Clinical psychologists are obligated to behave ethically in all their professional activities (Hummel, Bizar-Stanton, Packman, & Koocher, 2017; Pope & Vasquez, 2016). As such, discussion of ethical issues occurs at numerous points in this textbook. For example, among our considerations of diversity and culture, we discuss a subset of ethical standards most relevant to cultural sensitivity and competence. In another chapter, we discuss the ethical standards most relevant to research. In this chapter, we focus entirely on ethical issues as they apply to the wide spectrum of clinical psychology.

**AMERICAN PSYCHOLOGICAL ASSOCIATION’S CODE OF ETHICS**

The American Psychological Association published its first code of ethics in 1953. The appearance of the initial code corresponded with the rise of professional psychology.
around that time period. Subsequently, nine revised editions of the ethical code have been published, including the most recent edition published in 2002 (Behnke & Jones, 2012; Koocher & Campbell, 2016). Two amendments were added in 2010, emphasizing the fact that psychologists cannot use particular ethical standards to justify or defend the violation of human rights. These amendments relate to the disclosure that high-ranking members of the American Psychological Association had worked with the U.S. Department of Defense in their interrogation efforts, described by some as torture, of detainees during the war on terror [Bohannon, 2015; C. B. Fisher, 2017; Pope & Vasquez, 2016].} Since its inception, the code has applied not only to clinical psychologists but also to psychologists of all specialties. Some of its guidelines are especially relevant to the most common professional activities of clinical psychologists, such as therapy, assessment, research, and teaching.

**Aspirational and Enforceable**

The current American Psychological Association (2002) ethical code features two distinct sections: General Principles and Ethical Standards (Vasquez, 2015). Each of these sections steers psychologists toward ethical behavior in a different way. The items in the General Principles section are *aspirational*. In other words, they describe an ideal level of ethical functioning or how psychologists should strive to conduct themselves. They don’t include specific definitions of ethical violations; instead, they offer more broad descriptions of exemplary ethical behavior. There are five general principles, and in Table 5.1, each appears alongside a selected sentence cited from the lengthier description included in the ethical code.

In contrast to the General Principles section, the Ethical Standards section of the ethical code includes *enforceable* rules of conduct. Thus, if a psychologist is found guilty of an ethical violation, it is a standard (not a principle) that has been violated. These standards are written broadly enough to cover the great range of activities in which psychologists engage, but they are nonetheless more specific than the general principles. Although each general principle could apply to almost any task a psychologist performs, each ethical standard typically applies to a more targeted aspect of professional activity. The ethical standards are divided into 10 categories (listed in Table 5.2), and, collectively, these 10 categories include 89 individual standards.

In this chapter, we zoom in on some of the standards most relevant to clinical psychologists. Throughout our discussion, it’s important to remember that the ethical code should be understood not only as a list of rules to follow and mistakes to avoid but also as a source of inspiration for ethical behavior of the highest order. Knapp and VandeCreek (2006) describe these two approaches to ethics as “remedial” and “positive”
### Table 5.1 American Psychological Association’s General Ethical Principles

<table>
<thead>
<tr>
<th>Ethical Principle</th>
<th>Sample Sentence From Description in Ethical Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficence and Nonmaleficence</td>
<td>“Psychologists strive to benefit those with whom they work and take care to do no harm.”</td>
</tr>
<tr>
<td>Fidelity and Responsibility</td>
<td>“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.”</td>
</tr>
<tr>
<td>Integrity</td>
<td>“Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology.”</td>
</tr>
<tr>
<td>Justice</td>
<td>“Psychologists recognize that fairness and justice entitle all persons to access and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists.”</td>
</tr>
<tr>
<td>Respect for People’s Rights and Dignity</td>
<td>“Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination.”</td>
</tr>
</tbody>
</table>


### Table 5.2 Categories of American Psychological Association Ethical Standards

1. Resolving Ethical Issues
2. Competence
3. Human Relations
4. Privacy and Confidentiality
5. Advertising and Other Public Statements
6. Record Keeping and Fees
7. Education and Training
8. Research and Publication
9. Assessment
10. Therapy

ethics, respectively. A remedial approach to ethics would involve doing just enough to avoid any trouble that might come from a violation of ethical standards, but a positive approach to ethics would involve making every effort to ensure that one's professional behavior was as consistent with ethical principles as possible. As an example, Knapp and VandeCreek consider the ethical obligation of competence (which we discuss in more detail later in this chapter). Psychologists with a remedial approach to ethics might do the bare minimum to make themselves competent for a particular activity (e.g., taking courses, getting supervision), but psychologists with a positive approach to ethics will strive to become as competent as possible (e.g., additional courses, extra supervision, self-study, self-care).

**Ethical Decision Making**

When any ethical issue arises, a clinical psychologist should be equipped with a process by which to make the most ethical decision possible. The American Psychological Association’s (2002) ethical code does not offer any such decision-making models per se, but such models have been recommended by a number of experts in the field (e.g., Knapp & VandeCreek, 2006; Koocher & Keith-Spiegel, 2008; Pope, 2011; Treppa, 1998). One such expert is Celia Fisher, who served as chair of the American Psychological Association’s Ethics Code Task Force, the committee responsible for creating the 2002 revision of the ethical code. In her book *Decoding the Ethics Code*, Fisher (2017) proposes a model for ethical decision making. In slightly adapted language, that model is presented here:

1. Prior to any ethical dilemma arising, make a commitment to doing what is ethically appropriate.
2. Become familiar with the American Psychological Association’s ethical code.
3. Consult any law or professional guidelines relevant to the situation at hand.
4. Try to understand the perspectives of various parties affected by the actions you may take. Consult with colleagues (always protecting confidentiality) for additional input and discussion.
5. Generate and evaluate your alternatives.
6. Select and implement the course of action that seems most ethically appropriate.
7. Monitor and evaluate the effectiveness of your course of action.
8. Modify and continue to evaluate the ethical plan as necessary.

Before turning to any step-by-step ethical decision-making model, psychologists best prepare themselves to deal with ethical dilemmas by becoming generally ethical people with sound values. In other words, functioning as an ethical psychologist should not be a rote exercise in which a predetermined model for decision making is the sole guide. While such models can certainly enhance the psychologist’s chances of making the most ethical decision, they work best when utilized by a person who has already examined his or her own values and aligned them with the ethics of the profession (Tjeltveit & Gottlieb, 2010).
Psychologists’ Ethical Beliefs

The American Psychological Association’s (2002) ethical code may instruct psychologists on how to conduct themselves ethically, but what do psychologists actually believe about the ethicality of various behaviors they might perform? In other words, as a group, what ethical beliefs do psychologists hold? This question, especially as it applies to psychotherapy-related behaviors, was addressed in a large-scale survey of American Psychological Association members (Pope, Tabachnick, & Keith-Spiegel, 1987). In this study, more than 450 members of Division 29 (Psychotherapy) of the American Psychological Association rated the ethicality of 83 separate behaviors that a psychologist might perform toward, with, or in response to a client. Results indicated that a few behaviors—for example, sex with clients or former clients, socializing with current clients, and disclosing confidential information without cause or permission—are viewed as blatantly unethical. In contrast, a few other behaviors—for example, shaking hands with clients, addressing clients by first name, and breaking confidentiality if clients are suicidal or homicidal—are viewed as unquestionably ethical. But most of the 83 behaviors fell in the gray area between ethical and unethical, illustrating both the challenges that psychologists face in making wise judgments regarding ethical issues and the importance of a sound model of ethical decision making (Cottone, 2012).

In the years since the 1987 study by Pope et al., other researchers have used similar methodologies to further examine the ethical beliefs of psychologists. One study found that psychologists’ ethical beliefs may vary according to the point in time or the region of the country in which they are collected (Tubbs & Pomerantz, 2001), whereas others found that psychologists’ ethical beliefs may vary according to the gender or age of the clients toward whom the behaviors may be directed (Pomerantz, 2012a; Pomerantz & Pettibone, 2005). Thus, although the American Psychological Association’s (2002) ethical code serves as a guiding force, the beliefs psychologists actually hold, which correspond strongly with the behaviors they act out (Pope et al., 1987), may be subject to other influences.

CONFIDENTIALITY

One of the characteristics most closely associated with the ethical practice of clinical psychology is confidentiality (M. A. Fisher, 2012). In fact, confidentiality is specifically mentioned among the general principles (in Principle E: Respect for People’s Rights and Dignity) and in numerous specific ethical standards—including Standard 4.01, “Maintaining Confidentiality,” which begins, “Psychologists have a primary obligation and take reasonable precautions to protect confidential information” (American Psychological Association, 2002, p. 1066).

There is good reason for the emphasis on confidentiality in the profession of psychology: Our profession is entrusted by the public to provide professional services without sharing the private, personal details offered in the process. However, the public may be unaware of the fact that confidentiality is not absolute. Although most people outside of the mental health profession may assume that psychologists hold all information confidential (D. J. Miller & Thelen, 1986), the truth is that situations arise in which
psychologists are obligated to break confidentiality. Many such situations have been defined by court cases, including the well-known case involving the death of Tatiana Tarasoff.

**Tarasoff and the Duty to Warn**

In 1969, Prosenjit Poddar was a student at the University of California at Berkeley. He became romantically interested in Tatiana Tarasoff, and when their relationship did not advance as he hoped, his mental state worsened and he sought psychotherapy at the university counseling center from a psychologist, Dr. Lawrence Moore. During a session in August 1969, Poddar told Dr. Moore that he intended to kill Tarasoff. Dr. Moore believed that Poddar's comment was credible, so he broke therapist–client confidentiality and contacted campus police. The campus police interviewed Poddar but did not hold him, because he promised to avoid Tarasoff and seemed rational at the time of the interview. Poddar never returned to therapy. Two months later, on October 27, 1969, Poddar killed Tarasoff by stabbing and shooting her. Tarasoff's parents later sued Dr. Moore and the others involved in the case for wrongful death. The court found that the psychologist was liable for failure to warn Tarasoff of the danger (Knapp & VandeCreek, 2006). Two years later, the court reheard the case and slightly revised their verdict, from a duty to warn to a duty to protect (which could involve something other than a direct warning by the therapist); however, the “duty to warn” language is still commonly used (Bucker & Firestone, 2000; DeMers & Siegel, 2016; Focelli & Rosenfeld, 2015). Both “duty to warn” or “duty to protect” decisions suggest that the court saw Dr. Moore's actions as insufficient. Although he broke confidentiality and contacted campus police, the court determined that he should have made additional efforts to ensure that Tarasoff knew that she was in harm's way.

From the Tarasoff case, the duty to warn (and duty to protect) was born. Since the Tarasoff case set the legal precedent, clinical psychologists (and other therapists) have understood that there are limits to their confidentiality agreements with clients and that they have a duty to warn or protect people toward whom their clients make credible, serious threats. As stated in the first Tarasoff ruling, “The confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins” (Tarasoff v. The Regents of the University of California, 1974, p. 561, as cited in Tribbensee & Claiborn, 2003, p. 287).

Certainly, the rationale behind the duty to warn is clear: In the Tarasoff situation, a young woman's life could have been spared if a warning had been issued. And if we consider more recent tragedies—the mass shootings in Las Vegas and Newtown, Connecticut, or the September 11 terrorist attacks, for example—we can see how, if the perpetrators had disclosed their homicidal plans to therapists, the duty to warn could have prevented large-scale “public peril” (Pope, 2011). In its application, however, the duty-to-warn/protect issue is fraught with difficult questions for the clinical psychologists expected to uphold it. For example, how accurately can clinical psychologists assess the credibility of their clients’ threatening statements or their intent to follow through with them? What kinds of threats merit warnings—only blatant life-or-death threats, or other kinds of harm, such as drunk driving or intimate partner violence as
well (Guedj, Sastre, Mullet, & Sorum, 2009; Welfel, Werth, & Benjamin, 2012)? At what point in therapy and to what extent should psychologists prioritize the protection of potential victims over the treatment of their clients (Bersoff, 1976; Knapp & VandeCreek, 2006; Tribbensee & Claiborn, 2003)?

In recent decades, clinical psychologists have faced a version of the duty-to-warn decision regarding clients with HIV/AIDS (Chenneville, 2000; Peter, 1998). To exemplify this dilemma, imagine that Paul, a 30-year-old, single, HIV-positive client, is seeing Dr. Reed, a clinical psychologist, for depressive symptoms. During the course of their conversations, Paul mentions to Dr. Reed that he is sexually active, that he sometimes engages in sexual activity that could put his partner at risk, and that he has withheld from his partner that he is HIV positive. Dr. Reed immediately faces numerous challenging questions: Does Paul's behavior constitute a threat worthy of a warning to the potential victim? How does it compare with Poddar's threat to kill Tarasoff? If Dr. Reed breaks confidentiality to warn a potential victim, what effect will that have on the therapeutic alliance with Paul and, ultimately, on Paul's well-being? To whom does Dr. Reed have a primary obligation—Paul or someone whom Paul might endanger? Unfortunately for clinical psychologists, there are no easy answers to questions of this type.

Adding to the confusion for many psychologists is the fact that different states have adopted different interpretations of the rules and precedents created by the Tarasoff case and others like it. For example, some states require the breaking of confidentiality in situations where other states allow (but don’t require) it (G. A. H. Benjamin, Kent, & Sirikantraporn, 2009). States also differ on their definitions of a warning and what should trigger it. Some states’ rules even mention that the protecting the client could take the form of intensified treatment or hospitalization of the client (without notifying the client), while other states’ rules make no such mention (G. A. H. Benjamin & Beck, 2018).

The video available through Video Link 5.1 features the textbook author (with an actor playing the role of the client) navigating and commenting on numerous clinical situations in which questions related to breaking confidentiality could arise, including the client threatening (to varying degrees of credibility and specificity) different kinds of harm to another person.

When the Client Is a Child or Adolescent

More confidentiality-related challenges arise when clinical psychologists provide services to minors. One particular challenge centers on the fact that for many children and adolescents, the establishment of a close, trusting relationship with a clinical psychologist depends on the extent to which the psychologist reveals details of one-on-one conversations with the child’s parents (Knapp & VandeCreek, 2006; Richards, 2003; Tribbensee & Claiborn, 2003). Simply put, kids might choose to withhold rather than discuss important personal issues if they know that their psychologists will subsequently share the information with the kids’ parents. Of course, as legal guardians, parents are ultimately entitled to be informed about their children’s progress in therapy; moreover, it’s effective clinical practice to keep parents actively engaged in a child’s therapy.

Sometimes, clinical psychologists can discuss this confidentiality dilemma openly with child clients and their parents, and a mutually agreeable arrangement can be reached (Knapp & VandeCreek, 2006; Richards, 2003). In other words, “therapists
In My Practice . . .

In my practice, I once had a client named Sophie, who caused me to think quite a bit about Tarasoff related issues. Sophie, who was 26 years old, had generalized anxiety disorder. Throughout our work together, Sophie shared lots of worries about her day-to-day life. She worried unnecessarily about her health, her friendships, her money, her job, and much more.

One day, she came in with a very specific worry: “You know how I told you the walls in my apartment building are so thin that I can literally hear what my neighbors are saying sometimes? Well, last night the guy next door was talking on the phone and I’m pretty sure I heard him say something about robbing someone. It sounded like he was making a plan with the other person on the phone. I heard him say things like, ‘I know for sure that she won’t be home all day Sunday. Let’s do it then. She won’t even know the stuff is missing. We’ll totally get away with it. And if I’m wrong, and she is home, we’ll just deal with it.’”

Sophie went on to share her anxiety about living next to someone who might be a criminal, and I did my best to help her deal with those worries. But in the back of my mind, and after her session ended, I considered the Tarasoff case. Of course, Sophie’s situation had neither the clarity nor the high stakes of the actual Tarasoff case, in which the client explicitly stated his intentions, those intentions were life-threatening, and the person whose life was threatened was clearly identified. And in the end (spoiler alert), I did not break confidentiality in Sophie’s case. In fact, I didn’t give it very serious consideration. But many Tarasoff-related questions did occur to me. How dangerous does the potential behavior need to be to trigger a duty to warn? Do only life-or-death situations count, or could other forms of victimization (robbery, assault, kidnapping, identity theft, etc.) count as well under certain circumstances? How much should the credibility of a client’s story be affected by the client’s clinical issues—in this case, Sophie’s tendency to worry about things unnecessarily? How much credence should be given to a client’s secondhand reports—not dangerous behaviors they plan to do themselves, but dangerous behaviors they believe others might do? Once a client triggers thoughts in a psychologist’s mind of a possible duty to warn, how much responsibility does the psychologist have to “dig” for more information beyond what the client has volunteered, which (as in Sophie’s case) is often incomplete and unclear? When do psychologists’ obligations to potential victims outweigh psychologists’ obligations to their clients? These are the kinds of questions that make Tarasoff-related decisions especially challenging.

To see this box come to life as a whiteboard video, please visit edge.sagepub/pomerantz5e.
child's well-being, parents may refuse it, and the acceptability of such an arrangement may depend on cultural variables involving parent–child relationships. Koocher and Daniel (2012) offer this script as a prototype of what the psychologist may say to an adolescent client and his or her parent(s) together at the outset of therapy:

> Psychotherapy works best when people have confidence in the privacy of their conversations. At the same time, parents do want to feel confident about their child's well-being and safety. Since parents were once teenagers, you certainly know that an adolescent may want to use therapy to talk about sex, alcohol, smoking, or other activities that parents may not approve of. Let's talk about how we can assure your child of confidentiality so s/he can talk openly about what's on her/his mind and at the same time assure your parents about your safety. (p. 12)

When parents do accept such an arrangement, they place quite a bit of trust in the psychologist's judgment. Consider some of the behaviors in which minor clients might engage: smoking, drinking, sex, drug use, crime, and “cutting” (self-mutilation), to name a few. At what point or under what conditions do these behaviors constitute harm that merits the psychologist's informing the child's parents? To what extent is the child's age a factor?

As a clinical example, consider Danica, a 17-year-old girl seeing Dr. Terry, a clinical psychologist. Danica’s parents believe that Danica deserves some confidentiality with Dr. Terry, and they agree that Dr. Terry need not repeat the full contents of their sessions; however, they understandably insist that they be informed of any harm or danger that Danica may experience. As the sessions progress, the therapeutic relationship strengthens, and Danica begins to reveal to Dr. Terry details of her life about which Danica’s parents are unaware. These details include the fact that Danica drinks alcohol about once a week (but does not get drunk), that she intentionally cut her forearm with a razor blade once a few months ago, and that one night she was a passenger in a car driven by a friend who may have been high. Do any of these behaviors or situations call for Dr. Terry to inform Danica’s parents? If not, how much would the behaviors have to intensify before they did? What consequences might Dr. Terry be able to expect if she did or did not tell Danica’s parents? Would the answers differ if Danica was 14, or 11, or 8 years old?

A separate confidentiality issue for clients who are minors involves child abuse. Every state has laws requiring mental health professionals to break confidentiality to report known or suspected child abuse (Benjamin & Beck, 2018; Kenny et al., 2017; Knapp & VandeCreek, 2006; Koocher & Daniel, 2012; Tribbensee & Claiborn, 2003). (Many states have similar laws pertaining to abuse of vulnerable adults as well.) The rationale behind such laws is similar to the rationale behind the Tarasoff ruling; namely, some situations demand that the clinical psychologist's primary responsibility shift to the immediate prevention of harm. And, like duty-to-warn situations, child abuse situations often require the clinical psychologist to make difficult judgment calls. It can be exceedingly challenging to determine with confidence whether child abuse is likely to have taken place, especially with children who may not be entirely forthcoming, who may exaggerate claims against their parents, or whose communication skills may be limited. The clinical psychologist's overarching goal of treatment may remain simple—the well-being of the child—but in cases in which child abuse is suspected, determining the means to attain this goal can become complex.
As a final note on confidentiality, it is important to note the difference between legal standards and ethical standards. Although they may differ in rare situations, the directives for clinical psychologists listed in this section—duty to warn in *Tarasoff*-like situations and required reporting of suspected child abuse—often represent both legal standards and ethical standards. That is, state law typically requires such behavior by clinical psychologists, and the American Psychological Association’s (2002) ethical code includes standards that are consistent with these laws. In fact, one ethical standard (4.02, “Discussing the Limits of Confidentiality”) specifically instructs clinical psychologists to “discuss . . . the relevant limits of confidentiality” with clients (p. 1066). Such a discussion is a key component of the informed consent process to which we now turn our attention.

**Considering Culture**

**Confidentiality, Ethnicity, and Family**

Clients from diverse cultural groups, along with their relatives, may have very different beliefs regarding confidentiality in mental health (e.g., McGoldrick, Giordano, & Garcia-Preto, 2005b). An informative book on this topic, *Ethics, Culture, and Psychiatry* (Okasha, Arboleda-Florez, & Sartorius, 2000), focuses on such cultural differences regarding confidentiality and other ethical issues. It includes separate chapters on many specific groups, including African, Indian, Japanese, Latin American, German, West Mediterranean, and Chinese cultures. When directly compared with each other, two of these chapters—on Arab and Scandinavian culture—illustrate quite a contrast in beliefs regarding confidentiality. Regarding Arab culture, Okasha (2000) states the following:

- “In Arab culture, issues of illness are dealt with as family matters. Whether a patient is hospitalized, for example . . . is dependent not on what the patient wants himself or herself but on the estimation, need, or wish of the extended family.” (pp. 24–25)

- “In the Arab region, a person may actually change doctors . . . if the doctor persists in considering the patient the only decision maker.” (p. 26)

- “In Arab culture, the norm is to convey the [diagnostic] information to the family first and then leave it up almost entirely to the family to decide whether to inform the patient.” (p. 27)

Regarding Scandinavian culture, Kastrup (2000) offers these descriptions:

- “The key role of patient autonomy has been increasingly emphasized in recent years. A patient has the right to make decisions about his or her treatment without interference from family.” (p. 79)

- “Emphasis on autonomy is part of Scandinavian culture, and . . . lack of autonomy is considered the greatest unhappiness of the modern person . . . . The ideal is to be able . . . to live independently, without the need for support from others.” (p. 79)
It is clear that Arab clients and Scandinavian clients—and possibly their family members as well—may enter into a working relationship with a clinical psychologist holding very different assumptions about confidentiality. In one culture, it is assumed that family members will be included, whereas in the other, it is assumed that family members will be excluded. Other cultures will certainly have their own unique assumptions about confidentiality as well.

In culturally diverse countries such as the United States, a clinical psychologist could see both Arab clients and Scandinavian clients. Even if these clients have similar diagnoses, clinical psychologists may find themselves working in dissimilar ways, especially in terms of the involvement of family members. To be ethical, of course, clinical psychologists must adhere to the American Psychological Association’s (2002) code of ethics, yet to be culturally competent, they must also recognize that clients of various cultures will bring their own ethical values as well. If you were a clinical psychologist, how would you handle apparent conflicts between the ethical code and clients’ cultural norms? Besides confidentiality, in what other areas of ethics might culture play a role in clients’ expectations about clinical psychologists’ behavior?

INFORMED CONSENT

You may have been exposed to the notion of informed consent through psychological research. If you have participated in a psychological study, you probably received written information about the study first, and only after you provided consent by signing your name did the research begin. Research is certainly an important application of the ethical standards involving informed consent, but it is not the only one. Assessment and therapy also require informed consent according to the ethical code (American Psychological Association, 2002). Actually, in any professional activity conducted by psychologists, informed consent is an essential process. It ensures the person with whom...
the psychologist is working the opportunity to become knowledgeable about the activities in which they may participate, and it facilitates an educated decision. Moreover, it affords individuals the opportunity to refuse to consent if they so choose.

Regarding research, Standard 8.02 (“Informed Consent to Research”) of the American Psychological Association’s (2002) ethical code instructs psychologists to inform prospective participants about numerous aspects of the study, including its purpose, procedures, and length of time it may require; any predictable risks or adverse effects; incentives for participation; and the right to decline or withdraw from participation. If the study is an investigation of a treatment method, psychologists should also inform clients that the treatment is experimental in nature, that some clients may be assigned to groups that receive no treatment (control groups), and of available alternative treatments outside the scope of the current study.

It is also necessary to obtain informed consent for psychological assessments. According to Standard 9.03 (“Informed Consent in Assessments” [American Psychological Association, 2002]), psychologists should offer information about the nature and purpose of the assessment; any relevant fees; the involvement of other parties, if any; and limits of confidentiality (e.g., duty-to-warn or child abuse situations).

Psychotherapy requires an informed consent process as well. Ethical Standard 10.01 (“Informed Consent to Therapy”) explains that 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.

(American Psychological Association, 2002, p. 1072)

Several phrases of this ethical standard highlight the fact that therapy stands apart from other professional activities of clinical psychologists. For one, the phrase “as early as is feasible” suggests that there may be different points at which information could be presented to clients. In fact, a survey of psychologists providing therapy found that in general, they are comfortable providing some generic information, such as payment and confidentiality policies, at the outset of therapy, but more specific information, such as the length, goals, and substance of psychotherapy, requires more time for therapists to get to know their clients. As a result, informed consent to therapy—unlike informed consent to research or assessment—may be best understood as an ongoing process rather than a one-time event (Pomerantz, 2005). Another noteworthy phrase in Standard 10.01 is “the involvement of third parties”; indeed, it has been a subject of debate exactly what or how much to tell clients about managed care’s influence on the therapy process (e.g., J. Cohen, Marecek, & Gillham, 2006; Huber, 1997; Pomerantz, 2000). Finally, the phrase “provide sufficient opportunity for the client/patient to ask questions and receive answers” has been addressed by the publication of lists of questions that psychologists could offer...
to clients at the outset of therapy or at any other relevant point (e.g., J. M. Murphy & Pomerantz, 2016; Pomerantz & Handelsman, 2004). From this list, clients could choose the questions in which they have interest, some of which may not have occurred to them on their own.

Especially in psychotherapy, the informed consent process presents the clinical psychologist the chance to begin to establish a collaborative relationship with the client (Pomerantz, 2012b, 2015). As we examine in more detail in later chapters, this kind of relationship is central to the success of psychotherapy of all kinds. Thus, it can be beneficial for clinical psychologists to invite clients to participate actively in the informed consent process and genuinely to join in the decision-making process regarding their treatment plan (Knapp & VandeCreek, 2006; Pomerantz & Handelsman, 2004).

**BOUNDARIES AND MULTIPLE RELATIONSHIPS**

In general, it can be problematic for clinical psychologists to know someone professionally—as, say, a therapy client or student—and also to know that person in another way—as, say, a friend, business partner, or romantic partner. The term used to describe such situations is multiple relationships (although the term dual relationships has also been used). It would be nice to state that psychologists never engage in such relationships, but such a claim would be false (Borys & Pope, 1989); in fact, a significant portion of complaints to the American Psychological Association Ethics Committee involve “incidents of blurred boundaries” (Schank, Slater, Banerjee-Stevens, & Skovholt, 2003, p. 182).

**Defining Multiple Relationships**

Ethical Standard 3.05a (American Psychological Association, 2002) states that 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. (p. 1065)

So multiple relationships can form not only when a psychologist knows one person both professionally and nonprofessionally but also when a psychologist has a relationship with someone “closely associated with or related to” someone the psychologist knows professionally. As an example, if Monique, a 36-year-old woman, is the therapy client of Dr. Davis, a clinical psychologist, Dr. Davis would be forming a multiple relationship if she became Monique’s friend, business partner, or romantic partner. Additionally, Dr. Davis would be forming a multiple relationship if she became similarly involved
with Monique’s romantic partner, sibling, or close friend. For clinical psychologists considering this ethical standard, defining “closely associated or related” can be a challenge, especially considering the “six degrees of separation” nature of our cities and communities. For example, would Dr. Davis be forming a multiple relationship if she dated Monique’s second cousin, went into business with Monique’s neighbor, or became a friend of Monique’s coworker?

As indicated by the examples above, multiple relationships can take many forms (Sommers-Flanagan, 2012). Perhaps the most blatant and damaging are sexual multiple relationships, in which the clinical psychologist becomes a sexual partner of the client. The American Psychological Association’s (2002) code of ethics offers a direct and inflexible standard about such behavior: “Psychologists do not engage in sexual intimacies with current therapy clients/patients” (Standard 10.05, p. 1073). Such behavior represents a fundamental breach of the healthy therapist–client relationship and often results in significant psychological or emotional damage for the client (Pope, 1994; Sonne, 2012). Psychologists are human, of course, and they may experience feelings of attraction toward a client from time to time. Surveys of psychologists and other therapists suggest that such feelings do in fact occur (Sonne & Jochai, 2014). The important issue is how psychologists deal with such feelings: preferably by discussing them in consultation with other professionals or perhaps their own therapist, but certainly not by acting on them (Barnett, 2014; Gelso, Pérez Rojas, & Marmarosh, 2014).

The nonprofessional involvement between client and clinical psychologist need not be sexual to constitute a multiple relationship or to cause the client harm. Indeed, psychologists may have opportunities to engage in a wide variety of nonsexual multiple relationships: friendships, business or financial relationships, coworker or supervisory relationships, affiliations through religious activities, and many others (Anderson & Kitchener, 1996; Zur, 2007). An essential task for clinical psychologists is to appropriately recognize the overlapping nature of these relationships as well as their potential to cause problems for the client.

What Makes Multiple Relationships Unethical?

Not every multiple relationship is, by definition, unethical. To help identify the specific elements of multiple relationships that characterize them as unethical, we again turn to Ethical Standard 3.05a:

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. (American Psychological Association, 2002, p. 1065)

As this standard indicates, there are essentially two criteria for impropriety in a multiple relationship. The first involves impairment in the psychologist; if the dual role with the client makes it difficult for the psychologist to remain objective, competent,
or effective, then it should be avoided. The second involves exploitation or harm to the client. Psychologists must always remember that the therapist–client relationship is characterized by unequal power, such that the therapist’s role involves more authority and the client’s role involves more vulnerability, especially as a consequence of some clients’ presenting problems (Pope, 1994; Schank et al., 2003). Thus, ethical psychologists remain vigilant about exploiting or harming clients by clouding or crossing the boundary between professional and nonprofessional relationships. Above all, the client’s well-being, not the psychologist’s own needs, must remain the overriding concern.

As the last line of the standard above indicates, it is possible to engage in a multiple relationship that is neither impairing to the psychologist nor exploitive or harmful to the client. (And in some settings, such as small communities, such multiple relationships may be difficult to avoid. We discuss this in more detail later in this chapter.) However, multiple relationships can be ethically treacherous territory, and clinical psychologists owe it to their clients and themselves to ponder such relationships with caution and foresight. Sometimes, major violations of the ethical standard of multiple relationships are preceded by “a slow process of boundary erosion” (Schank et al., 2003, p. 183). That is, a clinical psychologist may engage in some seemingly harmless, innocuous behavior that doesn’t exactly fall within the professional relationship—labeled by some as a “boundary crossing” (Gabbard, 2009b; Zur, 2007)—and although this behavior is not itself grossly unethical, it can set the stage for future behavior that is. These harmful behaviors are often called “boundary violations” and can cause serious harm to clients, regardless of their initial intentions (Cohen-Filipic, 2015a; Gutheil & Brodsky, 2008; Zur, 2009).

As an example of an ethical “slippery slope” of this type, consider Dr. Greene, a clinical psychologist in private practice. Dr. Greene finishes a therapy session with Annie, a 20-year-old college student, and soon after the session, Dr. Greene walks to his car in the parking lot. On the way, he sees Annie unsuccessfully trying to start her car. He offers her a ride to class, and she accepts. As they drive and chat, Annie realizes that she left her backpack in her car, so Dr. Greene lends her some paper and pens from his briefcase so she will be able to take notes in class. Dr. Greene drops off Annie and doesn’t give his actions a second thought; after all, he was merely being helpful. However, his actions set a precedent with Annie that a certain amount of nonprofessional interaction ultimately be exploited or harmed. Although such “boundary erosion” is not inevitable (Gottlieb & Younggren, 2009), minor boundary infractions can foster the process. As such, clinical psychologists should give careful thought to certain actions—receiving or giving gifts, sharing food or drink, self-disclosing their own thoughts and feelings, borrowing or lending objects, hugging—that may be expected and normal within most interpersonal relationships but may prove detrimental in the clinical relationship (Gabbard, 2009b; Gutheil & Brodsky, 2008; Zur, 2009).

The videos available through the Video Links feature the textbook author (with actors playing the roles of clients) navigating and commenting on numerous clinical situations in which questions related to multiple relationships could arise, including the client giving a gift to the therapist, the client requesting various kinds of interactions outside of therapy, and the therapist self-disclosing information.
COMPETENCE

The American Psychological Association’s (2002) code of ethics devotes an entire section of ethical standards to the topic of competence. In general, competent clinical psychologists are those who are sufficiently capable, skilled, experienced, and expert to adequately complete the professional tasks they undertake (Nagy, 2012).

One specific ethical standard in the section on competence (2.01a) addresses the boundaries of competence: “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” (American Psychological Association, 2002, p. 1063).

An important implication of this standard is that having a doctoral degree or a license in psychology does not automatically make a psychologist competent for all professional activities. Instead, the psychologist must be specifically competent for the task at hand (Spotts-De Lazzer & Muhlheim, 2016). As an example, consider Dr. Kumar, a clinical psychologist who attended a doctoral training program in which she specialized in child clinical psychology. All her graduate coursework in psychological testing focused on tests appropriate for children, and in her practice, she commonly uses such tests. Dr. Kumar receives a call from Rick, an adult seeking an intelligence test for himself. Although Dr. Kumar has extensive training and experience with children’s intelligence tests, she lacks training and experience with the adult versions of these tests. Rather than reasoning, “I’m a licensed clinical psychologist, and clinical psychologists give these kinds of tests, so this is within the scope of my practice,” Dr. Kumar takes a more responsible, ethical approach. She understands that she has two options: Become adequately competent (through courses, readings, supervision, etc.) before testing adults such as Rick, or refer adults to another clinical psychologist with more suitable competence.

Psychologists not only need to become competent, but they must also remain competent: “Psychologists undertake ongoing efforts to develop and maintain their competence” (Standard 2.03, American Psychological Association, 2002, p. 1064). This standard is consistent with the continuing education regulations of many state licensing boards. That is, to be eligible to renew their licenses, psychologists in many states must attend lectures, participate in workshops, complete readings, or demonstrate in some other way that they are sharpening their professional skills and keeping their knowledge of the field current.

Among the many aspects of competence that clinical psychologists must demonstrate is cultural competence (as discussed extensively in the previous chapter). Ethical Standard 2.01b (American Psychological Association, 2002) states that when

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. (pp. 1063–1064)

Ethical psychologists do not assume a “one-size-fits-all” approach to their professional work. Instead, they realize that clients differ in important ways, and they ensure that
they have the competence to choose or customize services to suit culturally diverse clients (Salter & Salter, 2012). Such competence can be obtained in many ways, including through coursework, direct experience, and efforts to increase one's own self-awareness. Professional guidelines sponsored by the American Psychological Association, such as “Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality” (American Psychological Association, 2017), “Guidelines for Psychological Practice With Transgender and Gender Nonconforming People” (American Psychological Association, 2015), “Guidelines for Psychotherapy With Lesbian, Gay, and Bisexual Clients” (Division 44, 2000), and “Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations” (American Psychological Association, 1993), can also be important contributors to cultural competence for clinical psychologists.

It is important to note that ethical violations involving cultural incompetence (e.g., actions reflecting racism or sexism) are viewed just as negatively by nonprofessionals as other kinds of ethical violations, such as confidentiality violations and multiple relationships (D. L. Brown & Pomerantz, 2011). In other words, cultural competence is not only a wise clinical strategy; it is an essential component of the ethical practice of clinical psychology that can lead to detrimental consequences for clients when violated (Gallardo, Johnson, Parham, & Carter, 2009).

The American Psychological Association’s (2002) code of ethics also recognizes that psychologists’ own personal problems can lessen their competence: “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” (Standard 2.06, p. 1064). Of course, personal problems that impede psychologists’ performance can stem from any aspect of their personal or professional lives (Barnett, 2008). On the professional side, the phenomenon of burnout among clinical psychologists has been recognized in recent decades (e.g., Grosch & Olsen, 1995; Morrissette, 2004). Burnout refers to a state of exhaustion that relates to engaging continually in emotionally demanding work that exceeds the normal stresses or psychological “wear and tear” of the job (Pines & Aronson, 1988). Due to the nature of the work they often perform, clinical psychologists can find themselves quite vulnerable to burnout. In one study of more than 500 licensed psychologists practicing therapy (Ackerley, Burnell, Holder, & Kurdek, 1988), more than one third reported that they had experienced high levels of some aspects of burnout, especially emotional exhaustion. In this study, the factors that increased a psychologist’s susceptibility to burnout included feeling overcommitted to clients, having a low sense of control over the therapy, and earning a relatively low salary. A more recent study confirmed that over-involvement with clients correlates strongly with burnout, particularly in the form of emotional exhaustion (J. Lee, Lim, Yang, & Lee, 2011). Another study of more than 600 clinical psychologists found that about two thirds had experienced mental health problems themselves, with the most common being depression, anxiety, and eating disorders (Tay, Alcock, & Scior, 2018). Other research suggests that burnout is more common among therapists who repeatedly think about frustrating aspects of their work, therapists with relatively little experience, and therapists who have high levels of neuroticism and perfectionism, but burnout is less common among therapists who believe they have sufficient social support (Rzeszutek & Schier, 2014; Simpson et al., 2019). The impairment associated with burnout can definitely translate into less effective treatment. One study
found a strong correlation between higher rates of therapist burnout and lower therapy outcomes in clients with depression and anxiety, mostly because of disengagement by the therapists (Delgadillo, Saxon, & Barkham, 2018).

Clearly, burnout and other factors can contribute to a level of impairment—in the form of depression, substance use, or other manifestations—that directly interferes with clinical work (Tamura, 2012; B. E. Williams, Pomerantz, Pettibone, & Segrist, 2010). So, as the ethical standard suggests, psychologists should take action to prevent or minimize their own impairment, including professional burnout. Such actions can include varying one’s work responsibilities, keeping one’s expectations reasonable, consulting with other professionals, maintaining a balanced and healthy personal life, or seeking their own psychotherapy as necessary (Barnett, 2008; Grosch & Olsen, 1995; P. L. Smith & Moss, 2009). (About 80% of therapists, including 92% of psychologists, seek their own therapy at some point during their careers [Orlinsky, Schofield, Schroder, & Kazantzis, 2011; Ronnestad, Orlinsky, & Wiseman, 2016]). Such efforts fall under the heading of self-care, a priority that should be near the top of the list for psychologists (and graduate students) for their own sake and for the sake of their clients (Wise & Barnett, 2016; Zahniser, Rupert, & Dorociak, 2017). At the same time, it is important for psychologists to remain alert to signs that they are experiencing impairment—which, to some extent, is a universal experience for those who stay in the profession—and take appropriate action when such situations arise (Good, Khairallah, & Mintz, 2009). Collective efforts can also be helpful; that is, not only can each psychologist look out for herself or himself, but clinical psychologists can look out for one another, both informally (e.g., among colleagues) and formally via efforts by professional organizations to promote self-care among their members (Barnett & Cooper, 2009).

**ETHICS IN CLINICAL ASSESSMENT**

Many of the principles and standards discussed so far in this chapter relate to all clinical activities, but there are some that address assessment specifically. For example, the American Psychological Association’s (2002) code of ethics obligates psychologists to select tests that are appropriate for the purpose of the assessment and the population being tested. Test selection should entail a number of factors, including the psychologist’s competence; the client’s culture, language, and age; and the test’s reliability and validity. Additionally, psychologists must not select tests that have become obsolete or have been replaced by revised editions that are better suited to the assessment questions being addressed. Sometimes, psychologists find themselves in a position of constructing a new test rather than selecting from existing tests. Psychologists involved in test construction should do their best to establish adequate reliability and validity, minimize test bias, and accompany the test with a coherent, user-friendly test manual (Pomerantz & Sullivan, 2006).
Test security represents another specific area of focus of the American Psychological Association’s (2002) ethical code. Psychologists should make efforts to protect the security and integrity of the test materials they use. In other words, psychologists should prevent the questions, items, and other stimuli included in psychological tests from entering the public domain (Bersoff, DeMatteo, & Foster, 2012). When psychologists allow test materials to be taken home by clients, photocopied, or posted on Internet sites, not only might they be violating copyright laws, but they might also be allowing prospective test takers inappropriate access to tests. This could lead to preparation or coaching for psychological tests, which could, in turn, produce invalid test results. As described by Knapp and VandeCreek (2006), depending on the test in question, such invalid test results could place a nongifted student in a school’s gifted program, a psychologically unstable police officer on the streets, or a child in the custody of an emotionally unfit parent.

Although psychologists should keep test materials secure, the American Psychological Association’s (2002) ethical code explains that they are generally obligated to release test data to clients on request. Test data refers to the raw data the client provided during the assessment—responses, answers, and other notes the psychologist may have made. Although previous editions of the ethical code instructed psychologists not to release test data to clients, the current edition instructs psychologists to release test data unless there is reason to believe that the data will be misused or will harm the client. This revision reflects the more global shift toward patient autonomy in the health care field (C. B. Fisher, 2017).

ETHICS IN CLINICAL RESEARCH

The American Psychological Association’s code of ethics includes numerous standards that apply to research of all kinds, including clinical research. So, just like psychologists from other specialty areas, clinical psychologists who conduct research are ethically obligated to minimize harm to participants, steer clear of plagiarism, and avoid fabrication of data, among other things (C. B. Fisher & Vacanti-Shova, 2012). Here, we will focus our discussion on one issue particularly relevant to an essential area of clinical research: efficacy of psychotherapy.

When clinical psychologists conduct empirical studies to measure how well a particular therapy works, they typically conduct the therapy in question with one group of participants, whereas a second group does not receive this therapy. What should the second group receive? This is a question with important ethical implications (Imber et al., 1986; Lindsey, 1984; Saks, Jeste, Granholm, Palmer, & Schneiderman, 2002). Although studies of this type may ultimately benefit many clients via the identification of evidence-based treatments, psychologists should be careful not to mistreat or harm some of their clients/research participants in the process.

Most commonly, the participants in therapy efficacy studies who don’t receive the treatment being studied are placed in one of three conditions: no treatment (often called a “wait-list control” group), a placebo treatment (some kind of interpersonal interaction with a professional but with presumably therapeutic techniques deliberately omitted), or an alternate treatment (the efficacy of which may be unknown; Bjornsson, 2011;
Is it ethical to provide any of these options to people who have psychological problems and have chosen, presumably with the hope of improvement, to participate in a study on its treatment? Of course, it is essential to inform participants before they consent to the study that some of them may not receive the treatment being studied or any treatment at all. Even if participants agree to this arrangement, the ethicality of the treatment they receive throughout a study of this type has been questioned (e.g., Arean & Alvidrez, 2002; Street & Luoma, 2002). Indeed, it is a significant ethical challenge for clinical psychologists to determine empirically the efficacy of their therapies without unduly exploiting or failing to help some of the participants while doing so (Saks et al., 2002).

CONTEMPORARY ETHICAL ISSUES

Managed Care and Ethics

As we discuss in another chapter, managed care exerts a strong influence on the current practice of clinical psychology. Among the new challenges it has presented are numerous ethical issues.

To begin, managed-care companies can put clinical psychologists in a position of divided loyalty. Although psychologists are ethically committed to “strive to benefit” and “safeguard the welfare” of their clients (American Psychological Association, 2002, p. 1062), they may be professionally pressured to minimize the services they provide to limit the cost of mental health care. In other words, clinical psychologists may find themselves in a tug-of-war between the managed-care companies’ profits and their clients’ psychological well-being (Alarcón, 2000; Wilcoxon, Remley, Gladding, & Huber, 2007). Moreover, to the extent that clients can perceive that the clinical psychologist has divided loyalties, the therapeutic relationship may suffer (L. J. Haas & Cummings, 1991).

To deal with this issue, the clinical psychologist could tell the client about loyalties to managed-care companies—and much more about managed care for that matter—during the informed consent process. Indeed, there are many aspects of managed mental health care that could be included in the informed consent process. For example, managed-care plans typically require that a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis be assigned to a client to qualify for payment (Ackley, 1997; Chambliss, 2000). Also, managed-care companies typically require that the clinical psychologist share at least some clinical information about the problem or its treatment with the company. To what extent should clinical psychologists discuss this and other facts of managed-care therapy with clients at the outset of therapy? Although the question is important, the answer is unclear (Acuff et al., 1999). Little empirical research has been conducted on the question, but some studies have suggested that information on managed care strongly impacts attitudes toward therapy (e.g., Pomerantz, 2000).

The aforementioned requirement that clients must be diagnosed with a DSM disorder for their managed-care companies to pay for treatment can present another ethical dilemma for clinical psychologists. If a client is struggling with a problem that does not meet the criteria for any DSM disorder, or if a family or couple has problems that don’t stem directly from an identifiable disorder in one person, the psychologist can face
pressure to falsely assign a diagnosis to ensure that the managed-care company will pay the bill (Kielbasa et al., 2004; Pomerantz & Segrist, 2006; Wilcoxon et al., 2007). Or the psychologist may be tempted to “upcode,” or assign a more serious diagnosis than the client’s symptoms actually merit, to increase the number of sessions or amount of money the managed-care company will devote to treatment (C. B. Fisher, 2017; Parry, Furber, & Allison, 2009). Even if the psychologist’s motivation is the client’s welfare, such actions are unethical and can constitute the illegal act of insurance fraud as well (R. Miranda & Marx, 2003).

**Technology and Ethics**

Along with managed care, technological advances have led to changes in the practice of clinical psychology in recent years, and new ethical challenges have also arisen. For example, a quick Internet search will yield a wide array of so-called psychological tests of one kind or another, claiming to measure intelligence, personality, and other variables. Many of these tests have questionable validity or reliability, and the feedback they provide may be inaccurate and distressing to clients. Any clinical psychologist who creates or uses unscientifically sound tests of this type may be engaging in unethical practice (Buchanan, 2002). And online assessment raises many more ethical questions (e.g., Knapp & VandeCreek, 2006; Naglieri et al., 2004): As the client is taking the test, are the testing conditions standardized? Will the client keep the test materials secure? Is the client distracted by other tasks? Is the client actually the person completing the test? Are there important behavioral observations the psychologist might be missing because of the remote nature of the assessment?

Some of these concerns apply to online therapy practices as well (e.g., D. E. Shapiro & Schulman, 1996). When therapy is done via computer, the clinical psychologist and client may not be able to fully appreciate all aspects of communication (e.g., nonverbals). Moreover, online therapy gives rise to concerns about confidentiality and client identity that don’t exist when the clinical psychologist works with the client in person (C. B. Fisher & Fried, 2003; Kraus, 2004).

**Ethics in Small Communities**

Although they have become increasingly acknowledged and researched in recent decades, the ethical challenges unique to small communities are certainly not a recent development. Clinical psychologists who work and live in small communities have always experienced these challenges (Werth, Hastings, & Riding-Malon, 2010). Rural areas and small towns may be the most obvious examples of small communities, but there are many others as well. Even within large cities, clinical psychologists can find themselves living and working in small communities defined by ethnicity, religion, or sexual orientation, or on military bases, at small colleges, or in similar settings (Hargrove, 1986; Schank, Helbok, Haldeman, & Gallardo, 2010; Schank & Skovholt, 1997, 2006; Schank et al., 2003).

Multiple relationships are a distinctively difficult ethical issue for clinical psychologists in small communities. In fact, “nonsexual overlapping relationships are not a matter of if as much as when in the daily lives of many small- and contained-community
psychologists" (Schank et al., 2003, p. 191). Unlike clinical psychologists in larger communities, those in small communities may not be able to live in one population and practice in another, so keeping personal and professional aspects of their lives entirely separate may prove impossible. Consider Dr. Villanueva, the only clinical psychologist in a remote town with a population of 1,500. Any of Dr. Villanueva’s activities—shopping at the grocery store, working out at the gym, visiting a dentist—might require her to interact with a client or former client. And when we recall that multiple relationships can involve those close to clients (e.g., family, friends) in addition to clients themselves, the likelihood of such interactions increases tremendously. Dr. Villanueva may be the only qualified mental health professional in the community, so for her, referring clients to others may not be a viable option. Further complicating the situation is the fact that clients may know more about Dr. Villanueva than is typical in larger communities (Juntunen, Quincer, & Unsworth, 2018). For example, Dr. Villanueva may be working with a married couple who are considering divorce. If Dr. Villanueva gets a divorce herself and the couple finds out about it—more likely in a small community than in a large one—the couple may lose confidence in her ability to help them, whether such a loss of confidence is warranted or not.

For clinical psychologists such as Dr. Villanueva, it is wise to discuss the issue of multiple relationships with clients at the outset of psychological services as part of the informed consent process. Although multiple relationships may be somewhat inevitable, educating clients about the complications they can cause, as well as the psychologist’s ethical obligations, can clarify boundaries and prevent misunderstandings. In addition, clinical psychologists in small communities should do their best to live a healthy, well-balanced personal life to ensure that they don’t find themselves inappropriately leaning on clients to meet their own personal needs. And even if some degree of overlap is inevitable, clinical psychologists in small communities must nonetheless make every effort to avoid the impaired judgment and client exploitation that can make multiple relationships unethical and harmful (Curtin & Hargrove, 2010).

**Metaphorically Speaking**

*If You’ve Played the “Six Degrees of Kevin Bacon” Game, You Understand Multiple Relationships in Small Communities*

You may be familiar with the idea of “six degrees of separation,” which suggests that any person on earth can be connected to any other person on earth within just six steps (in a “friend of a friend” kind of way). But have you ever played the “six degrees of Kevin Bacon” version?

It’s nearly impossible to find a Hollywood actor or actress without a connection to Kevin Bacon. Hundreds have direct connections, meaning that they have costarred in films with him. Thousands more are indirectly connected to him, often through a surprisingly small number of links. Take Keira Knightley, for example. She’s just two links away from Kevin Bacon—she appeared in *Love Actually* with an actress who appeared in *Wild Things* with Kevin Bacon. Dwayne “The Rock” Johnson? Melissa McCarthy? Samuel L. Jackson? Seth Rogen?
Meryl Streep—all just a couple of steps away from Kevin Bacon. (Check www.oracleofbacon.org for more Kevin Bacon connections.)

The experience of clinical psychologists living and working in small communities might be a bit like Kevin Bacon’s experience at a Hollywood party. For Bacon, everyone at the party could be a friend or the friend of a friend; for the clinical psychologist, everyone in the community could be a client or a client’s friend, partner, brother, sister, parent, child, and so on. There are a few differences, however. For one, Kevin Bacon can skip the party if he chooses to avoid seeing people to whom he is connected, but that’s not so easy for the clinical psychologist, whose personal life requires regular contact with community members. Also, Kevin Bacon doesn’t need to be wary of ethical pitfalls as the clinical psychologist does; if he blurs relationship boundaries at the party, it might be called “networking,” but if a clinical psychologist does so in the small community, it might result in confusion, reduced objectivity, or even exploitation.

In larger communities, clinical psychologists may have more options to avoid multiple-relationship predicaments. They might be able to find accountants, physicians, yoga instructors, or basketball coaches for their kids who have no connections to their clients. But in smaller communities, the degrees of separation are far fewer, so multiple relationships can be unavoidable. It is possible to manage this situation successfully, however, and the American Psychological Association’s (2002) ethical code explicitly states that multiple relationships need not be unethical. An essential strategy for clinical psychologists in small communities includes communication with clients early in the professional relationship about the “ground rules” regarding multiple relationships and always steering clear of the most toxic elements of multiple relationships, such as exploitation and harm of clients.

CHAPTER SUMMARY

The American Psychological Association’s code of ethics was originally created in 1953 and was most recently fully revised in 2002. The current code includes both aspirational principles and enforceable standards. In addition to a thorough knowledge of the code, a psychologist’s ethical decision-making process should include a thoughtful consideration of the perspectives of all parties involved in the situation, consultation with trusted colleagues, and careful evaluation of all alternatives. Confidentiality is a particularly significant ethical issue for clinical psychologists. Although some clients may mistakenly believe that confidentiality is absolute, some situations necessitate a breach of confidentiality. For example, the ruling in the Tarasoff case assigns psychologists the duty to warn potential victims of harm, and state laws require psychologists to report ongoing child abuse. Policies regarding confidentiality and other aspects of psychological services should be addressed in the informed consent process. Unlike informed consent for research, which is typically a single event at the outset, informed consent for psychotherapy may be better understood as a process that continues over time as the psychologist is increasingly able to provide information specific to each client. Multiple relationships, in which a psychologist knows a client both professionally and nonprofessionally (or has a relationship with someone close to the client), can constitute ethical violations when they impair the psychologist’s objectivity, competence, or
effectiveness, or when they exploit or harm the client. Not all multiple relationships are unethical, however, and in small communities, some degree of overlapping relationships may be unavoidable. Regarding competence, psychologists should (1) ensure that their professional activities match their training and expertise, (2) make efforts to avoid any negative impact of burnout or personal problems on their work, and (3) attain cultural competence for a diverse range of clients. Some contemporary developments have created additional ethical concerns for psychologists, including diagnostic and informed consent issues related to managed care and numerous ethical issues related to online assessment and therapy.

KEY TERMS AND NAMES

aspirational 2  
boundaries of competence 16  
burnout 17  
child abuse 9  
code of ethics 1  
competence 16  
confidentiality 5  
continuing education 16  
duty to warn 6  
enforceable 2  
ethical decision making 4  
Ethical Standards 2  
Celia Fisher 4  
General Principles 2  
informed consent 11  
multiple relationships 13  
nonsexual multiple relationships 14  
sexual multiple relationships 14  
Tarasoff case 6  
test data 19  
test security 19  
test selection 18

CRITICAL THINKING QUESTIONS

1. What is the primary difference between the aspirational and enforceable sections of the American Psychological Association’s (2002) code of ethics? Which would you expect to have the most direct influence on the professional behavior of a clinical psychologist?

2. What conclusions do you draw from the research findings that psychologists’ ethical beliefs may vary across time, client gender, client age, or other variables?

3. Provide separate lists of examples of client threats that, in your opinion, do and do not invoke the “duty to warn” as established by the Tarasoff case.

4. In your opinion, what information is most essential to informed consent for psychotherapy?

5. If you were a clinical psychologist, what efforts would you make to ensure that you did not experience personal problems or burnout that impaired your work?

KEY JOURNALS

Links available at edge.sagepub/pomerantz5e

*Journal of Clinical Psychology*  
http://onlinelibrary.wiley.com/journal/10.1002/(ISSN)1097-4679  
*Journal of Contemporary Psychotherapy*  
http://link.springer.com/journal/10879  
*Ethics & Behavior*  
http://www.tandfonline.com/loi/hebh20#.V08aRfkrLX4  
*Professional Psychology: Research and Practice*  
STUDENT STUDY SITE RESOURCES

SAGE edge™

Visit the study site at edge.sagepub/pomerantz5e for these additional learning tools:

- Self-quizzes
- eFlashcards
- Culture expert interviews
- In My Practice demonstration video
- Full-text SAGE journal articles
- Additional web resources
- Mock assessment data

COPYRIGHT ©2020 BY SAGE PUBLICATIONS, INC.
THIS WORK MAY NOT BE REPRODUCED OR DISTRIBUTED IN ANY FORM OR BY ANY MEANS WITHOUT EXPRESS WRITTEN PERMISSION OF THE PUBLISHER.