DISCUSSION #1

Prior to beginning work on this discussion, read the Fisher (2009) article, "Replacing 'Who is the Client?' With a Different Ethical Question" and the APA's Ethical Principles of Psychologists and Code of Conduct: Including 2010 Amendments (Links to an external site.)Links to an external site. paying special attention to standard 3.11.

Informed consent is an important ethical component of research and practice. It is not, however, always sufficient or appropriate for consulting, program evaluation, job effectiveness assessment, or other psychological services delivered to or through organizations because it does not always address all the necessary elements of a given situation. These facts do not negate our responsibility as psychology professionals to inform clients and those who may be impacted by our services. In the discussion you will address these issues through the following case study.

You are an industrial organizational (I/O) psychologist and have been hired to evaluate a company's "Work From Home" policy to see if it has increased company production. In addition to a review of the employee records, the evaluation needs to include interviews with supervisors and employees on the value and limits of the policy. Since informed consent as typically considered in clinical, counseling, and research settings will not be sufficient in this instance, you will need to inform all supervisors and employees about your services.

In your initial post, briefly analyze and define who the client is in this case study. Assess your professional role as the I/O psychologist and your responsibility to the client as defined. Apply the APA's Ethical Principles of Psychologists and Code of Conduct (Links to an external site.)Links to an external site. to this scenario, specifically addressing what information should be provided to all supervisors and employees. Explain how you would disseminate this information and ensure understanding amongst all stakeholders. Elaborate on how you would establish trust with the employees, protect employee identities, and ensure the results are used in an ethical manner.

American Psychological Association

Including 2010 and 2016 Amendments

Effective date June 1, 2003 with amendments effective June 1, 2010 and January 1, 2017.

Introduction and Applicability

The American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct (hereinafter referred to as the Ethics Code) consists of an Introduction, a Preamble (?item=2) , five General Principles (?item=3) (A-E) and specific Ethical Standards (?item=4) . The Introduction discusses the intent, organization, procedural considerations, and scope of application of the Ethics Code. The Preamble and General Principles are aspirational goals to guide psychologists toward the highest ideals of psychology. Although the Preamble and General Principles are not themselves enforceable rules, they should be considered by psychologists in arriving at an ethical course of action. The Ethical Standards set forth enforceable rules for conduct as psychologists. Most of the Ethical Standards are written broadly, in order to apply to psychologists in varied roles, although the application of an Ethical Standard may vary depending on the context. The Ethical Standards are not exhaustive. The fact that a given conduct is not specifically addressed by an Ethical Standard does not mean that it is necessarily either ethical or unethical.

This Ethics Code applies only to psychologists' activities that are part of their scientific, educational, or professional roles as psychologists. Areas covered include but are not limited to the clinical, counseling, and school practice of psychology; research; teaching; supervision of trainees; public service; policy development; social intervention; development of assessment instruments; conducting assessments; educational counseling; organizational consulting; forensic activities; program design and evaluation; and administration. This Ethics Code applies to these activities across a variety of contexts, such as in person, postal, telephone, Internet, and other electronic transmissions. These activities shall be distinguished from the purely private conduct of psychologists, which is not within the purview of the Ethics Code.

Membership in the APA commits members and student affiliates to comply with the standards of the APA Ethics Code and to the rules and procedures used to enforce them. Lack of awareness or misunderstanding of an Ethical Standard is not itself a defense to a charge of unethical conduct.

The procedures for filing, investigating, and resolving complaints of unethical conduct are described in the current Rules and Procedures of the APA Ethics Committee (/ethics/code/committee.aspx) . APA may impose sanctions on its members for violations of the

standards of the Ethics Code, including termination of APA membership, and may notify other bodies and individuals of its actions. Actions that violate the standards of the Ethics Code may also lead to the imposition of sanctions on psychologists or students whether or not they are APA members by bodies other than APA, including state psychological associations, other professional groups, psychology boards, other state or federal agencies, and payors for health services. In addition, APA may take action against a member after his or her conviction of a felony, expulsion or suspension from an affiliated state psychological association, or suspension or loss of licensure. When the sanction to be imposed by APA is less than expulsion, the 2001 Rules and Procedures do not guarantee an opportunity for an in-person hearing, but generally provide that complaints will be resolved only on the basis of a submitted record.

The Ethics Code is intended to provide guidance for psychologists and standards of professional conduct that can be applied by the APA and by other bodies that choose to adopt them. The Ethics Code is not intended to be a basis of civil liability. Whether a psychologist has violated the Ethics Code standards does not by itself determine whether the psychologist is legally liable in a court action, whether a contract is enforceable, or whether other legal consequences occur.

The modifiers used in some of the standards of this Ethics Code (e.g., reasonably, appropriate, potentially) are included in the standards when they would (1) allow professional judgment on the part of psychologists, (2) eliminate injustice or inequality that would occur without the modifier, (3) ensure applicability across the broad range of activities conducted by psychologists, or (4) guard against a set of rigid rules that might be quickly outdated. As used in this Ethics Code, the term reasonable means the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time.

In the process of making decisions regarding their professional behavior, psychologists must consider this Ethics Code in addition to applicable laws and psychology board regulations. In applying the Ethics Code to their professional work, psychologists may consider other materials and guidelines that have been adopted or endorsed by scientific and professional psychological organizations and the dictates of their own conscience, as well as consult with others within the field. If this Ethics Code establishes a higher standard of conduct than is required by law, psychologists must meet the higher ethical standard. If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner in keeping with basic principles of human rights.

Preamble

Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and

expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness. This Ethics Code provides a common set of principles and standards upon which psychologists build their professional and scientific work.

This Ethics Code is intended to provide specific standards to cover most situations encountered by psychologists. It has as its goals the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students, and the public regarding ethical standards of the discipline.

The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees, and colleagues; and to consult with others concerning ethical problems.

General Principles

This section consists of General Principles. General Principles, as opposed to Ethical Standards, are aspirational in nature. Their intent is to guide and inspire psychologists toward the very highest ethical ideals of the profession. General Principles, in contrast to Ethical Standards, do not represent obligations and should not form the basis for imposing sanctions. Relying upon General Principles for either of these reasons distorts both their meaning and purpose.

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

Principle B: Fidelity and Responsibility
Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent

needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues' scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.

Principle C: Integrity

Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.

Principle D: Justice

Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices.

Principle E: Respect for People's Rights and Dignity

Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

Section 1: Resolving Ethical Issues

1.01 Misuse of Psychologists' Work

If psychologists learn of misuse or misrepresentation of their work, they take reasonable steps to correct or minimize the misuse or misrepresentation.

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General

Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.03 Conflicts Between Ethics and Organizational Demands

If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.04 Informal Resolution of Ethical Violations

When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved. (See also Standards 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority (#102) , and 1.03, Conflicts Between Ethics and Organizational Demands (#103) .)

1.05 Reporting Ethical Violations

If an apparent ethical violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution under Standard 1.04, Informal Resolution of Ethical Violations (#104) , or is not resolved properly in that fashion, psychologists take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, to state licensing boards, or to the appropriate institutional authorities. This standard does not apply when an intervention would violate confidentiality rights or when psychologists have been retained to review the work of another psychologist whose professional conduct is in question. (See also Standard 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority (#102) .)

1.06 Cooperating with Ethics Committees

Psychologists cooperate in ethics investigations, proceedings, and resulting requirements of the APA or any affiliated state psychological association to which they belong. In doing so, they address any confidentiality issues. Failure to cooperate is itself an ethics violation. However, making a request for deferment of adjudication of an ethics complaint pending the outcome of litigation does not alone constitute noncooperation.

1.07 Improper Complaints

Psychologists do not file or encourage the filing of ethics complaints that are made with reckless disregard for or willful ignorance of facts that would disprove the allegation.

1.08 Unfair Discrimination Against Complainants and Respondents

Psychologists do not deny persons employment, advancement, admissions to academic or other programs, tenure, or promotion, based solely upon their having made or their being the subject of an ethics complaint. This does not preclude taking action based upon the outcome of such proceedings or considering other appropriate information.

Section 2: Competence

2.01 Boundaries of Competence

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

(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies (#202) .

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

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

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

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

2.02 Providing Services in Emergencies

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

2.03 Maintaining Competence

Psychologists undertake ongoing efforts to develop and maintain their competence.

2.04 Bases for Scientific and Professional Judgments

Psychologists' work is based upon established scientific and professional knowledge of the

discipline. (See also Standards 2.01e, Boundaries of Competence (#201e) , and 10.01b, Informed Consent to Therapy (?item=13#1001b) .)

2.05 Delegation of Work to Others

Psychologists who delegate work to employees, supervisees, or research or teaching assistants or who use the services of others, such as interpreters, take reasonable steps to (1) avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity; (2) authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided; and (3) see that such persons perform these services competently. (See also Standards 2.02, Providing Services in Emergencies (#202) ; 3.05, Multiple Relationships (?item=6#305) ; 4.01, Maintaining Confidentiality (?item=7#401) ; 9.01, Bases for Assessments (?item=12#901) ; 9.02, Use of Assessments (?item=12#902) ; 9.03, Informed Consent in Assessments (?item=12#903) ; and 9.07, Assessment by Unqualified Persons (?item=12#907) .)

2.06 Personal Problems and Conflicts

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

(b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties. (See also Standard 10.10, Terminating Therapy (?item=13#1010) .)

Section 3: Human Relations

3.01 Unfair Discrimination

In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law.

3.02 Sexual Harassment

Psychologists do not engage in sexual harassment. Sexual harassment is sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with the psychologist's activities or roles as a psychologist, and that either (1) is unwelcome, is offensive, or creates a hostile workplace or educational environment, and the psychologist knows or is told this or (2) is sufficiently severe or intense to be abusive to a reasonable person in the context. Sexual harassment can consist of a single intense or severe act or of multiple persistent or pervasive acts. (See also Standard 1.08, Unfair Discrimination Against Complainants and Respondents (?item=4#108) .)

3.03 Other Harassment

Psychologists do not knowingly engage in behavior that is harassing or demeaning to persons with whom they interact in their work based on factors such as those persons' age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status.

3.04 Avoiding Harm

(a) Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

(b) Psychologists do not participate in, facilitate, assist, or otherwise engage in torture, defined as any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person, or in any other cruel, inhuman, or degrading behavior that violates 3.04(a).

3.05 Multiple Relationships

(a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.

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

(c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur. (See also Standards 3.04, Avoiding Harm (#304) , and 3.07, Third-Party Requests for Services (#307) .)

3.06 Conflict of Interest

Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation.

3.07 Third-Party Requests for Services

When psychologists agree to provide services to a person or entity at the request of a third party, psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations involved. This clarification includes the role of the psychologist (e.g., therapist, consultant, diagnostician, or expert witness), an identification of who is the client, the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality. (See also Standards 3.05, Multiple relationships (#305) , and 4.02, Discussing the Limits of Confidentiality.)

3.08 Exploitative Relationships

Psychologists do not exploit persons over whom they have supervisory, evaluative or other authority such as clients/patients, students, supervisees, research participants, and employees. (See also Standards 3.05, Multiple Relationships (#305) ; 6.04, Fees and Financial Arrangements (?item=9#604) ; 6.05, Barter with Clients/Patients (?item=9#605) ; 7.07, Sexual Relationships with Students and Supervisees (?item=10#707) ; 10.05, Sexual Intimacies with Current Therapy Clients/Patients (?item=13#1005) ; 10.06, Sexual Intimacies with Relatives or Significant Others of Current Therapy Clients/Patients (?item=13#1006) ; 10.07, Therapy with Former Sexual Partners (?item=13#1007) ; and 10.08, Sexual Intimacies with Former Therapy Clients/Patients (?item=13#1008) .)

3.09 Cooperation with Other Professionals

When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately. (See also Standard (javascript:goToItem(7);) 4.05, Disclosures (?item=7#405) .)

3.10 Informed Consent

(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent to Research (?item=11#802) ; 9.03, Informed Consent in Assessments (?item=12#903) ; and 10.01, Informed Consent to Therapy (?item=13#1001) .)

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

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

(d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards 8.02, Informed Consent to Research (?item=11#802) ; 9.03, Informed Consent in Assessments (?item=12#903) ; and 10.01, Informed Consent to Therapy (?item=13#1001) .)

3.11 Psychological Services Delivered to or Through Organizations

(a) Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about (1) the nature and objectives of the services, (2) the intended recipients, (3) which of the individuals are clients, (4) the relationship the psychologist will have with each person and the organization, (5) the probable uses of services provided and information obtained, (6) who will have access to the information, and (7) limits of confidentiality. As soon as feasible, they provide information about the results and conclusions of such services to appropriate persons.

(b) If psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of the service.

3.12 Interruption of Psychological Services

Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability, relocation, or retirement or by the client's/patient's relocation or financial limitations. (See also Standard 6.02c, Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work (?item=9#602c) .)

Section 4: Privacy and Confidentiality

4.01 Maintaining Confidentiality

Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. (See also Standard 2.05, Delegation of Work to Others (?item=5#205) .)

4.02 Discussing the Limits of Confidentiality

(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent (?item=6#310) .)

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

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

4.03 Recording

Before recording the voices or images of individuals to whom they provide services, psychologists obtain permission from all such persons or their legal representatives. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research (?item=11#803) ; 8.05, Dispensing with Informed Consent for Research (?item=11#805) ; and 8.07, Deception in Research (?item=11#807) .)

4.04 Minimizing Intrusions on Privacy

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

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

4.05 Disclosures

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

(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (See also Standard 6.04e, Fees and Financial Arrangements (?item=9#604e) .)

4.06 Consultations

When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation. (See also Standard 4.01, Maintaining Confidentiality (#401) .)

4.07 Use of Confidential Information for Didactic or Other Purposes

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

Section 5: Advertising and Other Public Statements

5.01 Avoidance of False or Deceptive Statements

(a) Public statements include but are not limited to paid or unpaid advertising, product endorsements, grant applications, licensing applications, other credentialing applications, brochures, printed matter, directory listings, personal resumes or curricula vitae, or comments for use in media such as print or electronic transmission, statements in legal proceedings, lectures and public oral presentations, and published materials. Psychologists do not knowingly make public statements that are false, deceptive, or fraudulent concerning their research, practice, or other work activities or those of persons or organizations with which they are affiliated.

(b) Psychologists do not make false, deceptive, or fraudulent statements concerning (1) their training, experience, or competence; (2) their academic degrees; (3) their credentials; (4) their institutional or association affiliations; (5) their services; (6) the scientific or clinical basis for, or results or degree of success of, their services; (7) their fees; or (8) their publications or research findings.

(c) Psychologists claim degrees as credentials for their health services only if those degrees (1) were earned from a regionally accredited educational institution or (2) were the basis for psychology licensure by the state in which they practice.

5.02 Statements by Others

(a) Psychologists who engage others to create or place public statements that promote their professional practice, products, or activities retain professional responsibility for such statements.

(b) Psychologists do not compensate employees of press, radio, television, or other communication media in return for publicity in a news item. (See also Standard 1.01, Misuse of Psychologists' Work (?item=4#101) .)

(c) A paid advertisement relating to psychologists' activities must be identified or clearly recognizable as such.

5.03 Descriptions of Workshops and Non-Degree-Granting Educational Programs

To the degree to which they exercise control, psychologists responsible for announcements, catalogs, brochures, or advertisements describing workshops, seminars, or other non-degree-granting educational programs ensure that they accurately describe the audience for which the program is intended, the educational objectives, the presenters, and the fees involved.

5.04 Media Presentations

When psychologists provide public advice or comment via print, Internet, or other electronic transmission, they take precautions to ensure that statements (1) are based on their professional knowledge, training, or experience in accord with appropriate psychological literature and practice; (2) are otherwise consistent with this Ethics Code; and (3) do not

indicate that a professional relationship has been established with the recipient. (See also Standard 2.04, Bases for Scientific and Professional Judgments (?item=5#204) .)

5.05 Testimonials
Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence.

5.06 In-Person Solicitation
Psychologists do not engage, directly or through agents, in uninvited in-person solicitation of business from actual or potential therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence. However, this prohibition does not preclude (1) attempting to implement appropriate collateral contacts for the purpose of benefiting an already engaged therapy client/patient or (2) providing disaster or community outreach services.

Section 6: Record Keeping and Fees

6.01 Documentation of Professional and Scientific Work and Maintenance of Records
Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law. (See also Standard 4.01, Maintaining Confidentiality (?item=7#401) .)

6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work
(a) Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium. (See also Standards 4.01, Maintaining Confidentiality (?item=7#401) , and 6.01, Documentation of Professional and Scientific Work and Maintenance of Records (#601) .)

(b) If confidential information concerning recipients of psychological services is entered into databases or systems of records available to persons whose access has not been consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers.

(c) Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice. (See also Standards 3.12, Interruption of Psychological Services (?item=6#312) , and 10.09, Interruption of Therapy (?item=13#1009) .)

6.03 Withholding Records for Nonpayment
Psychologists may not withhold records under their control that are requested and needed for a client's/patient's emergency treatment solely because payment has not been received.

6.04 Fees and Financial Arrangements

(a) As early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements.

(b) Psychologists' fee practices are consistent with law.

(c) Psychologists do not misrepresent their fees.

(d) If limitations to services can be anticipated because of limitations in financing, this is discussed with the recipient of services as early as is feasible. (See also Standards 10.09, Interruption of Therapy (?item=13#1009) , and 10.10, Terminating Therapy (?item=13#1010) .)

(e) If the recipient of services does not pay for services as agreed, and if psychologists intend to use collection agencies or legal measures to collect the fees, psychologists first inform the person that such measures will be taken and provide that person an opportunity to make prompt payment. (See also Standards 4.05, Disclosures (?item=7#405) ; 6.03, Withholding Records for Nonpayment (#603) ; and 10.01, Informed Consent to Therapy (?item=13#1001) .)

6.05 Barter with Clients/Patients

Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative. (See also Standards 3.05, Multiple Relationships (?item=6#305) , and 6.04, Fees and Financial Arrangements (#604) .)

6.06 Accuracy in Reports to Payors and Funding Sources

In their reports to payors for services or sources of research funding, psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided or research conducted, the fees, charges, or payments, and where applicable, the identity of the provider, the findings, and the diagnosis. (See also Standards 4.01, Maintaining Confidentiality (?item=7#401) ; 4.04, Minimizing Intrusions on Privacy (?item=7#404) ; and 4.05, Disclosures (?item=7#405) .)

6.07 Referrals and Fees

When psychologists pay, receive payment from, or divide fees with another professional, other than in an employer-employee relationship, the payment to each is based on the services provided (clinical, consultative, administrative, or other) and is not based on the referral itself. (See also Standard 3.09, Cooperation with Other Professionals (?item=6#309) .)

Section 7: Education and Training

7.01 Design of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that the programs are designed to provide the appropriate knowledge and proper experiences, and to meet the requirements for licensure, certification, or other goals for

which claims are made by the program. (See also Standard 5.03, Descriptions of Workshops and Non-Degree-Granting Educational Programs (?item=8#503) .)

7.02 Descriptions of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that there is a current and accurate description of the program content (including participation in required course- or program-related counseling, psychotherapy, experiential groups, consulting projects, or community service), training goals and objectives, stipends and benefits, and requirements that must be met for satisfactory completion of the program. This information must be made readily available to all interested parties.

7.03 Accuracy in Teaching

(a) Psychologists take reasonable steps to ensure that course syllabi are accurate regarding the subject matter to be covered, bases for evaluating progress, and the nature of course experiences. This standard does not preclude an instructor from modifying course content or requirements when the instructor considers it pedagogically necessary or desirable, so long as students are made aware of these modifications in a manner that enables them to fulfill course requirements. (See also Standard 5.01, Avoidance of False or Deceptive Statements (?item=8#501) .)

(b) When engaged in teaching or training, psychologists present psychological information accurately. (See also Standard 2.03, Maintaining Competence (?item=5#203) .)

7.04 Student Disclosure of Personal Information

Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.

7.05 Mandatory Individual or Group Therapy

(a) When individual or group therapy is a program or course requirement, psychologists responsible for that program allow students in undergraduate and graduate programs the option of selecting such therapy from practitioners unaffiliated with the program. (See also Standard 7.02, Descriptions of Education and Training Programs (#702) .)

(b) Faculty who are or are likely to be responsible for evaluating students' academic performance do not themselves provide that therapy. (See also Standard 3.05, Multiple Relationships (?item=6#305) .)

7.06 Assessing Student and Supervisee Performance

(a) In academic and supervisory relationships, psychologists establish a timely and specific process for providing feedback to students and supervisees. Information regarding the process is provided to the student at the beginning of supervision.

(b) Psychologists evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.

7.07 Sexual Relationships with Students and Supervisees

Psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority. (See also Standard 3.05, Multiple Relationships (?item=6#305) .)

Section 8: Research and Publication

8.01 Institutional Approval

When institutional approval is required, psychologists provide accurate information about their research proposals and obtain approval prior to conducting the research. They conduct the research in accordance with the approved research protocol.

8.02 Informed Consent to Research

(a) When obtaining informed consent as required in Standard 3.10, Informed Consent, psychologists inform participants about (1) the purpose of the research, expected duration, and procedures; (2) their right to decline to participate and to withdraw from the research once participation has begun; (3) the foreseeable consequences of declining or withdrawing; (4) reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort, or adverse effects; (5) any prospective research benefits; (6) limits of confidentiality; (7) incentives for participation; and (8) whom to contact for questions about the research and research participants' rights. They provide opportunity for the prospective participants to ask questions and receive answers. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research (#803) ; 8.05, Dispensing with Informed Consent for Research (#805) ; and 8.07, Deception in Research (#807) .)

(b) Psychologists conducting intervention research involving the use of experimental treatments clarify to participants at the outset of the research (1) the experimental nature of the treatment; (2) the services that will or will not be available to the control group(s) if appropriate; (3) the means by which assignment to treatment and control groups will be made; (4) available treatment alternatives if an individual does not wish to participate in the research or wishes to withdraw once a study has begun; and (5) compensation for or monetary costs of participating including, if appropriate, whether reimbursement from the participant or a third-party payor will be sought. (See also Standard 8.02a, Informed Consent to Research (#802a) .)

8.03 Informed Consent for Recording Voices and Images in Research

Psychologists obtain informed consent from research participants prior to recording their voices or images for data collection unless (1) the research consists solely of naturalistic observations in public places, and it is not anticipated that the recording will be used in a manner that could cause personal identification or harm, or (2) the research design includes deception, and consent for the use of the recording is obtained during debriefing. (See also Standard 8.07, Deception in Research (#807) .)

8.04 Client/Patient, Student, and Subordinate Research Participants

(a) When psychologists conduct research with clients/patients, students, or subordinates as participants, psychologists take steps to protect the prospective participants from adverse consequences of declining or withdrawing from participation.

(b) When research participation is a course requirement or an opportunity for extra credit, the prospective participant is given the choice of equitable alternative activities.

8.05 Dispensing with Informed Consent for Research

Psychologists may dispense with informed consent only (1) where research would not reasonably be assumed to create distress or harm and involves (a) the study of normal educational practices, curricula, or classroom management methods conducted in educational settings; (b) only anonymous questionnaires, naturalistic observations, or archival research for which disclosure of responses would not place participants at risk of criminal or civil liability or damage their financial standing, employability, or reputation, and confidentiality is protected; or (c) the study of factors related to job or organization effectiveness conducted in organizational settings for which there is no risk to participants' employability, and confidentiality is protected or (2) where otherwise permitted by law or federal or institutional regulations.

8.06 Offering Inducements for Research Participation

(a) Psychologists make reasonable efforts to avoid offering excessive or inappropriate financial or other inducements for research participation when such inducements are likely to coerce participation.

(b) When offering professional services as an inducement for research participation, psychologists clarify the nature of the services, as well as the risks, obligations, and limitations. (See also Standard 6.05, Barter with Clients/Patients (?item=9#605) .)

8.07 Deception in Research

(a) Psychologists do not conduct a study involving deception unless they have determined that the use of deceptive techniques is justified by the study's significant prospective scientific, educational, or applied value and that effective nondeceptive alternative procedures are not feasible.

(b) Psychologists do not deceive prospective participants about research that is reasonably expected to cause physical pain or severe emotional distress.

(c) Psychologists explain any deception that is an integral feature of the design and conduct of an experiment to participants as early as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the data collection, and permit participants to withdraw their data. (See also Standard 8.08, Debriefing (#808) .)

8.08 Debriefing

(a) Psychologists provide a prompt opportunity for participants to obtain appropriate information about the nature, results, and conclusions of the research, and they take reasonable steps to correct any misconceptions that participants may have of which the psychologists are aware.

(b) If scientific or humane values justify delaying or withholding this information, psychologists take reasonable measures to reduce the risk of harm.

(c) When psychologists become aware that research procedures have harmed a participant, they take reasonable steps to minimize the harm.

8.09 Humane Care and Use of Animals in Research

(a) Psychologists acquire, care for, use, and dispose of animals in compliance with current federal, state, and local laws and regulations, and with professional standards.

(b) Psychologists trained in research methods and experienced in the care of laboratory animals supervise all procedures involving animals and are responsible for ensuring appropriate consideration of their comfort, health, and humane treatment.

(c) Psychologists ensure that all individuals under their supervision who are using animals have received instruction in research methods and in the care, maintenance, and handling of the species being used, to the extent appropriate to their role. (See also Standard 2.05, Delegation of Work to Others (?item=5#205) .)

(d) Psychologists make reasonable efforts to minimize the discomfort, infection, illness, and pain of animal subjects.

(e) Psychologists use a procedure subjecting animals to pain, stress, or privation only when an alternative procedure is unavailable and the goal is justified by its prospective scientific, educational, or applied value.

(f) Psychologists perform surgical procedures under appropriate anesthesia and follow techniques to avoid infection and minimize pain during and after surgery.

(g) When it is appropriate that an animal's life be terminated, psychologists proceed rapidly, with an effort to minimize pain and in accordance with accepted procedures.

8.10 Reporting Research Results

(a) Psychologists do not fabricate data. (See also Standard 5.01a, Avoidance of False or Deceptive Statements (?item=8#501a) .)

(b) If psychologists discover significant errors in their published data, they take reasonable steps to correct such errors in a correction, retraction, erratum, or other appropriate publication means.

8.11 Plagiarism

Psychologists do not present portions of another's work or data as their own, even if the other work or data source is cited occasionally.

8.12 Publication Credit

(a) Psychologists take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have substantially contributed. (See also Standard 8.12b, Publication Credit (#812b) .)

(b) Principal authorship and other publication credits accurately reflect the relative scientific or professional contributions of the individuals involved, regardless of their relative status. Mere possession of an institutional position, such as department chair, does not justify authorship credit. Minor contributions to the research or to the writing for publications are acknowledged appropriately, such as in footnotes or in an introductory statement.

(c) Except under exceptional circumstances, a student is listed as principal author on any multiple-authored article that is substantially based on the student's doctoral dissertation. Faculty advisors discuss publication credit with students as early as feasible and throughout the research and publication process as appropriate. (See also Standard 8.12b, Publication Credit (#812b) .)

8.13 Duplicate Publication of Data
Psychologists do not publish, as original data, data that have been previously published. This does not preclude republishing data when they are accompanied by proper acknowledgment.

8.14 Sharing Research Data for Verification
(a) After research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release. This does not preclude psychologists from requiring that such individuals or groups be responsible for costs associated with the provision of such information.

(b) Psychologists who request data from other psychologists to verify the substantive claims through reanalysis may use shared data only for the declared purpose. Requesting psychologists obtain prior written agreement for all other uses of the data.

8.15 Reviewers
Psychologists who review material submitted for presentation, publication, grant, or research proposal review respect the confidentiality of and the proprietary rights in such information of those who submitted it.

Section 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 (?item=5#204) .)

(b) Except as noted in 9.01c (#901c) , 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 (?item=5#201) , and 9.06, Interpreting Assessment Results (#906) .)

(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.

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.

(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.

(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.

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.

(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.

(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 (?item=5#205) ; 4.01, Maintaining Confidentiality (?item=7#401) ; 9.01, Bases for Assessments (#901) ; 9.06, Interpreting Assessment Results (#906) ; and 9.07, Assessment by Unqualified Persons (#907) .)

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 (#911) .)

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

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.

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 (?item=5#201b) , and 3.01, Unfair Discrimination (?item=6#301) .)

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 (?item=5#205) .)

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.

(b) Psychologists do not base such decisions or recommendations on tests and measures that are obsolete and not useful for the current purpose.

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.

(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 (?item=5#201b) .)

(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.

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.

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 (#904) . 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.

Section 10: Therapy

10.01 Informed Consent to Therapy

(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent (?item=6#310) , 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 (?item=7#402) , and 6.04, Fees and Financial Arrangements (?item=9#604) .)

(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 (?item=5#201e) , and 3.10, Informed Consent (?item=6#310) .)

(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.

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 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 (?item=7#402) .)

(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 (?item=6#305c) .)

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.

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.

10.05 Sexual Intimacies with Current Therapy Clients/Patients

Psychologists do not engage in sexual intimacies with current therapy clients/patients.

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.

10.07 Therapy with Former Sexual Partners

Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies.

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.

(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 (?item=6#305) .)

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 (?item=6#312) .)

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.

(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.

(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.

History and Effective Date

The American Psychological Association's Council of Representatives (/about/governance/council/index.aspx) adopted this version of the APA Ethics Code during its meeting on Aug. 21, 2002. The Code became effective on June 1, 2003. The Council of Representatives amended this version of the Ethics Code on Feb. 20, 2010, effective June 1, 2010, and on Aug. 3, 2016, effective Jan. 1, 2017. Inquiries concerning the substance or interpretation of the APA Ethics Code should be addressed to the Director, Office of Ethics, American Psychological Association, 750 First St. NE, Washington, DC 20002-4242. The standards in this Ethics Code will be used to adjudicate complaints brought concerning alleged conduct occurring on or after the effective date. Complaints will be adjudicated on the basis of the version of the Ethics Code that was in effect at the time the conduct occurred.

The APA has previously published its Ethics Code as follows:

American Psychological Association. (1953). *Ethical standards of psychologists*. Washington, DC: Author.

American Psychological Association. (1959). Ethical standards of psychologists. *American Psychologist, 14*, 279-282.

American Psychological Association. (1963). Ethical standards of psychologists. *American Psychologist, 18*, 56-60.

American Psychological Association. (1968). Ethical standards of psychologists. *American Psychologist, 23*, 357-361.

American Psychological Association. (1977, March). Ethical standards of psychologists. *APA Monitor*, 22-23.

American Psychological Association. (1979). *Ethical standards of psychologists*. Washington, DC: Author.

American Psychological Association. (1981). Ethical principles of psychologists. *American Psychologist, 36*, 633-638.

American Psychological Association. (1990). Ethical principles of psychologists (Amended June 2, 1989). *American Psychologist, 45*, 390-395.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47*, 1597-1611.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57*, 1060-1073.

American Psychological Association. (2010). 2010 amendments to the 2002 "*Ethical Principles of Psychologists and Code of Conduct.*" *American Psychologist, 65*, 493.

American Psychological Association. (2016). Revision of ethical standard 3.04 of the "*Ethical Principles of Psychologists and Code of Conduct*" (2002, as amended 2010). *American Psychologist, 71*, 900.

Request copies of the APA's Ethical Principles of Psychologists and Code of Conduct from the APA Order Department, 750 First St. NE, Washington, DC 20002-4242, or phone (202) 336-5510.

Amendments to the 2002 "Ethical Principles of Psychologists and Code of Conduct" in 2010 and 2016

2010 Amendments

Introduction and Applicability

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner~~. If the conflict is unresolvable via such means,~~

~~psychologists may adhere to the requirements of the law, regulations, or other governing authority~~ in keeping with basic principles of human rights.

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority
If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. ~~If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing legal authority.~~Under no circumstances may this standard be used to justify or defend violating human rights.

1.03 Conflicts Between Ethics and Organizational Demands
If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and ~~to the extent feasible, resolve the conflict in a way that permits adherence to the Ethics Code.~~take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

2016 Amendment

3.04 Avoiding Harm
(a) Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

(b) Psychologists do not participate in, facilitate, assist, or otherwise engage in torture, defined as any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person, or in any other cruel, inhuman, or degrading behavior that violates 3.04(a).

Find this article at:
https://www.apa.org/ethics/code/index.aspx

Professional Psychology: Research and Practice
2009, Vol. 40, No. 1, 1–7

0735-7028/09/$12.00 DOI: 10.1037/a0014011

Replacing "Who Is the Client?" With a Different Ethical Question

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The familiar question, "Who is the client?" has become a distraction from more important ethical questions. By requiring a singular answer, the question obscures the fact that psychologists have ethical obligations toward every party in a case, no matter how many or how named. Making the question plural is not a sufficient solution, because identifying the client(s) should not be treated as an end in itself; it is simply a means of clarifying the nature of the relationship(s) and understanding the accompanying ethical obligations. After exploring the underlying implications for informed consent, confidentiality, and other ethical duties, the author suggests that psychologists adopt an alternative ethical question: "What are my ethical responsibilities to each of the parties in this case?" Finally, a case example illustrates the fact that the old question has several different meanings (and therefore different answers), depending upon whether it is asked as an ethical, clinical, legal, or reimbursement question. The proposed new question avoids such confusion because it is easily identifiable as an ethical question and its meaning is clear.

Keywords: ethics, informed consent, clients, obligations, ethical decision making

"Who is the client?" The question invites a singular answer. Yet in the very circumstances when the question is most relevant, the need for clarification arises precisely because there may be more than one client.

The question actually appears in this form only once in the American Psychological Association (APA; 2002) Ethics Code; Standard 3.07 ("Third-Party Requests for Services") poses the question in the singular. Two other ethical standards (3.11, "Psychological Services Delivered to or Through Organizations," and 10.02, "Therapy Involving Couples or Families") imply a plural answer. But the question, "Who is the client?" has become so familiar that psychologists tend to ask it across a range of cases.

The problem is that the question, "Who is the client?" encourages psychologists to name one person or entity as *the* client, even though they may have relationships with several different clients, perhaps several different types of clients, in a single case.

> The notion of a singular client has gotten us into a real bind. It has become an impediment to thinking in a careful and nuanced manner about our ethical obligations, which even in our binary approach extend beyond "the" client. (S. Behnke, personal communication, August 3, 2007)

In other words, the question obscures the fact that psychologists have ethical obligations to all parties in every case, regardless of the number or the nature of the relationships.

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Nevertheless, some casebooks that explicate the APA Ethics Code recommend that psychologists identify a single person or entity as the client. For example, regarding Standard 3.07, Nagy (2005) phrases the question as "Who, exactly, will be the client or recipient of your services?" (p. 84), suggesting that there is only one. C. B. Fisher (2003) similarly states that this ethical standard requires "identifying whether the third party or the individual receiving the services is the client" (p. 73), again suggesting that psychologists should specify only one individual or entity as the client.

This single-client recommendation sometimes appears even when the ethical standard itself implies the plural. For example, in therapy cases involving multiple clients who are related to each other, Standard 10.02 (APA, 2002) requires psychologists to ask, "Which of the individuals are patients or clients?" Nagy (2005) nevertheless suggests that psychologists must make clear "which person is actually your client or patient" (p. 297), implying a single answer. C. B. Fisher (2003) first uses a plural subject with a singular verb: "Psychologists must identify and explain which members of the couple or family is [sic] the primary client/patient" (p. 219). But the singular is emphasized by the suggestion that psychologists may identify as the client or patient either the multiperson unit or a single individual; there is no mention of the possibility that several individuals might be considered clients.

In contrast, Knapp and VandeCreek (2003), when discussing therapy with couples and families, do not mention identifying the client(s). Instead, their first recommendation is that psychologists "clarify their roles and their relationships with all parties" (p. 148). Similarly, Pope and Vasquez (2007) focus not on client identification but on ensuring that "informed consent and informed refusal is provided for each person" (p. 146). When Koocher and Keith-Spiegel (2008) discuss the question, "Who is the client?" in the context of challenging work settings, they provide a broad answer:

> The professional has an obligation to clarify the nature of the ethical duties due each party, to inform all concerned about the ethical constraints, if any, and to take any steps necessary to ensure appropriate respect for the rights of the person at the bottom of the client hierarchy. (p. 486)

Such clarification is considered so ethically important that the APA Ethics Code references the initial informed-consent conversation in a dozen separate ethical standards (M. A. Fisher, 2007). The content of this conversation necessarily varies, depending on the context and the nature of the prospective relationship; but it would be a mistake to presume that the psychologist needs to provide clarifying information to (or obtain consent from) only one party (i.e., a single client), whether about the limits of confidentiality or about other important aspects of the psychologist's policies. (See Table 1.)

Third-Party Requests

In cases involving third-party requests for services, it can be very misleading to name only one party as the client. These cases often have at least two different types of client: the individual or entity contracting for services and the individual receiving the services. For example, a forensic psychologist may have both a contracted relationship with a court to provide a court-ordered assessment and a clinical relationship with one or more individuals who receive the contracted services. Haas and Malouf (2005), in discussing the potential loyalty conflict in such cases, suggest that "it might reasonably be argued that the 'patient' is the court, at least as much as is the individual sitting in the consulting room" (p. 64). Describing the court as the "patient" in a forensic case seems very awkward, but it would certainly be appropriate to describe the court as a client—in this case, the contracted client.

In such a case, however, forensic psychologists are being trained to identify the court as the client. This has not always been the case. In the current forensic guidelines (APA & American Board of Forensic Psychologists, 1991), the word *client* is used only to refer to the examinee. However, in the proposed new guidelines for forensic psychologists (APA & American Board of Forensic Psychologists, 2008), the definition of *client* is limited to mean only "the attorney, law firm, court, agency, entity, party, or other person who has retained, and who has a contractual relationship with, the forensic practitioner to provide services" (p. 20). Throughout the document, the word *client* carries only this meaning; the person receiving the assessment services is described instead as the "examinee" (p. 20).

But ethically speaking, the person receiving the contracted services is certainly also a client in such cases, holding the rights (and deserving the protections) of any client receiving assessment services. Thus, although the confidentiality of the information obtained from forensic examinees may be limited (or even removed) by the third-party contract or court order, this does not mean the examinees have no rights at all about confidentiality. On the contrary, they have the right to be informed in advance about the potential limits (or complete absence) of confidentiality, about the foreseeable uses of the information that will be obtained from the assessment, and about their right to consent or refuse to participate. The ethical obligation to conduct this conversation with all assessment clients arises from Standards 3.10c, "Informed Consent"; 4.02, "Discussing the Limits of Confidentiality"; and 9.03, "Informed Consent to Assessments" (APA, 2002). In the context of forensic cases, this ethical duty becomes doubly important, because the examinee's legal and civil rights can be left unprotected if this information is not provided.

It thus seems most accurate to think of these two entities—the court and the examinee—as two different types or levels of client. All clients have rights. In this example, the court may have established (through its contract or in its order) the right to receive the results of a timely evaluation in the form of an accurate report (or for court-ordered therapy, a description of services rendered, a treatment summary or compliance report, etc.). The person receiving the contracted assessment services has the right to receive a competent evaluation, as well as the right to be informed in advance about the psychologist's prior relationship with the court and any limits of confidentiality that will be imposed by that contract. Regardless of whether a court or some other third party contracts for the services, naming only one entity as the client obscures the fact that the psychologist has important ethical obligations to both.

Koocher (2007) concurs that "both the entity requesting the service and the person undergoing evaluation hold a kind of client status in such cases" (p. 380). He includes such client-identification issues among the ethical challenges facing 21st-century psychologists; but that does not mean this issue is new. It was addressed as long ago as 1980, when Monahan made *Who Is the Client?* the title of a classic monograph about dilemmas faced by psychologists in the criminal justice system. "What psychology

Table 1
Ethical Responsibilities in Clarifying Client Relationships During Initial Informed Consent Interview

Ethical standard	Ethical mandate: Identify client(s) implies:		Ethical mandate: Clarify nature of all relationship(s); nature of services; role(s); fees; involvement of third parties; intended recipients of services; probable uses of information; limits of confidentiality, etc.
	Singular answer	Plural answer	
3.07 (Third-party requests for services)	√		√
3.11 (Services to/through organizations)		√	√
9.03 (Informed consent to assessments)			√
10.01 (Informed consent to therapy)			√
10.02 (Therapy with couples or families)		√	√

Note. Ethical standards are taken from American Psychological Association (2002).

appears to lack at the present time is an effective way to differentiate obligations owed to organizational as opposed to individual clients" (Monahan, 1980, p. 2). Noting the potential conflict between the interests of the referring entity and the interests of the individual receiving services, Monahan's (1980) first recommendation was that psychologists inform all parties of the circumstances that might affect confidentiality. The implications of this recommendation would apply in any third-party referral, whether the third party is a court, an agency or organization, an attorney, or another individual. (See also Services to or Through Organizations, below.)

Cases Involving Family Members

Matters become more complicated if the third party requesting the services is a family member of the person receiving the services. For example, psychologists who provide individual therapy to children usually do so at the request of some third party, most often the child's parents. If we think of this only as a third-party request, the "single client" rule in Standard 3.07 (APA, 2002) would seem to apply. But although it is appropriate to identify the child as the *therapy client*, it is important to remember that the psychologist incurs ethical responsibilities toward the parents as well. When he or she meets with them, they are not therapy clients; so what are they? The APA Insurance Trust (APAIT; 2006) suggests that they be considered *collaterals* to the child's therapy. If parents are seen separately, they might be called *parent consultation clients*, in addition to being considered third-party referral agents and/or collaterals. But what if child and parents are sometimes seen together? If this makes everyone *family therapy clients*, will Standard 10.02 apply? If so, that standard suggests the possibility of plural clients. But a family-systems therapist may argue that often the family unit should be considered the client, even if the family members are seen separately. What is obscured by this confusing client-identification process is the fact that psychologists have ethical responsibilities to all these family members, regardless of what they are called or how the case is structured.

Cases involving related individuals are also complicated when clinical services to the family are requested by an agency or ordered by a court. As in the third-party referrals described above, what is ethically important is that each party has a right to receive, in advance, an explanation of the psychologist's role; a clarification of the nature of the relationship; an explanation of rights; a discussion of probable uses of the services provided and the information obtained; and an explanation of limits of confidentiality, including how each party's confidentiality may be affected by the third party's involvement (see Standards 3.07 and 10.02; APA, 2002).

In all cases involving family members, Pope and Vasquez (2007) stress the importance of providing everyone with clear answers to such clinically important questions as, "Will the therapist hold confidential from one family member material disclosed by another family member?" (p. 146). Knapp and VandeCreek (2006) similarly note the importance of discussing with everyone "the role of secrets" and the "rules for confidentiality with minors" (p. 105). Therapists disagree about such matters, so their confidentiality rules in couple and family cases can vary greatly; this means that each psychologist is the only source of accurate information about exactly what the policies will be. This poses no ethical problem as long as psychologists "clarify their policy at the outset of therapy" (Knapp & VandeCreek, 2006, p. 117). However, failure to provide adequate explanations to all parties in advance is one of the common confidentiality pitfalls in therapies with couples and families (Weeks, Odell, & Methven, 2005).

This initial clarification is especially important in cases where the relationship will not be the same with all parties. Clinically speaking, all the members of the family may be therapy clients; but ethically speaking, this does not necessarily mean that they all have exactly the same rights. For example, a minor's confidentiality rights are not usually the same as those of the parent(s). Some difference in rights will likely arise voluntarily (as when psychologists have differential disclosure policies to protect the safety of minors or impaired family members), but other differences in rights can be imposed by law.

Legally speaking, minors' rights vary from state to state. Some states allow minors to seek outpatient mental health treatment without parental consent; many states allow parents to have access to the treatment records of their minor child; and some states allow both. This means that the psychologist must be very familiar not only with the minor's legal rights, but also with the parents' legal rights, whether or not the parents are to be considered therapy clients. Further complicating matters is the fact that the federal Health Insurance Portability and Accountability Act (HIPAA) regulations interact in complicated ways with these state laws, leading to differing privacy rights for minors across state jurisdictions. The APA Legal and Regulatory Affairs staff (APA, 2005) has provided a helpful discussion of these legal complications.

Regardless of the legal specifics, the initial informed-consent discussion can require significant preparation in any case involving minors. In advance, psychologists must determine their own preferences about what information they will voluntarily disclose to parents, and when; must learn how their policies will be affected by state laws, including abuse reporting laws; must clarify the HIPAA implications (if applicable); then must develop very clear policies consistent with those legal constraints. Only with such planning will the psychologist be prepared to fulfill the ethical obligation to describe in advance, to both the parent(s) and the minor(s), exactly when confidentiality will apply and when information will be disclosed (M. A. Fisher, 2002).

For documenting this conversation in adolescent therapy cases, Kraft (2005) has provided a sample informed-consent form to be signed by both the adolescent and the parents. As with all such forms, however, it must be adapted to match the policies in the setting; details will differ from therapist to therapist, depending on the combination of legally imposed and voluntarily imposed exceptions to confidentiality. With younger minors or with other family members legally incapable of giving informed consent, psychologists are ethically responsible for providing an age-appropriate explanation, seeking their assent to participate, considering their preferences and best interests, and obtaining formal consent from the parent(s) or guardian(s). (See Standard 3.10, "Informed Consent"; APA, 2002.)

Clearly, settling for a single answer to "Who is the client?" in such cases would not only have ethical and legal ramifications, but could also create unnecessary clinical complications. Family members who were not adequately informed in advance will have every reason to feel betrayed if information about them is later disclosed

unexpectedly to other family members or to third parties. Failing to address the important issues with all parties; making incompatible promises to different family members; and/or failing to encourage questions and provide honest answers—such ethical missteps at the beginning can deprive everyone of the opportunity to make an informed decision about whether to participate.

Services to or Through Organizations

In cases involving organizations, the APA Ethics Code suggests a plural answer to the "Who is the client?" question. But Standard 3.11 ("Psychological Services Delivered to or Through Organizations") is somewhat confusing in two respects. First, it applies to two very different types of circumstances (e.g., a psychologist providing consultation services *to* an organization and a psychologist providing services *through* an organization that employs or contracts with him/her). Second, the wording makes it difficult to be sure who is considered a client in either of these circumstances: "Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about . . . which of the individuals are clients" (APA, 2002, p. 1066). This standard leaves some important questions unanswered: First, are the clients of the first phrase the same as those of the second? If not, what is the relationship between the two? Second, are "those directly affected by the services" not also considered clients? If not, what are they? Will the answers vary depending on the circumstance or the psychologist's role?

Psychologists who provide services to organizations may encounter complications similar to those in third-party referral cases. For example, a psychologist might have a contract with a corporation, specifying a plan for providing leadership consultation to the CEO, in addition to case consultation to several of his managers who have problematic relationships with their supervisees. The psychologist might meet with the CEO, with the managers, with their supervisees, and perhaps with other employees. Asking "Who is the client?" may lead to the simple answer: "The corporation is my client, because it issued the contract and pays my fee." But this answer provides the psychologist with no guidance about specific ethical responsibilities in the complex relationships that will be developed with individuals within this corporate system. What are their individual rights? How do they differ? What will happen to the information confided to the psychologist by the CEO? By the managers? By their supervised employees? It probably will not be appropriate for the psychologist to promise the same level of confidentiality in each of these relationships; so the limits of the confidentiality will need to be defined in advance, explained at the initial informed-consent interview with the CEO, and made clear to each individual at each level of the consultation process. None of this will be adequately clarified in the mind of the consulting psychologist who relies on the "Who is the client?" question and settles for its single answer.

In organizational consulting relationships, a singular answer is usually presumed (Kramer, Kleindorfer, & Colarelli, 1992), even though "there are no specific guidelines for determining who the client is or should be in complex consulting situations" (Kramer, Kleindorfer, & Colarelli-Beatty, 1994, p. 12). As a result, psychologists who consult to organizations or agencies give very differing answers to the "Who is the client?" question when faced with sample case scenarios. The wide-ranging rationales for their choice of "most important client" include "who holds organizational authority, who is responsible to solve the problem, who will be impacted by the solution, and who is the initial contact person" (Kramer et al., 1994, p. 11).

Psychologists who provide services through organizations may encounter conflicting loyalties when the interests of the employing (or contracting) organization conflict with the interests of the party receiving the services. In this regard, no circumstances are more complex than those faced by psychologists who work within the school setting, with differing ethical responsibilities to their employer, to the students who receive their services, to the teachers who elicit their consultation, and to staff colleagues who are members of their team. No single-answer question would adequately clarify the potential conflicts of interest or the complicated confidentiality rules that must be established and explained among those relationships.

Less discussed are the potentially conflicting loyalties psychologists face when they sign legally binding managed care contracts or other reimbursement agreements, under which they become contracted providers for third-party-payer organizations. Legally speaking, this may not be considered the same as providing services through those organizations; but ethically speaking, similar issues are involved. Such contracts bind the psychologist to operate within the organization's guidelines, thus creating the ethical requirement that they inform persons receiving services about the implications of the prior organizational relationship. For providers of clinical services, this ethical duty might arise from several different APA ethical standards. Under Standard 3.06 ("Conflict of Interest"), psychologists must consider whether their contract with the reimbursement organization would create a potential conflict of interest (e.g., if it offers an incentive for the psychologist to limit services). Under Standard 3.11 ("Psychological Services Delivered to or Through Organizations"), therapy clients have the right to be informed about "the relationship the psychologist will have with each person and the organization" (APA, 2002, p. 1066). And under Standard 4.05 ("Disclosures"), clients have the right to give (or to refuse) consent for information to be disclosed to the contracted third party for obtaining reimbursement.

When asked as a reimbursement question, "Who is the client?" ordinarily requires a singular answer to meet third-party payer requirements; and that answer may be different from the answer obtained when the question is asked from a clinical, legal, or ethical perspective. (See case example, below.) Ethically, what is important to remember is that for the person who is to be billed as the client, the psychologist is the only possible source of information about what will be sent to the third-party payer. For disclosures to reimbursement organizations, the informed consent process therefore requires (a) designating the person under whose name the services will be billed; (b) informing that person about the nature of the information to be disclosed and the potential implications of disclosing it; and then (c) seeking explicit consent to make the disclosure. Once fully informed, the person can make a voluntary decision about whether to give consent for the planned disclosure or whether instead to give informed refusal. It is impossible at intake to predict the content of future disclosures, but the client's rights can be protected by renewing the informed consent discussion at the time of the disclosure (M. A. Fisher, 2008). In fact, Acuff et al. (1999) suggested that it should be the

"usual rule of thumb" to discuss each treatment plan at the time of transmission with the client in whose name it is being sent (p. 570).

New Ethical Question?

Obviously, to ask, "Who is the client?" is not helpful enough in these case examples. In fact, seeking a singular answer can create more problems than it solves. But making the question plural does not solve the problem. Whether singular or plural, the question obscures the fact that identifying the client(s) is only a beginning, not an end in itself. It is simply a means to the important end of clarifying the psychologist's ethical responsibilities.

If we stop asking "Who is the client?" what should we ask instead? Regardless of the type of case or the number of relationships it involves, the question psychologists should ask might be "Exactly what are my ethical responsibilities to each of the parties in this case?"

This new question reminds psychologists that they are responsible for protecting the rights of everyone involved—those who request services; those who receive services; those who participate as collaterals in the services provided to others; "outsiders" who provide information; others to whom information is disclosed, etc. This is consistent with the ethical duty to clarify the nature of relationships, regardless of what they are called; to conduct an informed-consent conversation that describes the psychologist's role; and to explain the resulting limitations on confidentiality as they will apply to each party (see Table 1).

This new question is consistent with the fact that psychologists have an ethical obligation to clarify such things with all involved parties, not just with the party requesting or receiving the psychological services. With third-party referrals, it is a reminder that psychologists have an ethical obligation to provide in advance (preferably in a written contract) clarification of the nature of all the proposed relationships, as well as a description of what (if any) information will be provided to the referring third party about the services received. Similarly, in cases involving collaterals (whether family members or others), it is a reminder of the obligation to inform them that their relationship with the psychologist (and their rights) will not be the same as those of the person(s) receiving the therapy or assessment (APAIT, 2006). In any type of case, this new question would help psychologists prepare to discuss with each party exactly how confidentiality will apply (or not apply) in the relationship, making it possible to obtain truly informed consent for their participation (M. A. Fisher, 2008).

This new question does not imply that psychologists should abandon the term *client* altogether. It does require, however, that psychologists identify the type of client as a means of understanding their differential ethical responsibilities. This becomes especially important for psychologists who provide therapy services. In its section on therapy relationships, the APA Ethics Code (2002) uses the terms *client* and *patient* interchangeably; but regardless of what they are to be called, persons in therapy relationships are deemed more vulnerable and are therefore given special rights and safeguards. Thus, psychologists in therapy relationships have ethical duties beyond those described above, including responsibility for explaining potential risks (Standard 10.01, "Informed Consent to Therapy") and for dealing ethically with issues of interruption or termination of the relationship (Standards 10.09, "Interruption of Therapy," and 10.10, "Terminating Therapy"). Furthermore, beyond the broadly applicable ethical requirement to avoid multiple relationships that might lead to exploitation or harm (Standard 3.05, "Multiple Relationships"), in therapy relationships psychologists have four additional ethical standards that bar sexual relationships (Standards 10.05, "Sexual Intimacies With Current Therapy Clients/Patients"; 10.06, "Sexual Intimacies With Relatives or Significant Others of Current Therapy Clients/Patients"; 10.07, "Therapy With Former Sexual Partners"; and 10.08, "Sexual Intimacies With Former Therapy Clients/Patients"). These ethical duties make it important for psychologists to clarify for themselves the nature of their relationships and the type of services to be provided, in order to differentiate therapy clients/patients from other types of clients.

"What are my ethical responsibilities to each of the parties involved?" The answer will differ depending on whether the relationship is with a therapy client/patient, an assessment client, a collateral participant, a supervisee, a consultee, a contracted party, a research subject, or some other type of client. Whereas the old question does not help psychologists make ethical distinctions among these potentially overlapping types of relationships, the new question requires them to define the nature of each relationship in order to know which ethical duties will apply.

"What are my ethical responsibilities to each of the parties involved?" This new question is longer. It's not as catchy. It has no single-word answer. It requires us to consider the full range of our ethical obligations toward everyone involved. But isn't that exactly the point? As suggested years ago,

> When psychologists do try seriously to articulate who their client is—where their loyalties are to be given . . . they sometimes appear to be under the impression that they are constrained to a multiple-choice answer . . . . It appears to us that there is no need for psychologists to impale themselves on the horns of this dilemma, because "Who is the client?" is not a multiple-choice question. It requires an essay answer. (Monahan, 1980, p. 5)

Clarification: Ethical Question, Clinical Question, Reimbursement Question, or Legal Question?

So far, we have addressed the question, "Who is the client?" only from an ethical perspective. But the very same question is often asked from other perspectives—clinical, reimbursement, legal—and this creates confusion about its meaning and about how it should be answered.

As illustrated in the following case example, the meaning of the question can be understood only if one clarifies the perspective from which the question is being asked.

> *Mrs. Smith, a prospective therapy patient, is so severely depressed that she can make it to the intake session only with Mr. Smith's help. The therapist is not sure Mrs. Smith can provide adequate information for making decisions about dangerousness or for planning treatment. Mr. Smith is therefore invited to join her in the intake session and to attend some of the early therapy sessions. Mrs. Smith meets the criteria for a mental health diagnosis, but the third-party policy provided by her employer does not cover outpatient therapy, so she will pay for each session herself. Mr. Smith does not meet the criteria for a mental health diagnosis. He remains involved, as needed, in joint sessions that focus on Mrs. Smith's current status and future needs.*

"Who is the client?" If this is a clinical question, the therapist's answer might be simply that Mrs. Smith is the therapy client (or patient). However, the proposed new ethical question requires that the therapist determine the rights of all parties and clarify the therapist's ethical obligations in behalf of those rights. So the ethical answer in this case might therefore be the following: Mrs. Smith, as the individual receiving therapy services, will have all the rights afforded to therapy clients by the APA Ethics Code. Mr. Smith, whose participation is collateral to her treatment, has the right to an informed-consent conversation in which the psychologist defines his role and clarifies the nature of Mr. Smith's involvement, including the important fact that Mr. Smith does not have all the same rights (e.g., he may not be promised the same level of confidentiality) as the therapy patient.

Mrs. Smith's condition improves, and she begins making new decisions for her own life. This complicates her relationship with Mr. Smith. Her therapist refers them to a marital therapist.

The marital therapist might say: "Clinically, I consider Mr. and Mrs. Smith to be equally my clients" (or perhaps, from a systems perspective, "Clinically, I consider the couple to be my client"). The answer to the new ethical question might be: Ethically, they each have all the rights afforded to therapy clients by the APA Ethics Code, including the right to know whether or not I promise to maintain the confidentiality of communications made to me by one person when the other is not present.

Mr. Smith requests that the marital therapist submit a reimbursement claim to his managed care organization, which provides coverage for outpatient therapy, including family therapy.

The couple's therapist now asks, "Who is the client?" as a reimbursement question. In that context, the question will require a singular answer because third-party payers require that claims be filed in the name of one covered individual, even if the services are provided to more than one person (as in couples or family therapy). In this case, the therapist must determine whether Mr. Smith's policy covers marital therapy and decide whether it is appropriate to file a claim under Mr. Smith's name, and if so, under what diagnosis. Depending upon who has coverage and who qualifies for a mental health diagnosis, the answer to the reimbursement question may be completely different from the clinical and/or ethical answers, which will remain the same regardless of how the reimbursement question is answered. In this case, the answer to the reimbursement question may be either "Mr. Smith" or "no one," but that answer will vary case by case. If the couple's therapist does decide to submit a claim for reimbursement under Mr. Smith's name, the new ethical question serves as a reminder to protect Mr. Smith's right to be informed about what will be disclosed and the implications of disclosing it and (once so informed) his right to give (or to refuse) consent.

Mr. and Mrs. Smith decide to separate. Mr. Smith files for divorce and for custody of their two minor children. He alleges that he has suffered great emotional distress as a result of Mrs. Smith's depression and that she is still not emotionally able to provide good parenting. To produce evidence of this in his custody case, he wants both therapists to testify at the custody hearing. His attorney suggests that before making that decision he should invoke his legal right under HIPAA to obtain copies of the records.

For both therapists, "Who is the client?" now becomes a legal question that may take numerous forms: "Who has a legal right to obtain a copy of mental health treatment records?" or "Whose consent is legally required for voluntarily releasing records in a multiclient case?" Further legal questions will need to be answered in the context of the court case if a subpoena or court order creates a legal demand for involuntary disclosure of records, but one party contests the disclosure. "If one client receiving couple therapy waives privilege, does the privilege still apply to the other member of the couple?" (Pope & Vasquez, 2007, p. 146). The legal answers will differ from state to state.

Note, however, that each of these legal questions may also be asked as an ethical question, clarifying each therapist's ethical responsibilities about the confidentiality and disclosure of records. In such cases, it is easy for psychologists to become so focused on one meaning of the question that they forget to ask and to answer the others. Focusing on the reimbursement question can distract from the clinical question, or can lead to the mistaken assumption that both answers must always be the same. Similarly, when confused about the legal question or intimidated by legal demands for information, psychologists may have difficulty separating this from the clinical and reimbursement questions. But it is even more problematic and potentially more harmful to clients if psychologists are confused about the ethical question or forget to ask it at all. In that event, the rights of all parties can be placed at risk.

Throughout this case example, the ethical question has remained the same: "What are my ethical responsibilities to each of the parties in this case?" The two therapists needed to give different answers. But for both, one part of the answer was that they had an ethical responsibility to protect the right of both parties to receive, in advance, information that might affect their decision to participate. This required both therapists to be prepared to communicate a great deal of information before the relationship ever began. Such planning could have helped them anticipate the potential ethical–legal dilemma about confidentiality, giving them the opportunity to consider, in advance, their ethical options for responding to it. "Virtuous psychologists who demonstrate practical wisdom will cultivate a habit of deliberating about the salient ethical issues that they are likely to encounter, anticipate them, and develop policies to proactively address them" (Knapp, Gottlieb, Berman, & Handelsman, 2007, p. 58).

Unlike "Who is the client?" the proposed new question is easily identifiable as an ethical question. Its meaning is so clear that it would never be mistaken for a legal, clinical, or reimbursement question. It encourages psychologists to clarify all their relationships, exercise forethought, and become more ethically planful. These are important advantages of making the change.

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Received June 23, 2008
Revision received September 2, 2008
Accepted September 3, 2008 ■

DISCUSSION #2 Pd

Prior to beginning work on this discussion, read the Grenyer & Lewis (2012) "Prevalence, Prediction, and Prevention of Psychologist Misconduct" article and the APA Practice Central's Professional Health and Well-being for Psychologists (Links to an external site.)Links to an external site., Tips from Practitioners on Finding Work-Life Balance (Links to an external site.)Links to an external site., and Tips for Self-Care (Links to an external site.)Links to an external site.online articles.
Select two complaints presented in the Grenyer & Lewis article (see Table 1) and explain the ramifications of these violations applying the APA's Ethical Principles of Psychologists and Code of Conduct (Links to an external site.)Links to an external site. to each situation. Assess the role of the APA in assisting psychology professionals in the identification of potential areas of misconduct. Describe and recommend a course of action to avoid these areas. Evaluate the contemporary role of psychology professionals and elaborate on the relationship between self-care and the issue of maintaining ethical principles and professional standards. Identify one or two self-care tips, tools, or suggested courses of action provided on the APA's Self-care resources for psychologists (Links to an external site.)Links to an external site. website that might address the issues which lead to the chosen complaints.

Australian Psychologist

APS Australian Psychological Society

Prevalence, Prediction, and Prevention of Psychologist Misconduct

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Studies of psychologist misconduct generally focus on unethical sexual behaviours. In contrast, the following study reports on all complaints by the public against psychologists reported to the New South Wales Psychologists Registration Board over a 4-year period. There were 248 independent notifications of misconduct about 224 registered psychologists, out of a total sample of 9,489 registered psychologists. The most frequent type of misconduct reported was in relation to poor communication standards (35.5%). Other complaints were in relation to professional incompetency (16.5%), poor report writing (14.1%), poor business practices (12.5%), boundary violations (9.7%), poor character (5.6%), registration status (3.2%), impairment (1.6%), and the inappropriate use of specialist titles (1.2%). Males were 2.5 times more likely to have a misconduct complaint made about them than females. Senior highly qualified psychologists attracted a greater number of complaints, but these were generally of a less serious nature. Over a 30-year career, about 20 out of every 100 psychologists can expect to receive a complaint from the public, and two will receive a serious misconduct complaint that might lead to deregistration. Strategies for preventing malpractice arising from these results include regular peer consultation, developing quality practise standards, and maintaining professional boundaries.

Key words: boundary violations; ethics; impairment; malpractice; misconduct.

What is already known on this topic

1. Sexual boundary violations are low prevalence but constitute serious misconduct.
2. Males are more likely to engage in unprofessional behaviours.
3. Practice in regional and rural areas present additional risks for boundary violations.

What this paper adds

1. One in five psychologists can expect a complaint over a 30 year career.
2. Poor professional communication and incompetent practices account for half of all malpractice complaints.
3. Peer supervision, evidence-based methods and professional practice standards reduce malpractice complaints.

Psychologist misconduct (also known as malpractice) comprises all instances in which psychologists violate their duty of care to members of the public. Registration of psychologists in Australia was put in place to protect the public, beginning in 1965 with the Victorian Psychological Practices Act. The last jurisdiction enacting psychologist legislation was the Australian Capital Territory in 1995 (Waring, 2008). In relation to psychology, the intention of regulation can be described to "protect the health and safety of members of the public by providing mechanisms to ensure that psychologists are fit to practice" (NSW Psychologists Act, 2001).

There is almost no published data, Australian or other, on the prevalence and outcomes of misconduct complaints about psychologists except for summary tables in the annual reports of registration boards. Moreover, most investigations of this nature tend to focus on the occurrence of serious sexual boundary violations. For example, North American and Canadian studies have reported as many as 4–8% of practising psychologists engaged in sexual relationships with their clients (Lamb & Catanzaro, 1998; Lamb, Catanzaro, & Moorman, 2003). Similarly, a British study (Garrett & Davis, 1998) indicated that 3.5% of psychologists have also reported having sexual contact with clients. Prevalence studies on Australian psychologists are limited, with only one relevant, but older study within Australia being located. Wincze, Richards, Parsons, and Bailey (1996) surveyed more than 500 registered psychologists in Western Australia (Australia) and Rhode Island (USA) and asked whether any of their clients had experienced sexual abuse by another therapist. In the Australian sample ($n = 360$), 22% of responding psychologists had reported treating at least one client who had previously been sexually involved with another therapist. About one third of the perpetrating therapists for the Australian sample were psychologists. Other perpetrating therapist groups included psychiatrists, social workers, clergy, marriage and family therapists, and physicians. The types of sexual misconduct by therapists ranged from non-touching suggestion through touching to intercourse. The Wincze et al.'s study also

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Accepted for publication 14 October 2010

doi:10.1111/j.1742-9544.2010.00019.x

asked about non-sexual boundary violations and reported that almost 60% of Australian respondents indicated they had treated clients who had reported non-sexual boundary violations by other therapists. These violations included social activities, employment, and financial arrangements.

Few recent studies have explored the characteristics of offending psychologists; however, earlier international studies of psychologists have indicated that certain personal characteristics are associated with the occurrence of sexual misconduct. Most consistently, studies have indicated that males are more likely than their female counterparts to engage in unprofessional behaviour such as sexual boundary violations. Specifically, studies have reported that males represent up to about 84% of offending psychologists (Garrett & Davis, 1998; Jackson & Nuttall, 2001; Lamb & Catanzaro, 1998; Lamb et al., 2003). The literature also suggests that boundary-violating psychologists are generally older (Lamb & Catanzaro, 1998; Pope, 1993) and are also more likely to have been providing psychological services for longer than their non-offending colleagues (Garrett & Davis, 1998). Psychologists with a history of childhood sexual abuse have also been found to be more likely to engage in sexual relationships with their clients. For example, one American study reporting that therapist groups (comprised of psychologists, psychiatrists, and social workers) with a history of severe sexual abuse are four times more likely to become sexually involved with a client than those with no history of sexual abuse (Jackson & Nuttall, 2001).

Gabbard and colleagues (Gabbard, 1996; Gabbard & Lester, 1995) worked on the assessment and treatment of offending therapists and developed personality profiles of psychotherapists who engage in sexual relations with their patients, ranging from masochistic surrender to lovesickness. However, most offenders are generally one-time offenders and present genuine remorse (Celenza & Gabbard, 2003). Typical precipitating factors might involve minor boundary crossings that can gradually lead to the blurring of boundaries referred to as the slippery slope (Gabbard & Lester, 1995).

Characteristics such as geographical location of practice, access to supervision, and type of psychological services provided (i.e., public or private) can be associated with misconduct. For example, one study found that psychologists who work in small private practices or isolated locations, and who experience a lack of collegial support and appropriate supervision, were more likely to engage in unethical boundary-crossing behaviours (Bouhoutsos, Holroyd, Lerman, Forer, & Greenberg, 1983). Psychologists living and practising in rural or regional geographical locations may find maintaining professional boundaries more challenging, as they are more likely to experience certain encounters with clients such as accidental meetings, confidentiality, and overlapping social relationships (Barbopoulos & Clark, 2003; Campbell & Gordon, 2003; Schank & Skovholt, 1997). One study found that almost 60% of psychologists practising in small or rural towns run into clients "sometime" or "more often" in the community and social gatherings compared with about 36% of psychologists practising in urban or suburban areas (Helbok, Marinelli, & Walls, 2006).

Certain theoretical orientations have also been implicated in the occurrence of misconduct. For example, one study found that non-psychodynamic-oriented therapists reported more unprofessional involvements than their counterparts who report their primary theoretical orientation as psychodynamic (Borys & Pope, 1989).

Despite the assumption that formal and professional postgraduate clinical psychology training programmes are superior in preparing psychologists to engage in exceptional ethical practice than non-university supervision programmes, there are no outcome studies that adequately explore the relationship between specific aspects of training (e.g., supervision pathway vs university masters) and ethical and safe practice.

Misconduct is not only represented in boundary violations, it also involves all other instances in which the public is not protected from trusted professionals. Despite this, the vast majority of literature concerns sexual violations. Other boundary violations such as financial dealings, confidentiality breaches, excessive self-disclosure, extending of session times, phone calls between sessions, meetings outside the office, shared activities, etc., can also be potentially harmful to the well-being of the client. Poor professional standards, including poor report writing, poor or fraudulent accounting, and rude or insensitive relationships, are also forms of practitioner misconduct. While these are less serious client complaints, they are certainly detrimental to the therapeutic outcome. There are almost no studies of these types of misconduct and no studies that sample the entire population of psychologists in a specific region.

The effect of misconduct behaviours on behalf of the therapist, particularly sexual boundary violations, can be serious and damaging to the client's well-being. Clients can experience high levels of distress (e.g., post-traumatic stress, major depressive symptoms, substance abuse, and suicide ideation) as a result of the relationship (Bouhoutsos et al., 1983; Leupker, 1999). Thus, although research in the field has not progressed for some time, and there is a dearth of Australian studies, this recent New South Wales (NSW) data highlighting the frequency of complaints among psychologists suggest that there is a need to further explore the types, consequences, and outcomes of psychologist misconduct. This type of research is important because it can serve to inform appropriate prevention strategies and training that will assist in protecting the public from harm. Using data from the NSW Psychologist Registration Board, this study describes the occurrence of different types of complaints made about NSW psychologists over a 4-year period. It will also describe the complaint handling processes used, outcomes of investigations, and individual consequences endured by these psychologists.

Furthermore, despite clinical wisdom and international reports, there have been no Australian studies investigating whether increased risk for misconduct can be attributed to factors such as training (highest level of qualification obtained), rural and remote versus metropolitan and suburban locations, and other demographic characteristics such as age and gender. Therefore, this study will also explore the demographic and educational characteristics of psychologists who have had a complaint made about them in comparison with the remaining sample of more than 9,000 NSW Psychologist Registration Board registrants. This study will also provide a detailed description and analysis of psychologists who have serious and multiple complaints filed against them. It is anticipated that this type of research will have important implications for the development

of appropriate educative and misconduct prevention strategies to help promote safe practice and to protect the public for current and prospective registrants.

Method

Samples

All data provided for this study were supplied by the NSW Health Professionals Registration Boards administrative staff to the researchers in a de-identified, anonymous form following Institutional Review Board ethical approval for the study. Data for all registered psychologists were used for this study. The population was split into two groups: the psychologist non-complaint group and the psychologist complaint group. The psychologist non-complaint group comprised all registered and provisionally registered psychologists in NSW, Australia, who had not had a complaint lodged against them between July 2003 and June 2007. Data collected on these psychologists included gender, date of birth, postcode, country of residence, and tertiary qualification history. The psychologist complaint group comprised all psychologists who had at least one complaint lodged against them between July 2003 and June 2007. In addition to the demographic and qualification data collected for both samples, the data collected for psychologist complaint sample also included the details of the complaint, the complaint history of the psychologist, and the route taken to obtain registration as a psychologist in NSW.

The NSW Psychologist Registration Board also received complaints about 64 practitioners who were not registered, or identifiable psychologists. Complaint details for this group were also collected and were reviewed in this article; however, given they were not registered with the board, their demographic and qualification data were unavailable. A portion of this sample was complained against "holding out", i.e., pretending to be a psychologist when they were not. Holding out is the use of "any name, initials, word, title, symbol, or description that (having regard to the circumstances in which it is used) indicates, or is capable of being understood to indicate, or is calculated to lead a person to infer, that the person is qualified to practise psychology or that the person practises psychology" (NSW Psychologists Act, 2001).

Procedure

For this study, data from the public in the form of written notifications, detailing the basis of the complaint against the practitioner, were coded and used in the analysis. The data on the type of complaint, assessment method by the board, and outcome of an investigation were coded twice by two staff who worked alone, then conjointly to discuss and resolve any incongruities or ambiguities in order to obtain a final set of consensus codes. All data were coded into nine categories, of which some were further broken down into subcategories for a more precise complaint description. See Table 1 for complaint categories. In instances where the complaint comprised more than one ethical concern, the issue considered to be primary was determined by whether it was mentioned first in the complaint notification and by the degree of seriousness. If the most serious issue was not mentioned first, the primary issue was allocated to the most serious issue. Up to four ethical issues were recorded for each complaint.

Table 1 Primary Complaints Made by Members of the Public Against Registered Psychologists in New South Wales, Australia, July 2003 to June 2007

	n	%
Professional—poor communication	88	35.5
Confidentiality/privacy breach	25	10.1
Rude/insensitive manner	22	8.9
Inappropriate communication (e.g., discrimination)	21	8.5
Wrong/misleading/inadequate information	11	4.4
Not informed and/or consent invalid	8	3.2
Failure to consult colleague	1	0.4
Professional—incompetency	41	16.5
Wrong/inappropriate diagnosis	10	4.0
Inadequate/inappropriate assessment	9	3.6
Inadequate treatment	8	3.2
Failure to notify government authority	4	1.6
Poor record keeping	3	1.2
Inadequate supervision	2	0.8
Miscellaneous (e.g., not following guidelines)	5	2.0
Professional—poor reports	35	14.1
General report	14	5.6
Workers compensation report	11	4.4
Family court report	7	2.8
Apprehended violence order report	2	0.8
Victim of crime report	1	0.4
Poor business practices	31	12.5
Commercial disputes	21	8.5
Poor billing	4	1.6
Plagiarism	2	0.8
Overcharging	1	0.4
Financial fraud	1	0.4
Inadequate private health insurance invoicing	1	0.4
Premises inadequate	1	0.4
Boundary violation	24	9.7
Sexual relationship	10	4.0
Non-sexual inappropriate friendship	5	2.0
Sexual behaviour (without relationship)	4	1.6
Non-sexual business relationship	2	0.8
Alleged sexual assault	2	0.8
Non-sexual touching	1	0.4
Character	14	5.6
Poor judgement	8	8.2
Illegal activities	4	1.6
Criminal matter (non-psychology)	2	0.8
Misleading registration claim (e.g., practice while lapsed)	8	3.2
Impairment (e.g., mental illness, addiction)	4	1.6
False use of Dr/Professor or specialist title	3	1.2
Total	248	—

Data concerning frequency of complaints, types of complaints, and tribunal particulars are also published in the NSW Psychologist Registration Board annual reports and in other domains that are available for public viewing, and these were included in this study.

Data Analysis

Once the data for both samples were available to the research team, the Accessibility/Remoteness Index of Australia (ARIA+;

Department of Health and Ageing, 2001) was used to convert postcodes into an index of remoteness. Although classification guidelines accompany the continuous ARIA+, the authors of this study adopted a classification system used by the Australian Psychological Society (APS; Mathews, Stokes, Crea, & Grenyer, 2010). The APS ARIA+ classification guidelines were designed to be more sensitive to the differences in degrees of remoteness than the Australian Bureau of Statistics (ABS) and to classify postcodes into five geographical categories: (1) major suburban areas of capital cities, (2) outer suburban/major regional cities, (3) regional centres, (4) outer regional/rural centres, and (5) remote areas.

Most of the data presented in this study are descriptive; however, to evaluate the demographic factors that were associated with misconduct complaints, chi-square analysis with age, geographical location, highest qualification, and gender as predictors of malpractice was used. Logistic regression modelling was further used to test whether the predictor effects were not due to the confounding effects of other predictors. Similar analyses were performed to examine the demographic variables associated with psychologists who have had multiple but independent complaints lodged against them, and psychologists who had serious complaints lodged against them (defined as those leading to the Psychologist Tribunal or an NSW Psychologist Registration Board Inquiry). The variables of age and geographical location, though originally continuous and ordinal (respectively), were categorised for the purpose of these analyses as follows. Age was categorised as "under 45" or "45 and over" (the cut-off was approximately derived from the mean age and median of the all board-registered psychologists), and the 5-point classification of geographical location was categorised as suburban/major regional city (ARIA+ Categories 1 and 2) or regional/rural/remote (ARIA+ Categories 3, 4, and 5).

Results

Sample Characteristics

Psychologist non-complaint group

The psychologist non-complaint group comprised all 9,265 psychologists registered in February 2008 who had no complaint lodged against them between July 2003 and June 2007. Of the psychologist non-complaint group, 7,011 (75.7%) were female, 2,254 (24.3%) were male, and the mean age was 44.03 (standard deviation (SD) = 12.98). Of those whom the qualifications were known (n = 8788), 65.9% had an undergraduate (bachelor's) degree as their highest qualification, and 34.1% had a postgraduate (master's or doctorate) degree. For the remaining 477 psychologists, qualification details were either missing, or the psychologist was mutually recognised in another state or territory—for whom the NSW Registration Board did not have access to qualification details. From the available postcode data (n = 8,651) and according to the APS remoteness classification of the ARIA+, 66.8% (n = 5,777) of the psychologist non-complaint group were located in a major suburban area of a capital city, 7.7% (n = 668) in an outer suburban area or major regional city, 20.8% (n = 1796) in a regional centre, 4.4% (n = 384) in an outer regional city or rural centre, and 0.3% (n = 26) in a remote location. The remaining postcodes were unavailable (n = 614), either missing from the dataset, or the psychologist had relocated to another country.

Psychologist complaint group

The psychologist complaint group comprised 224 psychologists who had misconduct complaints lodged against them between July 2003 and June 2007. Of this psychologist complaint group, 123 (54.9%) were female, 101 (45.1%) were male, and the mean age was 49.97 (SD = 11.11). Of those whose qualifications were known (n = 204), 53.4% had an undergraduate degree as their highest qualification, and 46.7% had a postgraduate qualification. From the available postcode data (n = 215), 60.0% (n = 129) of the psychologist complaint group was located in a major suburban area of a capital city, 10.2% (n = 22) in an outer suburban or major regional city, 23.7% in a regional centre, and 6.0% in an outer regional city or rural centre. Of the missing postcode data (n = 9), two are not currently located in Australia, and the remaining seven were missing from this dataset.

Of the psychologist complaint group, 39 psychologists (17.6%) had received multiple complaints, with total complaints ranging from 1 to 3 (M = 1.21, SD = 0.48), and 23 psychologists (11.3%) had received a serious complaint (defined as a complaint that was dealt with by the Psychologists Tribunal or Board Inquiry).

Non-psychologist complaint group

Sixty-four of the complaints (20.7%) received by the board between 2003 and 2007 were directed at persons (n = 64) who were not registered with the board. Of these persons, 51 (79.7%) were accused of falsely "holding out" to be a registered psychologist, another nine were legitimate complaints about practitioners but not registered psychologists (i.e., social workers, psychiatrists), and the remaining four notifications did not identify the person of whom the complaint was about.

Complaint Particulars of the Psychologist Complaint Group

Complaint types

Complaints were in the form of a written letter or statutory declaration sent to the board by members of the public detailing their complaint against a psychologist. For the 224 psychologists complained against, there were 268 separate written notifications detailing 248 independent instances of misconduct. In other words, 20 concerned the same instance of misconduct notified by several people. For example, a complaint about the accuracy of a single worker's compensation report was made by both the client and his wife. Because the nature of these notifications was essentially the same, the following analyses will comprise only the 248 independent misconduct instances.

On some occasions, a written complaint letter about a practitioner may have included allegations of several or more ethical breaches within the one written complaint. In these data, the majority (n = 187) of the misconduct instances (75.4%) were concerned with a single misconduct issue only. However, 52 (21.0%) instances were concerned with two ethical issues, four

(1.6%) with three, and five (2.0%) with four. Given the most serious misconduct issue is dealt with as the primary ethical breach, this article focuses on the primary ethical breaches reported. Table 1 provides a summary of the types and frequencies of the *primary* misconduct issues reported in the complaint categories and subcategories. Where there were additional ethical breaches reported (*total additional ethical breaches* =.75), they involved concerns about professional incompetency ($n = 25$), professional and communication issues ($n = 25$), business practices ($n = 12$), less serious boundary violations ($n = 9$), complaints about character and fitness to practise ($n = 3$), and possible impairment ($n = 1$).

Complaint handling

Of the 248 independent misconduct notifications concerning registered psychologists, 170 (68.5%) were handled internally by the NSW Psychologists Registration Board, 65 (26.2%) were handled by external investigators or prosecutors administered by the Health Care Complaints Commission, and 13 (5.2%) were withdrawn by the complainant prior to any further investigation. Some notifications handled both internally and externally (board inquiry and tribunal). However, for the purposes of this study, we report the highest disciplinary form of complaints handling (tribunal) only.

Of the notifications handled internally, 110 were handled by way of a board investigation, 8 through a board inquiry, 6 were dealt with by the Impaired Registrants Panel, and 15 by the Professional Care and Assessment Committee (which oversees competency and standards). The remaining 31 notifications were declined to be dealt with because either they were outside the board's jurisdiction (i.e., involved an industrial matter, $n = 24$) or the matters raised were unsubstantiated, trivial, and/or frivolous ($n = 7$). Of the notifications handled externally, 59 were investigated by external investigators (with 15 being referred to the Psychologist Tribunal), and 6 were directed for assisted resolution or conciliation (where there were disputes, for example, in fees).

Of the 248 independent misconduct instances, only 204 required an outcome (44 of the complaints were declined to be dealt with or were withdrawn prior to investigation). Details of the processes involved to resolve these complaints are provided in Table 2.

Serious complaints—tribunal and board inquiry

Twenty-three psychologists in the psychologist complaint group had a serious complaint lodged against them between July 2003 and June 2007. Of these complaints, 13 (56.5%) were concerned with matters related to the violation of appropriate professional boundaries. Specifically, these boundary violations were in the form of sexual relationships ($n = 5$), sexual behaviour without relationship ($n = 3$), non-sexual friendship ($n = 2$), non-sexual business ($n = 2$), and sexual assault of client ($n = 1$). The remaining serious complaints were concerned with matters relating to professional communication (e.g., confidentiality, $n = 3$), professional competency (e.g., inadequate treatment, $n = 5$), and character problems (e.g., criminal matters, $n = 2$). Outcomes following investigation are provided in Table 2.

Impaired Registrants Programme

Although four complaints were made to the NSW Psychologists Registration Board with direct mention of psychologist

Table 2 Outcomes from the Consideration of All Complaints and Serious Complaints Made by Members of the Public Against Registered Psychologists in New South Wales, Australia, July 2003 to June 2007

	All complaints		Serious complaints only	
	n	%	*n*	%
Deregistration of practitioner by tribunal	8	3.9	8	34.8
Deregistration—voluntary	2	1.0	—	—
Conditions imposed on practice:				
By tribunal	4	2.0	4	17.4
By board inquiry	2	1.0	2	8.7
By impaired practitioner panel	4	2.0	—	—
By professional panel of the board	4	2.0	—	—
Counselling of practitioner by the board	17	8.3	2	8.7
Written advice given to practitioner by the board	25	12.3	—	—
Ongoing at July 2007	13	6.4	7	30.4
No further action			—	—
Insufficient evidence of ethical breach	52	25.5	—	—
Adequate response provided by tribunal	30	14.7	—	—
Maters raised insufficient to warrant further investigation	27	13.2	—	—
Discontinued by external investigator (HCCC)	8	3.9	—	—
No outcome required—matters resolved upon assessment with assisted resolution or conciliation	6	2.9	—	—
Voluntary corrective action taken by psychologist	2	1.0	—	—

HCCC = Health Care Complaints Commission.

impairment, only two of these were believed by the board to have occurred because of psychologist impairment, and subsequently, only these two were assessed by the Impaired Registrants Panel. Four other misconduct complaints were assessed by the Impaired Registrants Panel; however, these misconduct complaints did not make specific mention of impairment and hence were coded otherwise—two as character problems, one as a professional communication problem, and one as professional incompetency. In sum, six complaints received between July 2003 and June 2007 were dealt with by the Impaired Registrants Panel, only two of which were directly related to an impairment complaint. Of these six complaints (psychologists) that were assessed by the Impaired Registrants Panel, four psychologists were placed in the Impaired Registrants Programme, in which conditions are placed upon their registration. The remaining two psychologists were given advice, comments, and/or recommendations by the board.

Non-psychologist complaint group

Of the 51 practitioners accused of falsely holding out, 46 involved the practitioner incorrectly leading the client to believe that he/she was qualified to practise psychology (i.e., by personal communication or by misrepresenting titles and qualifications on advertising, business cards, and/or other materials). The remaining five of these practitioners were recognised as a qualified psychologist in other states, territories, or countries; however, they had not applied for registration in NSW. All 51 practitioners holding out notifications were assessed by a brief board investigation, and the practitioners either provided a response that the board was satisfied with, or they were given recommendations, warnings, and/or comments, and subsequently, the board ensured corrective action was taken. Where there was a legitimate complaint about a practitioner who was not a registered psychologist (i.e., a social worker, psychiatrist, $n = 9$), the complaint was referred to the appropriate body where possible, and the four complaints where the psychologist/practitioner was not identified were discontinued upon assessment.

Psychologist Complaint Prediction

Chi-square analyses were performed to determine whether specific age groups (under 45, older than 45), genders (female, male), geographical locations (suburban/major regional, outer regional/rural/remote), and qualification types (undergraduate, postgraduate) were associated with a higher incidence of malpractice complaints. The results are presented in Table 3.

Logistic regression analysis was also performed to test whether some of the observed effects were not due to the confounding effects of the other variables. In a model containing gender, age, highest qualification, and location, all significant predictors in Table 3 remained significant at an alpha level of 0.05. The overall model with all predictors was also significant at an alpha level of 0.05 ($\chi^2 = 68.837$, −2 log likelihood = 1862.418).

Table 3 Chi-square, Odds Ratios, and 95% Confidence Intervals (CIs) for Predicting Occurrence of Complaints, Multiple Complaints, and Serious Complaints by Gender, Age, Highest Qualification, and Location

Variable	χ^2	p	Odds ratio (95% CI)
All complaints			
Male	50.524	.000**	2.554 (1.955–3.337)
Forty-five years or older	35.730	.000**	2.310 (1.742–3.062)
Postgraduate degree	14.943	.000**	1.721 (1.303–2.274)
Remote or rural location	2.724	.099	1.280 (0.954–1.711)
Multiple complaints			
Male	19.565	.000**	4.118 (2.149–7.888)
Forty-five years or older	1.700	.192	1.558 (0.797–3.046)
Postgraduate degree	0.985	.321	1.369 (0.736–2.548)
Remote or rural location	0.037	.847	1.067 (0.551–2.066)
Serious complaints			
Male	5.997	.014*	2.919 (1.203–7.084)
Forty-five years or older	1.104	.293	1.669 (0.637–4.376)
Postgraduate degree	0.096	.756	1.145 (0.488–2.685)
Remote or rural location	0.706	.401	1.452 (0.606–3.480)

*Significant at $p \leq .05$ **Significant at $p < .001$.

Multiple and serious complaint prediction

Thirty-nine (17.6%) psychologists in the complaint group had received more than one independent complaint between 2003 and 2007. Of these 39 psychologists, 32 had received two complaints, and seven had received three. Furthermore, there were 25 (11.3%) psychologists in the complaint group who were considered to have had serious complaints made about them (i.e., those who went to board inquiry or tribunal). Again, chi-square analyses were used to determine whether the psychologists who had received multiple independent complaints between 2003 and 2007, or those who had received serious complaints, differed according to the variables of age, gender, qualification, and geographical location. Results of the chi-square analyses are presented in Table 3.

Discussion

This study is one of the first to comprehensively report on all forms of misconduct within the psychology profession. The first aim was to investigate the prevalence, range, and types of misconduct. In the 4 years studied, there were 224 psychologists who had complaints lodged against them, making approximately 56 psychologists who attracted a complaint per year. In relation to a total sample of 9,472, this represents 0.6% of psychologists per year. Twenty-three had serious complaints, which led to disciplinary action including deregistration. Therefore, this represents nearly six a year of the total sample or 0.06% of psychologists per year. Assuming a 30-year professional career, a psychologist can expect a one in five chance (approximately 18%) of receiving a complaint at some time in their career. For serious complaints, two in every 100 psychologists (approximately 1.8%) will attract a serious complaint leading to disciplinary action at some stage in their career.

The range of complaints were diverse; however, two thirds could be considered objections to the psychologist's professional

practices. Within this, the largest group, comprising a third of complaints, concerned poor professional communication, such as rudeness, not respecting privacy, or providing misleading information. Another area of professional practice that attracted numbers of complaints concerned business practices, such as billing, employment conditions, and dissatisfaction in matters related to the referral of clients. A large component of psychologists' work, assessment, and report writing also attracted considerable numbers of complaints, particularly in relation to those reports prepared for courts of law and compensation tribunals. This is not surprising, as such reports can be important in helping to inform a court with regard to potentially important decisions that are made that affect a member of the public's welfare, such as child custody or the size of financial compensation awards. In relation to report writing complaints, there was evidence that these matters were treated cautiously in the regulatory complaints handling process, as complaints about report writing are sometimes made in order to influence the outcome of a court or compensation case. In these cases, the registration board had to carefully ascertain whether the grounds for the complaint involved legitimate problems in professional practice, as compared with disputes about psychological opinions so expressed in the reports, which should be properly tested in the original court or compensation tribunal and not by the regulatory body. Table 4 summarises some implications of the findings of this research in promoting safer psychology practice. This table was developed in reflection upon the root causes of the majority of complaints. It is presented as an educative summary in the form of recommendations.

Table 4 Ten Recommendations for Prevention of Misconduct, Based on Findings of Research Into New South Wales Psychologist Misconduct 2003–2007

1. Obtain regular supervision from an experienced practitioner.
2. Spend time to explain to clients the purpose of interviews, assessments, and treatments; the likely outcomes; the limits of confidentiality, and fees, and to obtain their understanding and consent in writing.
3. Treat clients with dignity and respect.
4. Maintain professional premises and business hours, and try to work in group practices with support rather than alone, and adhere to professional practice standards.
5. Attend to your private life and relationships to achieve a healthy work–life balance. Do not practise if you are impaired or going through major stress. Maintain appropriate professional boundaries in relationships.
6. Do not practise outside expertise—recognise limits in knowledge, experience, and skills.
7. Engage in continuous professional development and training, including study of ethical codes and best-practice report writing.
8. Only use recognised contemporary evidence-based practices and be able to justify your practices by reference to accepted professional treatment guidelines.
9. Put your professional psychology ethics and obligations above the needs of individual clients, employees, contractors, or lawyers. Act on mandatory reporting and registration board requirements.
10. Consult senior colleagues to obtain regular peer review of your professional practice.

Consistent with previous research, there were a small but serious group of complaints. Most serious complaints concerned boundary violations, including sexual relationships and inappropriate non-sexual relationships, amounting to 10% of all complaints. A smaller group of serious complaints concerned practitioners being involved in illegal activities. In relation to complaints of a sexual nature, there were 16 complaints over the 4 years, or approximately four per year, which is a base rate of 1:2,500 a year or approximately 1.6% lifetime prevalence. This is considerably lower than North American studies estimating 4–8% (Lamb & Catanzaro, 1998; Lamb et al., 2003) or UK studies estimating 3.5% (Garrett & Davis, 1998) of psychologists being involved in sexual behaviours at some time in their careers. One difference that might explain this discrepancy is that our data are based on complaints made by the public, whereas other studies are based on self-report by psychologists themselves. It may be that our figures are smaller because of the reluctance of some in the public to lodge complaints.

In the study period, there were 51 cases of non-psychologists "holding out" that they were registered. Closer analysis of these indicated that many possessed some incomplete psychology training, such as several years at university, or had not completed an internship. Most were discovered through advertising representations or public wording that was misleading; however, some were reported by members of the public who were told in conversation that the person "was a psychologist". A few had been mistakenly presented as psychologists by the media. Over the study period, all practitioners were issued with a warning letter that detailed the legal code and consequences related to "holding out" offences. A follow-up audit revealed that all had instigated corrective action, and thus, there were no recorded convictions.

One of the interesting questions in research on misconduct concerns the possible predictors of misconduct. In this study, four potential predictors were available for analysis: age, sex, qualifications, and location, and these were analysed in terms of likelihood of attracting a complaint, having multiple complaints, and having a serious complaint lodged. The results were remarkably consistent: males were found to be at higher risk for all three types. Males were 2.5 times more likely to attract a complaint, were four times more likely to attract multiple complaints, and were three times more likely to have a serious complaint lodged against them. The strength of these estimates is that they are based on complete data—100% of all registered practitioners within the jurisdiction formed the sample. These findings parallel criminal conviction rates. For example, in the same jurisdiction (NSW), four fifths of persons found guilty of crime are males (Statistical Services Unit, 2008). The increased risk of male psychologists being involved in boundary violations is also well known and reflected in the international literature (Borys & Pope, 1989; Jackson & Nuttall, 2001; Lamb et al., 2003). Despite these parallels, it is important to emphasise that those who cross boundaries are mostly one-time offenders (Celenza & Gabbard, 2003). For the one-time offenders, presumably better and stronger deterrents and educative support of professional behaviours will prevent boundary violations. Therefore, there is a role for psychology-specific support and preventative measures in relation to these risks.

We also found that older psychologists and those with higher degrees were more likely to attract a complaint. However, when this was analysed in terms of multiple complaints or serious complaints, this relationship disappeared (Table 3). This suggests that older, more highly trained psychologists receive more lower-level complaints. Perhaps this is because older psychologists with higher degrees are generally the most experienced workforce who specialise in areas of psychology that are likely to be at higher risk for complaints, such as medico-legal reports for courts or working with complex cases. Furthermore, the finding reinforces the importance of ongoing professional development and education. By the time psychologists are over 45 years of age, they will have been practicing post-university for about 20 years or more. It is likely that in some cases there has been a lowering of professional standards and competency over time. During the course of this research, the NSW Registration Board required ongoing professional development as part of maintaining registration, but it did not specify minimum standards. All health professions recognise professional development as integral to maintaining registration, and minimum standards have now been defined since this study was conducted. Significantly, the Psychology Board of Australia, which from July 2010 oversees all psychology regulation, has put in place compulsory continuing professional development for all psychologists and also has put additional obligations on those with endorsed scopes of practice, meaning those with the higher qualifications and more senior roles (see http://www.psychologyboard.gov.au).

There are several important limitations of this research. First, the research only considers misconduct as discovered by a member of the public or another psychologist making a complaint. It is likely therefore to represent an underreporting of instances of malpractice, as it is known that people are reluctant to make complaints. For example, the estimated lifetime prevalence of serious malpractice (usually sexual boundary violations) in this study was found to be 1.6%, whereas data derived from other methods, such as self-report, are closer to 3–4%. Second, data on higher education qualifications were incomplete. The board recorded all qualifications at the time of initial registration; however, if psychologists upgraded their qualifications at a later time (e.g., through completing a PhD), they were not compelled at the time of this research to record these additional qualifications with the board. To illustrate this limitation, 34.3% of the sample here had recorded higher qualifications. However, a National Psychology Survey conducted recently found that upwards of 46% had higher degrees (Grenyer, Mathews, Stokes, & Crea, 2010). Reports from the Victorian Psychologists Registration Board, which has accurate qualifications data, suggest more malpractice in those with lower qualifications (K. Frankcom, personal communication, September 26, 2009). The third limitation was in the recording of regional versus remote locations. At present, these data were based on an analysis of postcodes that were coded according to census remoteness estimations. Unfortunately, these assumptions were based on accessibility to services and thus do not reflect the actual location of a psychologist. For example, a remote town that had a local hospital was generally coded as having "accessible" services and thus was interpreted as a high-accessibility index, irrespective of the fact it might be more than 4,000 km from a major city. To try to overcome this limitation, we adopted a coding developed by the APS (Mathews et al., 2010); however, this coding remains somewhat limited because it relies on the original formulas applied to postcodes.

It is important to note that many claims of misconduct remained unsubstantiated, unlikely to be proven, or resolved without further action. These in part might likely form "early-warning signs" for potentially more serious complaints against a psychologist or, alternatively, may at times reflect upon the types of persons prone to making complaints. Specifically, in 61% of the complaints directed to the board, no further action was taken against the named psychologist. In general, complaints that did not proceed involved cases where there was insufficient evidence, the psychologist's response was adequate, or where the complaint had subsequently been resolved or withdrawn.

Recognising the types of misconduct complaints and risk factors could inform the development of educational and preventative measures that have the potential to minimise the occurrence of both unsubstantiated and actual ethical breaches. The implications of such measures have the potential to reduce harm to vulnerable members of the public, to maintain the profession of psychology with the utmost integrity (Allan & Love, 2010), and to contribute to the development of further ethical standards (Lewis, Sandquist, Stark, & Grenyer, 2009). In relation to this, the new Psychology Board of Australia's new minimum standards for ongoing registration, including mandatory peer consultation, may play a role in reducing malpractice that could be the topic of further research using the data presented here as a potential baseline. Furthermore, with the profession in Australia moving towards minimum postgraduate master's or doctorate programmes as recognised requirements for registration as a psychologist, future studies that further explore the relationship between ethical practice and training are timely and warranted. The findings presented here reinforce the importance of prevention strategies and educational programmes to highlight the common reasons why psychologists attract complaints, including some of the high-risk areas of malpractice. This article takes into consideration the implications of these findings as they relate to prevention strategies that would reduce the likelihood of complaints. The findings also reinforce the necessity for lifelong professional development programmes that focus on the psychologists' own practice, to continue to reinforce competent and professional attitudes and behaviours.

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AMERICAN PSYCHOLOGICAL ASSOCIATION

Self-care resources for psychologists

April 2014, Vol 45, No. 4
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Promoting wellness and preventing professional distress are important to the well-being of the individual psychologist and for professional psychology. Practitioners are encouraged to take care of themselves so that they do not become stressed or progress further along the continuum to distress or impairment. Recognizing signs of personal or collegial distress can be challenging. Here are some resources to help from APA Practice Central (http://www.apapracticecentral.org/ce/self-care/index.aspx) .

- An action plan for self-care (http://www.apapracticecentral.org/good-practice/secure/Spring09-SelfCare.pdf) . (PDF, 378KB)
- Professional health and well-being for psychologists (http://www.apapracticecentral.org/ce/self-care/well-being.aspx) .
- Occupational vulnerability for psychologists (http://www.apapracticecentral.org/ce/self-care/vulnerability.aspx) .
- Intervening with an impaired colleague (http://www.apapracticecentral.org/ce/self-care/intervening.aspx) .
- Tips from practitioners on finding work-life balance (http://www.apapracticecentral.org/ce/self-care/balance.aspx) .
- Not going it alone: peer consultation groups (http://www.apapracticecentral.org/ce/self-care/peer-consult.aspx) .
- Risk factors and self-care for practitioners working with trauma clients (http://www.apapracticecentral.org/ce/self-care/trauma-clients.aspx) .
- Alcohol and problem drinking (http://www.apapracticecentral.org/ce/self-care/drinking.aspx) .
- The pregnant therapist: caring for yourself while working with clients (http://www.apapracticecentral.org/ce/self-care/pregnancy.aspx) .
- Retirement: making a successful transition (http://www.apapracticecentral.org/ce/self-care/retirement.aspx) .
- Tips for self-care (http://www.apapracticecentral.org/ce/self-care/acca-promoting.aspx) .

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