).

Nonsexual physical contact with clients/patients such as handshakes or nonerotic

hugging is not a violation of Standard 10.05. However, the nonerotic intentions of

a therapist are often misperceived as sexualized by clients/patients. In addition,

research indicates that for some psychologists, such seemingly minor blurring of

boundaries as hugs, self-disclosures, or meetings outside the therapist’s office are

often precursors of sexual misconduct (Lamb & Catanzaro, 1998; see also the section

on unforeseen potentially harmful multiple relationships in Chapter 6 under

Standard 3.04b, Multiple Relationships).

**10.06 Sexual Intimacies With Relatives**

**or Significant Others of Current Therapy Clients/Patients**

Psychologists do not engage in sexual intimacies with individuals they know to be close relatives,

guardians, or significant others of current clients/patients. Psychologists do not terminate therapy

to circumvent this standard.

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Engaging in sexual intimacies with another person who is related to or in a significant

relationship with a current client/patient is prohibited. Sexual intimacies

with such persons harm the client/patient by impairing the psychologist’s treatment

objectivity, blurring the therapist–client roles and relationships, and risking

exploitation of the client/patient to attain or maintain a sexual relationship with a

third party. This standard applies to a client’s/patient’s parents, siblings, children,

legal guardians, and significant others. It may also apply to other relatives if they are

emotionally or otherwise close to the client/patient. The phrase “they know to be”

applies to the rare instance when psychologists are unaware that someone they are

seeing romantically is a close relative, guardian, or significant other of a current

client/patient. Standard 10.06 also prohibits psychologists from terminating therapy

to circumvent the prohibition.

􀀴 A psychologist began dating the mother of a child who was currently in therapy with

the psychologist.

􀀴 A psychologist terminated marriage therapy with a couple with the intent to begin a

sexual relationship with one of the spouses.

**10.07 Therapy With Former Sexual Partners**

Psychologists do not accept as therapy clients/patients persons with whom they have engaged in

sexual intimacies.

Under Standard 10.07, psychologists are prohibited from providing therapy to

former sexual partners. Conducting therapy with individuals with whom psychologists

have had a previous sexual relationship risks compromising the effectiveness

of professional services. The knowledge gained about the individual from former

sexual relationships and romantic and sexualized feelings that may reemerge during

therapy can impair the psychologist’s ability to objectively evaluate the client’s/

patient’s treatment needs and response to treatment. In addition, intimate and

personal knowledge about the psychologist that the client/patient gained during

the former relationship can create role confusion and interfere with the client’s/

patient’s ability to benefit from the psychologist’s professional communications.

􀀴 A psychologist received a call from a man with whom she had a sexual relationship

during college. The man asked if he could see her professionally to discuss some serious

problems that had recently arisen in his life. The psychologist told him that she did

not think it was a good idea for her to see him professionally because they had been

in a previous personal relationship. The man started crying and told the psychologist

that he had just moved to the town in which the psychologist practices and she was

the only person he could trust with his problems. The psychologist agreed to see him

for just one session.

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**10.08 Sexual Intimacies With**

**Former Therapy Clients/Patients**

(a) Psychologists do not engage in sexual intimacies with former clients/patients for at least two

years after cessation or termination of therapy.

Standard 10.08a prohibits psychologists from engaging in sexual intimacies for at

least 2 years after the therapy has ended. Posttherapy sexual relationships can be

harmful to clients/patients in many ways, including (a) depriving former clients/

patients of future services with a practitioner who is familiar with their mental history

and with whom they had a good therapeutic rapport, (b) threatening client/

patient privilege when the blurring of personal and professional boundaries allows

the court to require a psychologist to testify about the former client/patient in his or

her personal role, (c) compromising the credibility of previous professional reports

written by the psychologist about the client/patient and jeopardizing the credibility

of court testimony that may be needed regarding the client’s/patient’s past mental

status, and (d) client/patient exploitation and psychological deterioration.

**Two-Year Moratorium**

Under Standard 10.08a, any sexual intimacies with a former client/patient

within 2 years following the last professional contact are an ethical violation. The

standard has a 2-year moratorium period rather than a permanent prohibition

against sex with former clients/patients because most complaints involving sexual

intimacies with former clients/patients received by the APA Ethics Committee and

licensing boards pertain to relationships that began during the first year following

the cessation of therapy, and complaints about relationships that began 2 years

posttherapy are infrequent. However, as discussed below under Standard 10.08b,

such behavior is not unconditionally acceptable after 2 years.

􀀴 A year after therapy ended, a traumatic event in a former patient’s life created a need

for additional treatment. The patient had begun a sexual relationship with his psychologist

a few months following termination of treatment and thus could not reenter

therapy with the psychologist. The former patient, fearful that another psychologist

would be critical of his relationship with his former therapist, chose not to seek

needed treatment.

􀀴 A year after therapy terminated, a client entered into a sexual extramarital relationship

with her former therapist and continued to discuss her mental health problems

in this nonprofessional relationship. During this period, her husband sued her for

divorce, naming the therapist as his wife’s extramarital partner. The former client

wanted to exert her privilege to keep her mental status and thus her involvement in

therapy confidential. Due to the blurring of personal and professional boundaries, the

judge issued a court order to call the psychologist as a witness.

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(b) Psychologists do not engage in sexual intimacies with former clients/patients even after a

two-year interval except in the most unusual circumstances. Psychologists who engage in such

activity after the two years following cessation or termination of therapy and of having no sexual

contact with the former client/patient bear the burden of demonstrating that there has been no

exploitation, in light of all relevant factors, including (1) the amount of time that has passed since

therapy terminated; (2) the nature, duration, and intensity of the therapy; (3) the circumstances

of termination; (4) the client’s/patient’s personal history; (5) the client’s/patient’s current mental

status; (6) the likelihood of adverse impact on the client/patient; and (7) any statements or actions

made by the therapist during the course of therapy suggesting or inviting the possibility of a

posttermination sexual or romantic relationship with the client/patient. (See also Standard 3.05,

Multiple Relationships.)

Standard 10.08a prohibits psychologists from engaging in a sexual relationship

with a former client/patient for at least 2 years following the termination of therapy.

However, sexual intimacies with former clients/patients even 2 years following the

cessation of therapy can result in exploitation and harm. If an ethics complaint is

made against the psychologist regarding a 2-year posttermination sexual relationship,

Standard 10.08b places the ethical burden on the psychologist to demonstrate

that the sexual relationship is not exploitative. The standard describes seven relevant

factors that could be applied to determine such exploitation. These factors are

listed along with examples of how they might be applied to a finding of violation

of this standard for a psychologist who engaged in sexual relationships with a former

client/patient after the 2-year period:

1. *The amount of time that has passed since therapy terminated.* Following the

termination of therapy, the psychologist frequently met a former client/

patient for lunch. A sexual relationship was initiated immediately following

the 24-month period.

2. *The nature, duration, and intensity of the therapy.* The client/patient was seen

by the psychologist three times a week for several years in intensive psychodynamic

psychotherapy.

􀀴 A psychologist began a sexual relationship with a former patient soon after therapy

was terminated. Several months later, the former patient was injured on the job, and

his attorney advised him to pursue a disability insurance claim for mental distress

created by the accident. The patient needed the psychologist to testify regarding his

mental status prior to the injury. However, the psychologist–client sexual relationship

compromised the psychologist’s ability to provide or appear to provide objective

information to the court.

􀀴 A client with a history of child sexual abuse had transferred to the psychologist the

feelings of both powerlessness and eroticism that she felt for her childhood abuser.

The psychologist took advantage of these feelings and told the client that she could

overcome the mental health consequences of this early trauma by terminating therapy

and becoming his lover. The patient agreed to end therapy. A few weeks into the posttherapy

sexual relationship with the psychologist, her depression escalated and she

attempted suicide.

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3. *The circumstances of termination.* The client/patient abruptly stopped coming

to therapy after expressing strong erotic fantasies for the psychologist.

4. *The client’s/patient’s personal history.* During the therapy, the client/patient

had been diagnosed with bipolar disorder marked by periods of mania

involving promiscuous and high-risk sexual activity.

5. *The client’s/patient’s current mental status.* When the posttermination sexual

relationship with the psychologist began, the patient was being treated by

another psychologist for major depression.

6. *The likelihood of adverse impact on the client/patient.* Based on a sexual abuse

family history, borderline diagnosis, and current major depression, it was

reasonable to assume that a client/patient would be extremely vulnerable to

reexperiencing some of the early trauma if engaged in a sexual relationship

with his or her former therapist whom he or she perceived as a powerful

parent figure.

7. *Any statements or actions made by the therapist during the course of therapy*

*suggesting or inviting the possibility of a posttermination sexual or romantic*

*relationship with the client/patient.* The psychologist had a habit of hugging

the client/patient at the end of each therapy session.

**10.09 Interruption of Therapy**

When entering into employment or contractual relationships, psychologists make reasonable

efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in

the event that the employment or contractual relationship ends, with paramount consideration

given to the welfare of the client/patient. (See also Standard 3.12, Interruption of Psychological

Services.)

This standard applies to ethical obligations of psychologists at the time they

enter into employment or contractual agreements with other providers, group

practices, managed care providers, institutions, or agencies. Employment or contractual

agreements can end when psychologists have a time-limited contract or

employment period, when they elect to leave for professional or personal reasons,

or when the employer or company terminates their position or contract. Under

Standard 10.09, psychologists must make reasonable efforts to ensure at the outset

that the employment agreement or contract provides for orderly and appropriate

resolution of responsibility in the event that the employment or contractual

arrangement ends (Principle B: Fidelity and Responsibility).

Psychologists can comply with Standard 10.09 by determining through preemployment

discussions whether the organization, group practice, or other entity in

which a work arrangement is being considered has policies designed to ensure continuity

of care when a practitioner can no longer provide services. If no such policies

exist, psychologists can help develop such policies or include in their employment or

contractual agreements permission to resolve treatment responsibility appropriately

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in the event their employment or contract ends (see Standard 1.03, Conflicts

Between Ethics and Organizational Demands). Steps the psychologist can recommend

be taken to protect client/patient welfare when treatment can no longer be

provided by the psychologist include providing pretermination counseling and

referrals, supervising appropriate transfer and storage of client/patient records, assisting

in the transition of the client/patient to a new treatment provider if clinically

indicated, or continuing treatment with the client/patient in a different venue. The

phrase “make reasonable efforts” recognizes that in some situations, despite a psychologist’s

efforts, employers, organizations, group practices, or other providers will

refuse to promise or follow through on promises to protect client/patient welfare

through an orderly and appropriate resolution of care when there is a change in staff.

􀀵 A school psychologist was hired on a 9-month (October through June) contract to

provide counseling services for grade school students who had lost parents in the

September 11, 2001, attack on the World Trade Center. It was reasonable to assume

that some children might need continued care during the summer. The school psychologist

raised this issue when asked to take the position. The school superintendent

responded that such services were not available through the schools during the summer.

The psychologist worked with the superintendent to develop an agreement with

a social services agency to provide treatment for students who needed continued care

over the summer. The superintendent also agreed to set up a system that facilitated

the appropriate transfer of student records to the social service agency. The psychologist

also laid out a plan for identifying children who would need summer services and

for informing their guardians about the availability of such services.

Standard 10.09 does not prohibit psychologists from signing a noncompete

clause barring the psychologist from continuing to see specific clients/patients after

the employment or contractual agreement has ended as long as other provisions for

protecting client/patient welfare are in place.

**10.10 Terminating Therapy**

(a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no

longer needs the service, is not likely to benefit, or is being harmed by continued service.

Psychologists are committed to improving the condition of individuals with

whom they work and to do no harm (Preamble; Principle A: Beneficence and

Nonmaleficence). In some instances, continued therapy with a client/patient may

be nonbeneficial or harmful. Standard 10.10a requires psychologists to terminate

therapy under three conditions that either fail to benefit clients/patients or could

be harmful if therapy is continued. Although the need to continue or terminate a

therapeutic relationship requires professional judgment based on knowledge of the

specific treatment context, the phrase “reasonably clear” in this standard indicates

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**The Client/Patient Is Not Likely to Benefit**

Psychologists must also terminate therapy when the client/patient is not likely to

benefit from the treatment. This criterion applies when, during the course of

therapy, it becomes reasonably clear that the client/patient is not responding to

treatment, a newly uncovered aspect of the client’s/patient’s disorder is not amenable

that it is ethically inappropriate for a psychologist to continue therapy under conditions

in which most psychologists engaged in similar activities in similar circumstances

would judge it unnecessary, nonbeneficial, or harmful.

**Services Are No Longer Needed**

Psychologists who continue to see clients/patients professionally after they no

longer need mental health services are in violation of this standard. The need for

continued services depends on the nature of the client’s/patient’s disorder and the

goals of treatment as identified during the initial informed consent and throughout

the therapeutic process. Psychologists who continue to treat clients/patients when

the problems associated with entering treatment have been adequately addressed

violate this standard. The standard does not prohibit psychologists and clients/

patients from reevaluating treatment needs and continuing in a therapeutic relationship

to address additional mental health needs. However, failure to reevaluate the

need for continued therapy after treatment goals are met would violate the standard.

Psychologists who continue to see clients/patients solely to fulfill the psychologists’

own training requirements or for financial gain violate this standard and also risk

violating Standards 3.06, Conflict of Interest, and 3.08, Exploitative Relationships.

Psychologists who continue to bill a third-party payor for mental health services

when the services are no longer required place themselves at risk for accusations of

insurance fraud and are in potential violation of Standards 6.04b, Fees and Financial

Arrangements, and 6.06, Accuracy in Reports to Payors and Funding Sources.

􀀴 A licensed psychologist in independent practice had sought additional training at a

prestigious postgraduate psychotherapy institute. The institute required a certain

number of hours of supervision with clients with specific disorders to obtain a certificate

of completion. The psychologist had 8 more hours of supervision for treatment of

anxiety disorders to complete before he could qualify for the certificate. The client who

met the diagnostic criteria for supervision had been doing very well in treatment. She

had resolved most of the problems at work and at home that had brought her to

therapy and viewed terminating treatment with eagerness and a sense of pride. She

asked the therapist whether they could have one final session to complete the therapy.

The psychologist told her that although she had been doing well, there were a

few unresolved issues that would take about eight more sessions to address adequately.

The client reluctantly agreed.

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to the type of treatment modality in which the psychologist has been trained (see

also Standard 2.01a, Boundaries of Competence), or a client/patient is unwilling or

unable to comply with treatment (e.g., when a client/patient continuously refuses

to follow the terms of a behavioral contract).

􀀵 A counseling psychologist had been seeing a client for career counseling who was

recently fired from a management position that he had held for 10 years. The client

was angry and believed that the termination was undeserved. After three sessions, the

psychologist determined that there was a clinically paranoid feature to the client’s

distress and that more intensive psychotherapy was needed before career counseling

could be beneficial. The psychologist discussed her concerns with the client and

referred him to another practitioner who worked with more seriously disturbed clients.

The psychologist also informed the client that her services would be available to him

when he was ready to resume career counseling.

**The Client/Patient Is Being**

**Harmed by Continued Service**

Psychologists are prohibited from continuing therapy if it is reasonably clear

that the client/patient is being harmed by the treatment (Principle A, Beneficence

and Nonmalfeasance; Standard 3.04, Avoiding Harm). For example, in some

instances, clients/patients may unexpectedly react to a specific treatment modality

with major depression, a psychotic episode, or an exacerbation of impulsive or

addictive behaviors that do not respond to continued efforts by the psychologist.

The phrase “reasonably clear” indicates that the criteria for determining whether a

client/patient is being harmed by continued services are determined by what would

be the prevailing judgment of psychologists engaged in similar activities in similar

circumstances, given the knowledge the psychologist had or should have had at the

time. Psychologists who find that a client’s/patient’s mental health is deteriorating

may find it helpful therefore to consult with colleagues regarding whether services

should be continued. When it is appropriate to terminate, patients should be

referred to alternative treatments that may be more effective.

􀀵 A psychologist was providing psychoanalytic therapy to a patient with narcissistic

personality disorder. The treatment appeared to be going well until the patient began

to discuss in detail a traumatic rape experience that occurred when she was a young

adult. In the weeks that followed, the patient kept putting herself in dangerous situations

that appeared to be reenactments of the earlier event. She was engaging in

sexual relationships with men she barely knew, having unprotected sex, and frequenting

dangerous areas of the city. In therapy during the next 5 weeks, the psychologist

continued to explore with the patient her feelings and behaviors associated with the

initial trauma. Instead of abating the risky behavior, each session appeared to lead to

more extreme behaviors. The psychologist was concerned that the patient might again

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(b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/

patient or another person with whom the client/patient has a relationship.

Standard 10.10b permits psychologists to terminate therapy abruptly if they are

threatened or endangered by a client/patient or another person with whom the client/

patient has a relationship such as a family member, significant other, friend, employer,

or employee. Such situations can include verbal or physical threats or any other evidence

that the psychologist is endangered. In such situations, neither advance notification

be raped, assaulted, or contract HIV and consulted with several colleagues regarding

continuation of services. On the basis of these consultations, he concluded that continuing

the therapy would be harmful to this patient and that she might benefit from

a different therapeutic approach. He discussed this with the patient over several sessions

and referred her to a group practice specializing in treatments for rape trauma.

**Need to Know:**

**Abandonment Considerations**

Although neither the APA Ethics Code nor case law defines termination of mental health

services as “abandonment” the terms are often confused by the public and psychologists

alike. Termination based on reasonable professional judgment and proper pretermination

counseling is not abandonment. Abandonment occurs when a client/patient in imminent

need of treatment is harmed by termination of services in the absence of a clinically and

ethically appropriate process (Younggren, Fisher, Foote, & Hjelt, 2011; Younggren & Gottlieb,

2008; Standard 3.04, Avoiding Harm). Conducting appropriate terminations requires keeping

up-to-date with the empirical and professional literature and consulting colleagues

when necessary (Standards 2.03, Maintaining Competence, and 2.04, Bases for Scientific

and Professional Judgment). D. D. Davis and Younggren (2009) suggest the following additional

steps to foster appropriate and client–therapist collaborative terminations:

Develop plans for termination at the outset of psychotherapy and include a discussion

of factors influencing the length of treatment during informed consent.

Continuously evaluate client/patient progress.

Review ethical and legal duties.

Develop a well-conceptualized rationale for termination based on clinical, relational,

and situational factors and consult with client/patient on these factors when

clinically feasible.

Construct a timeline for termination and be responsive to client/patient responses.

Create a record documenting key components of the termination rationale and process.

Clinicians should also proceed cautiously when considering persistence in contacting a

client/patient who abruptly drops out of treatment. To avoid the necessity for potentially

intrusive follow-up letters or other contacts, psychologists should consider inclusion

during informed consent of the psychologist’s policies for client/patient nonattendance

(D. D. Davis & Younggren, 2009).

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of termination nor pretermination counseling as described in Standard 10.10c is

required. Psychologists may also request a protective order against clients/patients or

others whom they suspect will threaten or harm them. Prohibitions against revealing

confidential information do not apply when psychologists must call on authorities or

others to protect them from threats or harm (see Standard 4.05b, Disclosures).

(c) Except where precluded by the actions of clients/patients or third-party payors, prior to termination

psychologists provide pretermination counseling and suggest alternative service providers

as appropriate.

Termination based on reasonable professional judgment and proper pretermination

counseling is ethically appropriate. In addition to the situations described

in Standard 10.10a and b above, ethically permissible and professionally appropriate

reasons to end a therapeutic relationship include the following: (a) an organized

system of health or managed care company rejects a psychologist’s

recommendations for additional therapy sessions; (b) an unforeseen potentially

harmful multiple relationship arises (Standards 3.05b, Multiple Relationships, and

10.02b, Therapy Involving Couples or Families); (c) a client/patient repeatedly

refuses to pay for services (Standard 6.04e, Fees and Financial Arrangements);

(d) a psychologist becomes ill or finds therapy with a particular client/patient stressful

in a manner that risks compromising professional services (Standard 2.06b,

Personal Problems and Conflicts); (e) during the course of therapy, unexpected treatment

needs arise that are outside the psychologist’s area of expertise (Standard 2.01,

Boundaries of Competence); or (f) the psychologist is relocating or retiring.

Under Standard 10.10c, psychologists must provide pretermination counseling

prior to ending a therapeutic relationship. Pretermination counseling includes

(a) providing clients/patients sufficient advance notice of termination (when

possible), (b) discussing with the client/patient the reasons for the termination,

(c) encouraging the client/patient to ask questions regarding termination, and

(d) providing referrals to alternate service providers when appropriate. Psychologists

need to plan for pretermination counseling for group as well as individual therapies

(D. D. Davis & Younggren, 2009; Mangione, Forti, & Iacuzzi, 2007). Psychologists

are not in violation of this standard if pretermination counseling is precluded by

client/patient or third-party payor actions. For example, parents may abruptly end

their child’s therapy, making further contact with the child inappropriate or unfeasible;

health plans may prohibit or place restrictions on provider referrals.

**HMO**

􀀵 A psychotherapy patient changed to a health plan that she later realized would not

reimburse her current psychologist’s services. She told the psychologist that she would

not be able to come to any more sessions because she could not afford to pay for

therapy out of pocket and thus would be continuing services with a provider covered

by her new health plan. The psychologist discussed the patient’s concerns about leaving

therapy. The patient appeared ready to terminate the relationship. The psychologist

told her that he was not familiar with any of her new health plan’s approved providers

but, with her written authorization, would be willing to speak with her new therapist

if the need arose.

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􀀵 A psychologist in independent practice accepted a job offer from a treatment center

in another state. The psychologist agreed to start the new position in 4 weeks. At their

next sessions, the psychologist told each of her clients that she would be relocating

at the end of the month and that they would have time to discuss over the next few

weeks their feelings about terminating therapy and their plans for the future. At each

of the remaining sessions, she encouraged clients to discuss any concerns they might

have about the termination. The psychologist provided appropriate referrals to those

who wished to continue in therapy with another professional. She told the other clients

how to contact her if they wished a referral in the future. One client had serious

difficulty adjusting to the termination. The psychologist offered to have phone sessions

with this client until a suitable referral could be found.

􀀵 A patient who recently lost his job had not paid his last two monthly bills for psychotherapy.

The psychologist had discussed the issue of nonpayment with the patient

several times during the past month. Neither a reduced fee nor payment plan was

economically feasible for the patient. The psychologist told the patient that she

would not be able to continue to see him pro bono indefinitely and that they would

have two more sessions to discuss any questions he might have and his plans for the

future. She also provided the patient with a list of several free clinics in the area that

offered therapy.

**HOT TOPIC**

Ethical Issues for the Integration of

Religion and Spirituality in Therapy

The past decade has witnessed increased attention to the importance of understanding and respecting client/

patient spirituality and religiosity to psychological assessment and treatment, as well as recognition that religious

and spiritual factors remain underexamined in research and practice (APA, 2007d). Advances in addressing

the clinical relevance of faith in the lives of clients/patients have raised new ethical dilemmas rooted in

theoretical models of personality historically isolated from client/patient faith beliefs, the paucity of research

on the clinical benefits or harms of injecting faith concepts into treatment practices, group differences in religious

practices and values, and individual differences in the salience of religion to mental health (Shafranske &

Sperry, 2005; Tan, 2003).

**The Secular–Theistic Therapy Continuum**

Integration of religion/spirituality in therapy can be characterized on a secular–theistic continuum. Toward the

secular end of the continuum are “religiously sensitive therapies” that blend traditional treatment approaches

with sensitivity to the relationship of diverse religious/spiritual beliefs and behaviors to mental health. Midway

on the continuum are “religiously accommodative therapies” that do not promote faith beliefs but, when

clinically relevant, use religious/spiritual language and interventions consistent with clients’/patients’ faith

values to foster mental health. Toward the other end of the continuum are “theistic therapies” that draw on

psychologists’ own religious beliefs and use sacred texts and techniques (prayer, forgiveness, and meditation)

to promote spiritual health.

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The sections that follow highlight ethical challenges that emerge along all points of the secular–theistic

therapy continuum.

**Competence**

All psychologists should have the training and experience necessary to identify when a mental health problem

is related to or grounded in religious beliefs (Standards 2.01b, Boundaries of Competence, and 2.03,

Maintaining Competence; see also Bartoli, 2007; W. B. Johnson, 2004; Plante, 2007; Raiya & Pargament, 2010;

Yarhouse & Tan, 2005). Personal faith and religious experience are neither sufficient nor necessary for competence

(Gonsiorek, Richards, Pargament, & McMinn, 2009). There is no substitute for familiarity with the foundational

empirical and professional mental health knowledge base and treatment techniques. While personal

familiarity with a client’s/patient’s religious affiliation can be informative, religious/spiritual therapeutic competencies

for mental health treatment include

understanding how religion presents itself in mental health and psychopathology;

self-awareness of religious bias that may impair therapeutic effectiveness, including awareness that

being a member of a faith tradition is not evidence of expertise in the integration of religion/spirituality

into mental health treatment;

techniques to assess and treat clinically relevant religious/spiritual beliefs and emotional reactions; and

knowledge of data on mental health effectiveness of religious imagery, prayer, or other religious

techniques.

*Collaboration With Clergy.* Collaborations with clergy can help inform psychologists about the origins

of the client’s beliefs, demonstrate respect for the client’s religion, and avoid trespassing into theological

domains by increasing the probability that a client’s incorrect religious interpretations will be addressed appropriately

within his or her faith community (W. B. Johnson, Redley, & Nielson, 2000; Richards & Bergin, 2005;

Standard 3.09, Cooperation With Other Professionals). When cooperation with clergy will be clinically helpful

to a client/patient, psychologists should

obtain written permission/authorization from the client/patient to speak with a specific identified member

of the clergy,

share only information needed for both to be of optimal assistance to the client/patient (Standard 4.04,

Minimizing Intrusions on Privacy),

discuss with the clergy where roles might overlap (e.g., family counseling, sexual issues), and

determine ways in which the client/patient can get the best assistance.

**Avoiding Secular–Theistic Bias**

Psychologists must ensure that their professional and personal biases do not interfere with the provision of

appropriate and effective mental health services for persons of diverse religious beliefs (Principle D: Justice and

Principle E: Respect for People’s Rights and Dignity; Standards 2.06, Personal Problems and Conflicts, and

3.01, Unfair Discrimination).

*Disputation or Unquestioned Acceptance of Client/Patient Faith Beliefs.* Trivializing or disputing

religious values and beliefs can undermine the goals of therapy by threatening those aspects of life that some

clients/patients hold sacred, that provide supportive family and community connections, and that form an

integral part of their identity (Pargament, Murray-Swank, Magyar, & Ano, 2005; Standard 3.04, Avoiding Harm).

Similarly, some religious coping styles can be deleterious to client/patient mental health (Sood, Fisher, &

Sulmasy, 2006), and uncritical acceptance of theistic beliefs, when they indicate misunderstandings or distortions

of religious teachings and values, can undercut treatment goals by reinforcing maladaptive ways of

thinking or by ignoring signs of psychopathology. In addition, psychologists should not assume that religious

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or spiritual beliefs are static and be prepared to help clients/patients identify changes reflecting spiritual maturity

positively tied to treatment goals (Knapp, Lemoncelli, & VandeCreek, 2010). To identify if clients’/patients’

religious beliefs are having a deleterious effect on their mental health, psychologists should explore whether

their beliefs (a) create or exacerbate clinical distress, (b) provide a way to avoid reality and responsibility,

(c) lead to self-destructive behavior, or (d) create false expectations of God (W. B. Johnson et al., 2000). When

appropriate, psychologists should consider consulting with clergy to determine if a clients’/patients’ religious

beliefs are distortions or misconceptions of religious doctrine.

**Imposing Religious Values**

Using the therapist’s authority to indoctrinate clients/patients to the psychologists’ religious beliefs violates

their value autonomy and exploits their vulnerability to coercion (Principle E: Respect for People’s Rights and

Dignity; Standard 3.08, Exploitative Relationships). When clients/patients are grappling with decisions in areas

in which religious and secular moral perspectives may conflict (e.g., divorce, sexual orientation, abortion,

acceptance of transfusions, end-of-life decisions), therapy needs to distinguish between those religious values

that have positive or destructive influences on each individual client’s/patient’s mental health—not the religious

or secular values of the psychologist. Professional license to practice psychology demands that psychologists

provide competent professional services and does not give them license to preach (Plante, 2007).

Psychologists should guard against discussing religious doctrine when it is irrelevant to the clients’/patients’

mental health needs (Richards & Bergin, 2005).

*Confusing Religious Values With Psychological Diagnoses.* The revised *Guidelines for Psychological*

*Practice With Lesbian, Gay and Bisexual Clients* (APA, 2012d) encourages psychologists to consider the

influences of religion and spirituality in the lives of lesbian, gay, and bisexual specifically and transgender and

questioning clients in general. The linking of religious values and psychotherapies involving LGBT clients/

patients has drawn a considerable amount of public attention. Spiritually sensitive, accommodative, and theistic

therapies have a lot to offer LGBT clients/patients (Lease, Horne, & Noffsinger-Frazier, 2005). LGBT persons

vary in their religious backgrounds and the extent to which it affects their psychological well-being. Ethical

problems arise, however, when psychologists confuse a client’s/patient’s conflicted feelings about their sexual

orientation and religious values with psychological diagnoses. Such ethical challenges have raised considerable

professional dialogue as they relate to the application of conversion therapies to alter sexual orientation.

All major professional mental health organizations have affirmed that homosexuality is not a mental disorder

(www.apa.org/pi/lgbc/publications/justthefacts.html#2). In addition, to date, empirical data dispute the effectiveness

of conversion/reparative therapies aimed at changing sexual orientation (www.Psychology.org.au/Assets/

Files/reparative\_therapy.pdf). Psychologists who offer such therapies to LGBT clients/patients risk violating

Standard 2.04, Bases for Scientific and Professional Judgments. Moreover, when psychologists offer “cures” for

homosexuality, they falsely imply that there is established knowledge in the profession that LGBT sexual orientation

is a mental disorder. This, in turn, may deprive clients/patients of exploring internalized reactions to a hostile

society and risks perpetuating societal prejudices and stereotypes (Cramer, Golom, LoPresto, & Kirkley, 2008;

Haldeman, 1994, 2004; Principle A: Beneficence and Nonmaleficence; Principle B: Fidelity and Responsibility; and

Principle D: Justice; Standard 3.04, Avoiding Harm). In addition, when psychologists base their diagnosis

and treatment on religious doctrines that view homosexual behavior as a “sin,” they can be in violation of

Standard 9.01, Bases for Assessments, and may be practicing outside the boundaries of their profession.

**Multiple Relationships**

Multiple relationship challenges arise when clergy who have doctoral degrees in psychology provide mental

health services to congregants or nonclergy psychologists who treat members of their faith communities

(Standard 3.05, Multiple Relationships).

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*Clergy–Psychologists.* Clergy–psychologists providing therapy for members of their faith over whom they

may have ecclesiastical authority should take steps to ensure they and their clients/patients are both aware of

and respect the boundaries between their roles as a psychologist and as a religious leader. Distinguishing role

functions becomes particularly important in addressing issues of confidentiality. Psychologists and clergy have

different legal and professional obligations when it comes to mandated reporting of abuse and ethically permitted

disclosures of information to protect clients/patients and others from harm (Standard 4.05, Disclosures).

Therapists at all points along the secular–theistic continuum who share the faith beliefs of clients/patients

or work with fellow congregants must take steps to ensure that clients do not misperceive them as having

religious or ecclesiastical authority and understand that the psychologists do not act on behalf of the church

or its leaders (Gubi, 2001; Richards & Potts, 1995). This may be especially challenging for nonclergy religious

psychologists working in faith-based environments (Sanders, Swenson, & Schneller, 2011). Psychologists also

need to take steps to ensure that their knowledge of their joint faith community does not interfere with their

objectivity and that clients/patients feel safe disclosing and exploring concerns about religion or behaviors that

might ostracize them from this community.

*Fee-for-Service Quandaries.* While psychologists can discuss spiritual issues in therapy, when services

are provided as a licensed psychologist eligible for third-party payments, the primary focus must be

psychological (Plante, 2007). A focus on religious/spiritual rather than therapeutic goals may risk inappropriately

charging third-party payors for nonmental health services not covered by insurance policies

(Tan, 2003; see also Principle C: Integrity; Standard 6.04, Fees and Financial Arrangements). Clergy and

nonclergy psychologists practicing theistic therapies may find it difficult to clearly differentiate in reports

to third-party payors those goals and therapeutic techniques that are accepted mental health practices

and those that are spiritually based. In most instances clergy–psychologists should encourage their congregants

to seek mental health services from other providers in the community and refrain from encouraging

their congregants to see them for fee-for-service therapy (Standard 3.06, Conflict of Interest). When

clergy or nonclergy psychologists provide spiritual counseling free of charge in religious settings, they

should clarify they are counseling in their ecclesiastical role and that content will be specific to pastoral

issues (Richards & Bergin, 2005).

**Informed Consent**

The role of religion/spirituality in clients’/patients’ worldview may determine their willingness to participate in

therapies along the secular–theistic continuum. Some may find the interjection of religion into therapy discomforting

or coercive, while others may find the absence of religion from therapy alienating.

When scientific or professional knowledge indicate that discussion of religion may be essential for effective

treatment (Standards 2.01b, Boundaries of Competence; 2.04, Bases for Scientific and Professional Judgments),

informed consent discussions can help the client/patient and psychologist identify and limit for treatment those

religious beliefs and practices that facilitate or interfere with treatment goals (Rosenfeld, 2011; Shumway &

Waldo, 2012). In some contexts, it may be ethically appropriate to discuss the risks involved in exploration of

the client’s religious beliefs, including loss of current coping mechanisms, stress produced by self-questioning

of religious beliefs, and diminished capacity to seek support from one’s religious community (Rosenfeld, 2011).

The goal of such discussions is to enhance the therapeutic alliance and treatment context through client–

therapist mutual understanding and respect.

When treatments diverge from established psychological practice, clients/patients have a right to consider

this information in their consent decisions. Consequently, informed consent for theistic therapies should

explain the religious doctrine and values upon which their treatment is based, the religious methods that will

be employed (e.g., prayers, reading of scripture, forgiveness), and the relative emphasis on spiritual versus

mental health goals. In addition, since theistic therapies are relatively new and currently lack empirical

evidence or disciplinary consensus regarding their use (Plante & Sherman, 2001; Richards & Bergin, 2005),

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psychologists practicing these therapies should consider whether informed consent requirements for “treatments

for which generally recognized techniques and procedures have not been established,” described in

Standard 10.01b, apply.

**Conclusion**

There is a welcome increase in research examining the positive and negative influences of religious beliefs and

practices on mental health and the clinical outcomes of treatment approaches along the secular–theistic

therapy continuum. Ethical commitment to do what is right for each client/patient and well-informed

approaches to treatment will reduce, but not eliminate, ethical challenges that will continue to emerge as

scientific and professional knowledge advances. Psychologists conducting psychotherapy with individuals of

diverse religious backgrounds and values will need to keep abreast of new knowledge and ethical guidelines

that will emerge, continuously monitor the consequences of spirituality and religiously sensitive treatment

decisions on client/patient well-being, and have the flexibility and sensitivity to religious contexts, role responsibilities,

and client/patient expectations required for effective ethical decision making.