Ethics Series

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ETHICS SERIES

by Genie Skypek, PhD

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ARE YOU BEING ETHICAL WHEN YOU USE THE TERM PATIENT COMPLIANCE?

An intriguing question – asked back in 1992 by William G. Bartholome, M.D.* in an article addressing the history of the role of ethics in transforming health care decision making. He says

> that use of the term, "patient compliance", reflects a profound misunderstanding about and disrespect for the essential role of the patient in decision-making. The era of the "provider knows best" (also known as Marcus Welby, MD) has ended. Science is not "value-free". Scientific decisions, including health care decisions, incorporate or assume the existence of values and reflect commitments to values. Thus, for a health care decision to be "right", it must fit into and be responsive to the experienced needs – the "lived life" of an individual patient. It must be judged to be valuable and good by and for the particular patient. *He states that the history of the health care ethics movement can be characterized as the gradual triumph of autonomy over paternalism or "parentalism".*
>
> Autonomy received ultimate recognition in the Cruzan v Director decision, in which the freedom of patients to make their own health care decisions was recognized as a fundamental "liberty interest" protected by the US Constitution. The passage of the federal Patient Self-Determination Act dramatically reflects the occurrence of a revolution. This legislation requires organizations to provide adult patients with written information regarding their rights, especially their right to complete advance directives.

The role of truth or knowledge in the provider-patient relationship is a major area of gain for patients. As Dr. Bartholome describes,

> In the past the ethical approach to knowledge allowed providers to dispense knowledge like they dispensed medication. If they felt it was right for the patient, they would share it. The practice of "therapeutic lying" was accepted, that is, the practice of withholding information, even lying, if professionals thought that the truth might be harmful to patients.

> Today, however, *patients are viewed as entitled to know the truth -– the whole truth*. They are to be fully informed in order to make good choices. In most jurisdictions, they have the right to have access to all of their medical records. The most recent statement of ethical principles by the American Medical Association (1980) for the first time in its history directs physicians that it is their ethical obligation to "...deal honestly with patients and colleagues…."

Certainly, this development culminates in the patients' rights movement. According to Bartholome,

> perhaps the most fundamental right is the right to be treated as a person, the right to respect as an autonomous moral equal*, the right to be regarded as the provider's moral equal*. This followed on the heels of the evolution of the concept of informed consent. Fully embracing this concept means that health care providers see themselves as obligated to maximize the capacity of the patient to participate as a full moral agent. This obligation expands to all providers involved in a given patient's care. The new approach to ethical decision making involves most fundamentally an ability to listen carefully, a willingness to hear and respect the voices of others, a particular kind of conversation or dialogue.

While much of Dr. Bartholome's article refers to hospital and specific medical practice ethics, the history is certainly relevant to behavioral health care decision-making. Who among us hasn't used the term "patient compliance"? How many of our theories of human behavior and effective treatment contain an underlying "parentalism" to them? How hard did we fight to restrict patient access to their clinical records? How fully do we actually inform our patients of all the available alternatives for addressing their problems?

While few organizations score below substantial compliance on the Rights, Responsibilities and Ethics standards in the Joint Commission manual, further exploration of "ethics" issues or "integrity management", as it is now being called, might provide an expanded view of how you could address ethics in your organization. Obviously, once one begins to examine ethical issues, one raises many more questions than one answers. That is my intent. I hope you find it of interest.

In the next issues, we will explore ethics issues that arise in managed care, your organization's ethical stance vis a vis its staff, the community, its governing body and more.

References:

* Bartholome, William G: "A Revolution in Understanding: How Ethics Has Transformed Health Care Decision Making". *QRB: The Journal of Quality Improvement*; JCAHO, Volume18/Number 1: 6-11, January, 1992.

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HAS MANAGED CARE FORCED US TO BE MORE ETHICAL?

by Genie Skypek, Ph.D.

"Absolutely not!" would be the response of most behavioral health practitioners I know. However, consider the following questions.

1. Is it ethical to provide more care than is absolutely necessary?
2. Is it ethical to provide the more costly treatment than the less costly treatment, especially when there is no clear data to support the efficacy of one over the other?
3. Is it ethical to figure "costs" only in terms of outright expenditures or should we include "cost-benefit" analyses as part of our determination of "cost of care"? Might that produce a different definition of what is costly and what is not?
4. Is it ethical for us to argue for one form of treatment over another without those figures?
5. Is it ethical to keep a client the full length of a program's expected stay when they have achieved all their goals and objectives?
6. Is it ethical to discharge a client as "successful" when the only success they achieved was staying the full length of stay?
7. Is it ethical to NOT KNOW how effective you are? Or, is it ethical to allow "normal narcissism" to guide our judgments about whether our treatment was helpful?
8. Is it ethical to describe your treatment philosophy as one that involves (almost requires) families and then not have an active family education and/or outreach and/or treatment service? Is it ethical to say you can't do your "best" treatment without them and then to do it without them – and to not invest more energy in involving them?
9. Is it ethical to use psychological tests that are outdated or are not appropriate for the specific conditions in which they are being used – for example, which psychological tests help clinicians focus their treatments to maximum effectiveness in the shortest time possible?
10. Is it ever ethical to give no treatment? For example, is it ever the case that a given affect or set of behaviors is simply a normal response to conditions in the individual's life? Is the ethical thing to "treat" normality, to advocate for changes in the condition (if warranted) or to simply let time pass?
11. Is it ethical to doubt if a given "course of action" is the best and most prudent?
12. Is it ethical to NOT fully inform a client of all the treatment approaches to her or his problem or diagnosis? Is it ethical to only inform them of the ones you agree with, especially if there is data that supports the efficacy of the others?
13. Is it ethical to NOT know of the resources available to clients "on-line", especially if you believe it is your responsibility to know of the resources available in your town or city or area?
14. Is it ethical to NOT tell your client his or her diagnosis?
15. Is it ethical to NOT tell your client of the pressures to choose certain forms of treatment exerted by managed care organizations, state government, or other such controlling entities?
16. Is the following statement from Marlene Maheu, Ph.D. ethical:

> "Patients ought to be able to choose their mode of treatment for any identifiable disorder: medication, self-help and support groups, online e-mail interactions within discussion lists, newsgroups, distance learning classrooms or chat rooms, bibliotherapy, art therapy, psychotherapy - alone, or in combination. For example, patients can be asked whether they want to explore the existential nature of their life situation, and/or prefer to develop and implement a strategy for behavior change using face-to-face contact with a therapist, with or without online self-help through psychoeducational reading and participating in an email support group.

http://cybertowers.com/selfhelp/ppc/viewpoint/truth.html

17. In other words, is it ethical to treat patients as consumers with decision-making powers?
18. Is it ethical to tolerate unethical behavior because the state allows you to or for any other reason?

Certainly, the advent of managed care has forced us to ask some of these questions – questions that we did not ask, unfortunately, when we appeared to be more in charge of treatment choices. How many of you and/or your organizations have "grappled" with these issues as questions of ethics – as a study of "right" human conduct in providing services to behavioral health consumers?

The standards of the Joint Commission concerning ethics only require that you have a code of ethics. Further, they require that you address certain practices, such as billing and marketing practices, in that code of ethics. So, the standards themselves or the surveyor interpreters of those standards may not require the kind of in-depth self-examination implicit in an attempt to answer the above questions from an ethical perspective. Do you require that level of self-examination of yourselves? Consider your answer to my last question of the day:

19. Is ethics incidental to success or a necessary condition of it?

Resources for the above questions and further consideration of some of them can be found at the following sites:

1. Marlene Maheu, Ph.D, *Truth, Deception and Ethics of Integrating Online Services in the Land of Managed Care* http://cybertowers.com/selfhelp/ppc/viewpoint/truth.html
2. *Telehealth Net* http://telehealth.net/articles/essays.html

Other interesting sites from which to start "surfing the net" on ethics:

1. Communique The Newsletter of the Center for Ethics and Human Rights by the ANA http://www.ana.org/readroom/cmqsp97.htm
2. *Ethos System,* a software product that provides an algorithm for analyzing and solving the ethical problems that a professional encounters in their practice. http://www.taknosys.com/prod01.htm
3. The Ethics Connection http://www.scu.edu/SCU/Centers/Ethics/homepage.shtml
4. APA Monitor on Psychology, April, 2000 *Online experiments: Ethically fair or foul?* http://www.apa.org/monitor/apr00/fairorfoul.html
5. APA Monitor on Psychology, April, 2000 *How will the rules on Telehealth be written?* http://www.apa.org/monitor/apr00/telerules.html
6. *Best Practices in e-Therapy: Confidentiality and Privacy* http://psychcentral.com/best/best2.htm

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HOW DOES YOUR ORGANIZATION COMMIT TO ETHICAL PRACTICES?

by Genie Skypek, Ph.D.

As you know by now, if you've been reading my columns, I often like to raise questions more than provide answers. That's partly because I think, in dealing with issues of standards compliance, too many organizations let the standards deprive them of any creativity. When the focus is on "letter-of-the-law" compliance rather than examination of the intent and potential value of given standards to the operating practices of the organization, they become deadening. I've seen this happen in several areas – ethics is one of them. So I will continue to ask you questions, hoping to stir (if it's not already there) some excitement about addressing ethics at your organization in a way that is much "bigger" than what is "required to pass" by the Joint Commission.

In my last two columns, I summarized some of the important historical events that moved our field from "parentalism" to something more akin to "equality" in its approach to clients. I also identified some of the questions we need to be exploring as part of our commitment to ethical practice. I'd like to ask you to look now at your organization as an organization – not just as a set of clinicians.

More questions –

Staff -

- How do you educate your staff about your commitment to ethics? How frequently do you train them around ethical issues? Do you make some of the issues I mentioned in my last article ethical issues and provide a forum for discussion?
- Do you, as an organization, have copies of all the different professional Codes of Ethics that your staff must follow? Have you even reviewed them in writing your Code of Ethics? Do you review the various Codes of Ethics when faced with questions about practice – or do you just go to an attorney?
- If one discipline's ethical standards are "higher" than another, do you hold everyone in your organization to the highest standard?
- How do you track violation of ethical standards by employees? What does your Code of Ethics or Personnel Policies and Procedures say about the consequences of violation of your Code of Ethics?
- Does ethical behavior help employees advance in your organization? Is it considered as part of your Performance Evaluation?
- Are there models in your organization that are upheld as ethical leaders and examples? What are the "stories" about your organization? Is ethical behavior part of them?

Vendors –

- Do you expect vendors and suppliers to be ethical? How do you tell them this? How do you hold them to it?
- Would you pay more to buy quality products from an "ethical" source?

Environmental Impact –

- Do you consider your impact on the environment as part of "ethical" practices? If so, how do you measure your impact?
- Are you aware that some "ethical" organizations are beginning to publish environmental impact statements as part of their annual reports?

Community –

- What are some of the ethical concerns for your surrounding community or for the population you serve? How do you address them – with staff, with clients and with the community?
- How is the community "improved" as a result of your product or service? Is the community improved?

Cultural values -

- How are you as an organization dealing with the intensely competitive business world in which you operate? Do you consider yourselves a "family-friendly" organization? If so, how do you practice that? What are your expectations of individuals with family when there's a special project due with resulting time demands on everyone? How do you handle the complaints of employees with no children who may see themselves asked to pick up more of the load? Is there a forum for discussion?

Most importantly, what is your forum for addressing these issues? How have you systematically planned in that they will be addressed? We all know that, if we don't plan it in, it (whatever the "it" might be) will easily get lost.

If you would like to start a dialogue on any of these questions in this column, please e-mail me. I will put your comments in and open it up to others – or you can certainly go to our chat facility.

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DO OUR PROFESSIONAL CODES OF ETHICS PROVIDE ENOUGH GUIDANCE?

by Genie Skypek, Ph.D.

"When first confronted with the [JCAHO] ethics standards, many administrators find themselves at something of a loss. They cannot think of any recent 'ethical problems' nor can they recall but possibly one or two such problems in the past. Indeed, the leadership is often hard pressed to create an organizational code of ethics or to identify what an ethics committee would possibly discuss. That ethical issues arise almost daily among and between staff, patients, families and volunteers are quite beyond the initial awareness of many behavioral health administrators(1)."

All too often this is true for clinicians as well as administrators. I thought it might be of value to everyone concerned with ethical practice to provide examples of the range of ethical issues that an organization might systematically examine as part of the "work"

of an ethics committee. For more in-depth explorations of these examples, please refer to the cited references.

Children and Adolescents

Morris (1993) says that there is a lack of clear ethical guidelines for the provision of psychological services to the population of children and adolescents(2). One of the common ethical issues that has been discussed in the literature is that of confidentiality. Morris says, "Work with children and adolescents is unique in that typically it is the parent and not the child who seeks treatment for the child. This raises the issue of with whom does the therapist's duty of confidentiality lie – with the parent or with the child/adolescent…. Legal considerations may be quite different than ethical ones… *[He goes on to discuss the issues and suggest that*](3) whatever position the provider takes regarding confidentiality should also be stated in writing and signed (and dated) by both the therapist, child/adolescent client and client's parents/guardians."(4)

Practice in Hospitals

Linton (1993) also discussed confidentiality issues, albeit in hospital settings where he says that "hospitals are notoriously open, and the risk of betraying confidential material is high….Everyone who deals with the patient records data, observations, opinions….This is standard procedure, so that all staff will be informed and thereby do a better job of caring for the patient's needs…. Learning to balance the need to contribute to a patient's care while protecting details that are potentially harmful from disclosure is a skill that should be discussed in training sessions and in practice settings. The best defense against potential charges is a clear written rationale in advance for your decision to include or exclude specific information on the chart(5)." He goes on to discuss the handling of physician requests for psychological consultations with the patient, competence for hospital practice and dual relationships as ethical issues that may require additional consideration in hospital practice settings for behavioral health providers.

Religious Psychotherapy

Younggren (1993) discusses issues that might result from the inclusion of moral values, spiritual issues and religion in psychotherapy or treatment. The basic issue appears to be between the understanding of a common value system between therapist and patient versus a rule-based approach to therapy driven by religious or spiritual dogma. For example, he says the "religious psychotherapist must have a clear understanding of how he or she will operate when confronted with a treatment problem where the guidance, or even the rules of his or her own personal beliefs would or could lead in a direction that is opposite from the guidance that would extend from the current research in psychotherapy. Topics like abortion, homosexuality, Satanic and demonic involvement …present clear and risky areas for this type of therapist(6)."

Ethnic, Linguistic and Culturally Diverse Populations

The following are examples of statements from the Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations(7):

3. Psychologists [*or any health care providers]* recognize ethnicity and culture as significant parameters in understanding psychological processes.

    a. Psychologists *[or any health care providers*] seek to help a client determine whether a "problem" stems from

racism or bias in others so that the client does not inappropriately personalize problems.

Illustrative Statement: The concept of "healthy paranoia" whereby ethnic minorities may develop defensive behaviors in response to discrimination, illustrates this principle.

4. Psychologists *[or any health care providers*] respect the roles of family members and community structures, hierarchies, values and beliefs within the client'' culture.

    a. Clarification of the role of the psychologist and the expectations of the client precede intervention. Psychologists seek to ensure that both the psychologist and client have a clear understanding of what services and roles are reasonable.

Illustrative Statement: It is not uncommon for an entire Native American family to come into the clinic to provide support to the person in distress. Many of the healing practices found in Native American communities are centered in the family and the whole community.

Ageist and Sexist Language

To the extent that language choices reflect and support stereotypes, the choice of language used in talking about and to patients can be considered an ethical issue. There are numerous guidelines available for using language that is non-sexist. An interesting brochure that describes the policy of an educational institution regarding sexist language can be found on the Internet at http://www.uts.edu.au/div/publications/policies/select/language.html. Schaie (1993) writes about ageist language in psychological research and psychological practice. Examples of his recommendations are "Age-group differences should be characterized as such and not labeled as 'decline'. Often the term age/cohort difference is to be preferred. Age differences in research [and behavior] can often be explained by other variables and interactive effects; these should be ruled out before 'age' is assumed to be the cause of differences in the dependent variable [or behavior]. In general, age should not be referred to as a 'causal' variable(8)."

Perhaps you might ask your staff to make a list of ethical questions that they face daily in working with their patients/clients, colleagues, and so on. If they don't know, then you may have clear evidence that some mechanism is needed to train staff at all levels to be increasingly aware of these issues.

References

(1) Goldman, Arnold R. (1997). The Application of Ethics in Behavioral Health. *Practical Communications: Accreditation & Certification*, Vol. X, No. 3, 2-7.

(2) Morris does note that several professional organizations concerned with specific target groups of children and youth have developed their own guidelines. These include the Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons, 1978; National Society for Autistic Children,

1975 and the National Association for Retarded Children, 1975. Many of these may have been updated since his article was written.

(3) Italics in brackets are the author's - throughout

(4) Morris, Richard J. (1993). Ethical Issues in the Assessment and Treatment of Children and Adolescents. *Register Report: The Newsletter for Health Service Providers in Psychology*, Vol. 19, No. 1, 4,10-13.

(5) Linton, John C. (1993). Current Ethical Issues in Hospital Settings. *Register Report: The Newsletter for Health Service Providers in Psychology*, Vol. 19, No. 1, 9-10.

(6) Younggren, Jeffrey N. (1993). Ethical Issues in Religious Psychotherapy. *Register Report: The Newsletter for Health Service Providers in Psychology*, Vol. 19, No. 4, 1,7-8.

(7) American Psychological Association (1993). Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations. *American Psychologist*, January, 1993, 45-48.

(8) Schaie, K. Warner (1993) Ageist Language in Psychological research. *American Psychologist*, January, 1993, 49-51.

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A CASE STUDY: ETHICAL ISSUES AND THE PROFESSIONAL PRACTICE OF PSYCHOLOGY

by Richard J. Morris, Ph.D.

The following case description is the second in an upcoming series of columns regarding the professional practice of psychology. The series will present various ethical and related professional issues that may impact the delivery of psychological services.

Case Study

Dr. Rorey Shock is a Caucasian psychologist who recently joined a small group practice with two other licensed psychologists and a certified social worker in Cactus River, Arizona "population: 85,000." He graduated 15 years ago from an APA approved clinical psychology program and completed both his predoctoral and postdoctoral clinical internships in inpatient and outpatient psychiatric settings that focused exclusively on adults. Prior to his move to Cactus River in August, 1997, he worked for 12 years in a full-time solo private practice in a large metropolitan area in the northeast. In addition to his fee-for-service and managed care work in the present group practice, he also has a contract with the local school district to perform independent

psychological evaluations for the district. Although his training and experience in working with children and adolescents is quite limited, he was hired by the school district because he is fluent in Spanish and the district has no Spanish-speaking school psychologist on staff to perform evaluations on those children whose primary language is Spanish.

One day he received a call from the school district's Director of Special Education asking him to perform an independent psychological evaluation on a nine-year-old Mexican-American child whose family recently moved to Cactus River from a small border town in New Mexico. The Director of Special Education indicated that the purpose of the evaluation was to determine whether the student met the district's I.Q. requirement for placement in their gifted education program. When the mother brought the child to Dr. Shock's office, he learned from the mother that the boy was bilingual in English and Spanish, although Spanish was the primary language spoken in the home by both parents and their three children. In fact, the mother preferred to speak to Dr. Shock in Spanish because she felt that her English was not very well developed.

After meeting the boy, Miguel, and confirming that he was bilingual, Dr. Shock decided to perform the psychological evaluation in English. A few days later, he called the mother and asked her to come to his office to discuss the results of the psychological testing. Upon her arrival the following week, Dr. Shock indicated to her in Spanish that during the testing Miguel gave some "unusual" answers and, as a consequence, he decided to do some additional testing which was why the evaluation took longer than originally scheduled. He said that in addition to administering the standard intelligence test he also used "a few extra tests" to assess Miguel's academic skills.

Dr. Shock told the mother that the results of the testing showed that Miguel met the criteria for the district's gifted education program but it also appeared that he had a "learning disability related to attention deficits." The mother was surprised by this finding and asked Dr. Shock not to tell the school—to report only that her son met the IQ requirements for the gifted education program. Dr. Shock agreed with her request and wrote his report and submitted it with his bill to the school district, including in the bill a fee covering the extra time he spent doing the "additional testing." When the Director of Special Education looked at the bill, she called Dr. Shock and asked why the bill was almost twice the amount than what was specified in the contract that he had with the district. She also wanted to know why Dr. Shock conducted the evaluation in English when he was contracted specifically to do evaluations in Spanish for Spanish-speaking children.

Dr. Shock told the Director that he decided to do the evaluation in English because he felt Miguel was equally comfortable in both languages and that "the results would be more valid if they were conducted in English." He also said that the reason for the higher fee was because he did "some additional testing" but that Miguel's mother did not want him to release the other test results to the school district, and he felt that he must respect the mother's wishes. The Director of Special Education demanded to know what other testing was performed and what the results were—otherwise, she indicated she would not authorize any payments be made to Dr.

Shock by the district. He told her that he would ask the mother to reconsider her decision.

After talking with the mother on two different occasions about releasing the additional test results, Dr. Shock called the Director of Special Education and indicated that the mother would not consent to the release of the test results, and he again asked for full payment from the district. The Director refused to pay for any of the psychological services. Dr. Shock then turned over the bill to a lawyer for payment collection.

Upon receiving the lawyer’s demand for payment, the Director of Special Education immediately filed a complaint with the professional organizations with which Dr. Shock is a member, maintaining that Dr. Shock was behaving in an unethical manner. In the various complaints that were filed, the Director indicated that Dr. Shock was only asked to conduct an evaluation regarding whether the child met the I.Q. requirements for the gifted education program. She did not request any additional testing, maintained that Dr. Shock was remiss in not sharing his additional findings with the school district from the supplemental testing, and felt that Dr. Shock should have told the school district that the child’s English was sufficiently well developed that one of the district’s school psychologists could test him in English.

Dr. Shock indicated that he had an obligation to his client (i.e., Miguel’s mother) not to reveal information that she did not want released. In addition, the decision to test Miguel in English was made on the "spur-of-the-moment" because he felt that the test findings would have "less error/more validity" if the test was administered in English rather than Spanish. Finally, he administered additional assessment instruments because of the "...unusual pattern of Miguel’s responses on the short term memory and distractibility subtests of the intelligence test."

Sections of the APA "Ethical Principles and Code of Conduct" that are of concern regarding this case:

1.04 Boundaries of Competence.

(a) Psychologists provide services, teach, and conduct research only within the boundaries of their competence, based on their education, training, supervised experience, or appropriate professional experience.

1.05 Maintaining Expertise

Psychologists who engage in assessment, therapy, teaching, research, organizational consulting, or other professional activities maintain a reasonable level of awareness of current scientific and professional information in their fields of activity and undertake ongoing efforts to maintain competence in the skills they use.

1.17 Multiple Relationships

(c) If a psychologist finds that, due to unforseen factors, a potentially harmful multiple relationship has arisen, the psychologist attempts to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.

1.25 Fees and Financial Arrangements

(a) As early as is feasible in a professional or scientific relationship, the psychologist and the patient, client, or other appropriate recipient of psychological services reach an agreement specifying the compensation and the billing arrangements.

(b) Psychologists do not exploit recipients of services or payers with respect to fees.

(d) Psychologists do not misrepresent their fees.

(f) If the patient, client, or other recipient of services does not pay for services as agreed, and if the psychologist wishes to use collection agencies or legal measures to collect the fees, the psychologist first informs the person that such measures will be taken and provides that person an opportunity to make prompt payment.

2.04 Use of Assessment in General and With Special Populations

(a) Psychologists who perform interventions or administer, score, interpret, or use assessment techniques are familiar with the reliability, validation, and related standardization or outcome studies at, and proper applications and uses of, the techniques they use.

(c) Psychologists attempt to identify situations in which particular interventions or assessment techniques or norms may not be applicable or may require adjustment in administration or interpretation because of factors such as individuals’ gender, age, race, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status.

2.09 Explaining Assessment Results

Unless the nature of the relationship is clearly explained to the person being assessed in advance and precludes provision of an explanation of results (such as in some organizational consulting, pre-employment or security screenings, and forensic evaluations), psychologists ensure that an explanation of the results is provided using language that is reasonably understandable to the person assessed or to another legally authorized person on behalf of the client. Regardless of whether the scoring and interpretation are done by the psychologist, by assistants, or by automated or other outside services, psychologists take reasonable steps to ensure that appropriate explanations of results are given.

4.02 Informed Consent to Therapy

(a) Psychologists obtain appropriate informed consent to therapy or related procedures, using language that is reasonably understandable to participants. The content of informed consent will vary depending on many circumstances; however, informed consent generally implies that the person (1) has the capacity to consent, (2) has been informed of significant information concerning the procedure, (3) has freely and without undue influence expressed consent, and (4) consent has been appropriately documented.

(b) When persons are legally incapable of giving informed consent, psychologists obtain informed permission from a legally authorized person, if such substitute consent is permitted by law.

(c) In addition, psychologists (1) inform those persons who are legally incapable of giving informed consent about the proposed interventions in a manner commensurate with the persons psychological capacities, (2) seek their assent to those interventions, and (3) consider such persons' preferences and best interests.

5.01 Discussion of the Limits of Confidentiality

(a) Psychologists discuss with persons and organizations with whom they establish a scientific or professional relationship (including, to the extent feasible, minors and their legal representatives) (1) the relevant limitations on confidentiality, including limitations where applicable in group, marital, and family therapy or in organizational consulting, and (2) the foreseeable uses of the information generated through their services.

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

Additional issues that may need to be addressed:

1. Informing the mother in the initial interview of the following:

   a. the school district is Dr. Shock's client and that he is providing a contractual psychological service to Miguel on behalf of the school district
   b. The school district will be paying for Miguel's psychological services;
   c. a report summarizing the findings will be sent to the school district and if Miguel's mother has any questions regarding the findings, she can contact the Director of Special Education;
   d. at the school district's request, Dr. Shock would be pleased to meet with Miguel's mother to clarify any statements made in the psychological report;

2. Providing psychological services in English when Dr. Block was hired under contract to provide psychological services in Spanish;

3. The education, training, and supervised experiences of Dr. Shock in regard to the etiology, assessment and diagnosis of children's learning and behavior problems.

*Please Note: This is a fictitious case and was developed by Dr. Morris for illustrative purposes only. Any opinions or comments made by Dr. Morris are his own and do not necessarily reflect the views of the National Register or American Psychological Association. The reader is referred to the following reference for additional clarification: American Psychological Association (1992). "Ethical Principles of Psychologists and Code of Conduct". *American Psychologist*, 47, 1597-1611.

MULTIPLE RELATIONSHIPS

by Erica Wise, Ph.D.

This is a companion article to our series of articles on ethical issues. Some of the most difficult ethical dilemmas faced by psychologists relate to the complex and conflicting roles and relationships in which we find ourselves.

In this article, we hope to dispel certain misconceptions concerning multiple relationships:

1. Any and all multiple relationships are inherently unethical and harmful.
2. Multiple relationships only occur when treating a therapy patient or client.
3. Multiple relationships only involve conflicting personal and professional roles.
4. Multiple relationships only involve conflicting professional roles.
5. The APA Ethics Code offers little guidance as to what constitutes a "harmful" multiple relationship.
6. Multiple relationships always involve sexual behavior.

As you read this article we encourage you to get out your copy of the Ethics Code and refer back to this list. As we begin, let us set the stage by reminding ourselves that, "This Ethics Code applies only to psychologists' work-related activities, that is, activities that are part of the psychologists' scientific and professional functions or that are psychological in nature. ...These work-related activities can be distinguished from the purely private conduct of a psychologist, which ordinarily is not within the purview of the Ethics Code." (See Introduction, APA Ethical Principles, 1992.) Why is this important? It is important because distinguishing between our professional roles and activities vs. our personal roles and activities gives us a context for understanding what frequently occurs when we blur the distinction between our personal and professional relationships.

References to multiple relationships can be found throughout the APA Ethics Code. In "Principle B: Integrity" of the General Principles, the last sentence states that, "Psychologists avoid improper and potentially harmful dual relationships." In the Ethical Standards portion of the code there are varied references (some direct and some indirect to this concept.) Under the General Standards (potentially applicable to all psychologists), Standard 1.03 states that, "Psychologists provide diagnostic, therapeutic, teaching, research, supervisory,

consultative, or other psychological services only in the context of a defined professional or scientific relationship or role." Harmful multiple relationships are more likely to occur when psychological services are provided in the absence of a defined professional relationship. There is obviously no prohibition against giving informal advice to friends, family, and neighbors. However, training in child management techniques provided to a teacher with whom one is consulting or to the parent of a child whom one is treating is a psychological service and therefore should occur within a defined professional relationship or role. We frequently have professional responsibility to individuals who are not our direct therapy patients or clients. It is the psychologist's responsibility to ensure that our relationships are clearly defined and to address any misunderstandings that may occur. Standard 1.17, entitled "Multiple Relationships", acknowledges that multiple relationships cannot always be avoided. "A psychologist refrains from entering into or promising another personal, scientific, professional, financial, or other relationship with such persons if it appears likely that such a relationship reasonably might impair the psychologist's objectivity or otherwise interfere with the psychologist's effectively performing his or her functions as a psychologist, or might harm or exploit the other party." Therefore, the central "tests" that define a harmful multiple relationship are those that have the potential to result in impaired objectivity, interference with effective performance, and/or harm or exploitation to the recipient of services. Standards 1.17 (b) and 1.17 (c) address, respectively, not taking on professional obligations in situations in which a preexisting relationship creates risk or harm, and attempting to resolve the situation if a potentially harmful multiple relationship occurs.

Standard 1.18 states that, "Psychologists ordinarily refrain from accepting goods, services, or other nonmonetary remuneration from patients or clients in return for psychological services because such arrangements create inherent potential for conflicts, exploitation, and distortion of the professional relationship." The standard goes on to say that any barter relationships must not be clinically contraindicated or potentially exploitative. Relevant to our discussion is the notion of the potential for exploitation. It can be argued that any barter relationship creates a multiple relationship. When this involves an exchange for personal services (e.g., a patient or client engages in office work, house cleaning, babysitting) the potential for abuse is obvious. Who determines the rate of exchange? What if one party or the other is dissatisfied with the services provided? How do you protect the patient from the inherent power differential in the situation? Situations between the psychologist and the patient can pose considerable threat to the integrity of the therapeutic effort, and are easily misunderstood within the context of a therapy relationship. We caution psychologists to use great care in defining, setting and maintaining appropriate safeguards if they choose to use bartering arrangements.

Standard 1.19 (a) states that, "Psychologists do not exploit persons over whom they have supervisory, evaluative, or other authority...." Standard 1.19 (b) stands out in that there is a specific prohibition, "Psychologists do not engage in sexual relationships with students or supervisees in training over whom the psychologist has evaluative or direct authority, because such relationships are so likely to impair judgment or be exploitative." You may first notice language that is familiar from Standard 1.17. The critical difference is that sexual behavior is specifically prohibited in Standard 1.19 (b). This standard offers an absolute prohibition

against sexual relationships with students and trainees rather than leaving this matter to the judgment and discretion of faculty, supervisors and students or trainees. In the Standards on Therapy, Standard 4.05 similarly offers an absolute prohibition against sexual intimacies with current patients/clients. One may deduce that students/trainees have been determined to be in an inherently vulnerable position that makes them especially prone to exploitation. Standard 4.07 (a) provides an absolute prohibition against sexual intimacies with patients or clients for at least two years following termination of professional services. Standard 4.07 (b) offers a number of caveats concerning sexual intimacies even after two years have elapsed. We do not want to understate the caution that a psychologist needs to use in this area, both in terms of avoiding harm or exploitation to a potentially still vulnerable patient and the possibility of ethical complaints even after two years have elapsed. Often psychologists are held to a high standard of accountability with regard to engaging in sexual relationships with both current and former patients.

The section of the code that addresses Evaluation, Assessment, or Intervention, Standard 2.01 (a) states that, "Psychologists perform evaluations, diagnostic services, or interventions only within the context of a defined professional relationship." This notion was discussed earlier. It is a reminder that it is important to keep professional roles clear in order to lessen confusion to the recipients of our services as well as ourselves. Standard 4.03 (a) and 4.03 (b) both address the potential for conflict between various professional roles in treating families. Several relevant standards can be found in the section on Forensic Activities. Standards 7.03 and 7.05 both address the importance of clarifying potentially conflicting roles in forensic situations.

In summary, we hope to have stimulated your thinking in this area and hope that any misconceptions you may have had have been challenged. There are several critical points that we anticipate you will take with you from this article:

1. The notion of multiple relationships applies generally to the provision of psychological services and to the full range of psychological activities.
2. Given the applicability of the code to our work-related activities, it is incumbent upon psychologists to clearly differentiate between personal and professional relationships.
3. Portions of the code apply to conflicts among personal and professional roles, whereas others apply to conflicts among professional roles.
4. There are specific prohibitions in the code against sexual relationships with clients/patients and students/trainees in addition to specific judgment rules to apply in other potentially harmful multiple role situations.
5. Psychologists are held to a high level of accountability in those areas in which members of the public are vulnerable and in which confusion is likely to occur.

REVIEW OF ARTICLES BY RICHARD MORRIS, PH.D. AND ERICA WISE, PH.D.

by Jeffrey N. Younggren, Ph.D.

We are truly in an era of accountability, liability, scrutiny and risk management. Whether that takes the form of peer review and consultation, managed care case review or more serious ethics and legal actions, psychologists, like never before, need to be most cautious to make sure that their conduct is consistent with existing standards of care as defined by codes of conduct and law. In that respect, the two articles written by Richard Morris, Ph.D. and Erica Wise, Ph.D. deal with very important and timely issues that impact professional practice.

In his vignette, Dr. Morris clearly points out how easy it is to get into professional difficulty. He describes a case that, upon first review, appears to be rather "run of the mill." However, what at first cut looks simple, suddenly becomes most complex; a complexity that could have easily been avoided with a little consultation, clarity and caution. From the outset, the psychologist in question, Dr.Rorey Shock, appears not even to know who his client is. Since he is working for the local school district who hired him to do evaluations of Spanish-speaking children, Dr. Shock's client, in actuality, was the school district, and the young man being evaluated was simply the subject of evaluation. However, without that clear understanding at the outset, he seemed to not recognize for whom he was really working and this lack of clarity led him into significant difficulty.

Dr. Shock also failed to fulfill the requirement of informed consent by not clarifying with Miquel's mother at the start of the evaluation the purpose of the assessment, for whom he was working, and how the results were going to be used. Consistent with the APA Ethical Principles and Code of Conduct (1992) he also should have obtained signed consent from her to evaluate her son. In addition, he needed her consent to expand the nature of the assessment to include testing that was not initially requested. However, instead of defining at the outset what he was going to do and getting approval to do so, Dr. Shock, on his own, proceeded to expand the purpose of the assessment and in the process discovered important clinical information about Miquel that he did not have approval to find.

Dr. Shock's professional errors extend even further beyond those of violating informed consent requirements. Dr. Shock also failed to get the approval of his client, the school district, to extend the purpose of the assessment. In addition, since he had been hired to conduct an assessment in Spanish, his performing the evaluation in English without the approval of his client, also violated his professional obligations since that was why the district had hired him in the first place. To make matters worse, when Miquel's mother refused to allow him to release the additional information to the district, he attempted to bill the district for his expanded services without giving the school district the information he had obtained. While he may have conducted an excellent assessment of Miquel, by this time he had committed so many procedural, ethical and administrative errors that he placed himself at risk with both his client and with Miquel's mother.

Unrelenting and still unaware of the precarious position he was in, Dr. Shock then attempted to obtain payment by turning the district's bill over to his attorney for collection. Appropriately so, the district filed complaints with Dr. Shock's professional organizations alleging he had committed professional misconduct in the way he had conducted the assessment and in his attempt to obtain payment from the district for work they

had not authorized him to do.

Regardless of whether or not he obtained payment for his services (some or all), Dr. Shock's conduct in this case was a clear violation of the standards of professional practice for a psychologist. He violated the requirements of informed consent in the way he conducted the assessment and also failed to establish his fees and services with the district prior to performing the psychological assessment. All of this could have far reaching and serious impact upon his career; all of this could have been avoided with a little consultation and forethought.

It is rather perplexing why some psychologists find it so difficult to tell their clients what they plan to do, to get their consent to do it and then do what they said they were going to do.

The companion article by Dr. Wise explores one of the most common areas of professional misconduct, that of relationship violations. Nowhere else have psychologists gotten themselves into more serious ethical and legal difficulty than in this area. However, most professionals do not even understand what constitutes a relationship violation and the term "dual relationship" is viewed by some as equivalent to unethical behavior. In her article, Dr. Wise appropriately points out that not all dual relationships are unethical nor are they really unavoidable. She addresses the fundamental principles that create this type of violation: exploitation, loss of objectivity and disruption of the delivery of professional services. She then goes on to point out how those fundamental principles are evident in various standards of the APA Ethical Principles.

Two of the most important points made in this article deal with the misconception that all dual relationships are unethical and that relationship violations can only occur within a treatment setting. In dealing with the first point, Dr. Wise clearly points out how the code explicitly allows for dual relationships. For example, it explicitly allows psychologists to barter for professional services, thereby creating an inherently dual relationship. However, she also points out how complex barter can be and how even the APA Code itself cautions those who barter to only engage in this type of relationship if it is not clinically contraindicated and if it is not exploitative. For those who find themselves in a dual relationship it important to remember that the outcome of the dual relationship, whether negative or positive, is always the responsibility of the therapist. In addition, please note that one cannot avoid the professional responsibility for committing this type of professional violation through a procedure like informed consent. For example, a client could not consent to have sex with his/her therapist by being informed of the inherent risks that go along with this type of relationship.

Dr. Wise also points out how multiple relationships can occur outside of a treatment or therapy relationship. She notes how the APA Code explicitly prohibits sexual relationships with students and supervisees and points out how these standards reflect a belief that these individuals are in an inherently vulnerable position that makes them prone to exploitation. In fact, this type of exploitation was considered to be so serious by the APA that the Rules and Procedures of the Ethics Committee were changed in order to allow students who had been exploited by faculty additional time to file their complaints. The Committee's belief was that students,

specifically, were in an inherently vulnerable position that sometimes lasted years in duration and often even beyond graduation. This reality forced the APA to give them more time to file complaints against faculty who could continue to have control of, or impact upon their careers.

One final topic in Dr. Wise's article deserves further discussion. This deals with the provisions of the APA Code that address the additional risks of committing a relationship violation when one is serving in a forensic capacity. Psychologists who choose to provide forensic services need to be aware of the types of violations that are frequently found in this specific area. For example, they need to be aware of the risk that one incurs when changing roles in a matter and how some roles are potentially conflicting, e.g., providing therapeutic and forensic services to the same individual or family. In addition, forensic psychologists need to take special care to clarify the potential conflicts that exist at the outset of the delivery of their professional services. This situation has become so severe and, at times, subtle, that psychologists have found themselves as defendants in civil actions because they filed declarations that did not identify the nature of their relationship with a client and the inherent limitations of that relationship. Psychologists who provide forensic services need to take great care to avoid these less obvious types of relationship conflicts.

In summary, these two articles provide helpful insight and direction to those who have questions about informed consent, relationship violations and risk management. They serve to sensitize the reader to some common areas of professional difficulty that can have dire consequences.

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CULTURAL RELATIVITY OR CULTURAL IMPERIALISM?
ETHICAL DILEMMAS IN EXTENDING THE DOMESTIC VIOLENCE MOVEMENT

WORLDWIDE

by Sherry Hamby, Ph.D.

A researcher recently asked, "How do you get 240 women to participate in a program that goes against the moral and religious values they've been taught all their lives?" This rhetorical question was offered as an apology for a low participation rate in a treatment outcome study. Here, the question is used as a starting point for an analysis of ethical issues that inevitably arise when domestic violence interventions developed and applied by primarily middle-class White Americans are extended to other class, ethnic, and cultural groups. A significant disjunction exists between academic ideals, which tend to promote cultural relativity, and current interventions, which often have the effect of imposing Western middle-class values along with the offer of services. Individual and social interventions need to consider cultural differences regarding such issues as divorce, family honor, and disclosure of family matters.

The most important steps for the ethical provisions of interventions are to become familiar with the cultural norms and values of groups one proposes to work with, and to be willing to make substantial changes to interventions or develop new programs for use in each sociocultural setting. Studies with minority or disadvantaged groups are still scarce, and the majority of adaptations for different groups, if programs are modified at all, can be described as "cosmetic changes." The most common cosmetic change involves re-printing stimulus materials (videos, pamphlets, etc.) with people who appear to belong to the target ethnic group because of physical appearance or name. While such modifications are usually positive, they fall far short of making meaningful adaptations of program content. Another adaptation might be called "gratuitous changes." Typically the endorsement of a consultant or focus group who belongs to the target ethnic or cultural group is solicited. Gratuitous changes often include making revisions around the fringes of a program or assessment tool, such as omitting or rewording one or two items on a questionnaire, or editing out potentially offensive material. Substantial content changes are avoided. While this approach gives the target group a greater voice and makes a preliminary effort to address issues of cultural sensitivity or language barriers, it too falls short of the ideal.

A more ethical approach involves making what might be called "genuine changes." Establishing intervention goals with community members, involving key informants, and abandoning a one-size-fits-all approach are crucial to making genuine changes in interventions. Potential value conflicts should be explicitly acknowledged. Focus groups are one way of making genuine changes, if providers are willing to make substantial changes in response to feedback and to develop new materials for each community group. For evaluations, it would be appropriate to develop new items or scales that are tailored to the community in question. Other ways of effecting genuine change include incorporating local sociocultural traditions into interventions. For example, sweat lodges and talking circles are sometimes offered to domestic violence victims in native communities. It is important that traditional modalities however, are not included as mere adjuncts to Western techniques. Traditional providers should be accorded the same status as outside professionals

(Duran, Guillory, & Tingley, 1993).

One example of a program that made genuine changes is the Mending the Sacred Hoop program for domestic violence batterers. While the program is based on an adaptation of the well-known Duluth model (Pence & Paymar, 1993), the native version has substantial changes. For example, the original Power and Control wheel with eight segments of abstractions such as "Intimidation" has been replaced with a traditional Medicine Wheel which has four brief narrative sections. Further, in trainings with American Indian groups, the trainers encourage each tribe to make further adaptations as necessary to reflect their core values and beliefs. It is also true that a separate set of videos has been developed with American Indian actors, illustrating that cosmetic changes can be part of a genuine effort at adaptation but are not sufficient in and of themselves.

The most culturally sensitive approach would be to develop programs from the ground up for specific non-majority communities. Such programs will hopefully become less rare.

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