

CHAPTER 13

Standards on Therapy

10. Therapy

10.01 Informed Consent to Therapy

(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality, and 6.04, Fees and Financial Arrangements.)

To comply with this standard of the APA Ethics Code (APA, 2002b), psychologists must obtain and document written or oral consent in the manner set forth in Standard 3.10, Informed Consent. They must also provide prospective therapy clients/patients and, when appropriate, their legal guardians a clear explanation of the nature and anticipated course of therapy, fees, involvement of third parties, and the limits of confidentiality. This information must be presented in a language reasonably understandable to the client/patient, and the consent process must provide sufficient opportunity for questions and answers.

As Early as Feasible

Standard 10.01 explicitly uses the phrase *as early as is feasible* to indicate that in some cases, obtaining informed consent during the first therapy session may not be possible or clinically appropriate. Psychologists may need to wait for feedback from a client's/patient's HMO before consent discussions regarding fees can be completed. Informed consent during the first session may be clinically contraindicated



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if a new client/patient is suicidal or experiencing some other crisis needing immediate therapeutic attention. In such situations, consent is obtained as soon as all information is available or the crisis has subsided (see also Standard 6.04a, Fees and Financial Arrangements).

- ✓ At the beginning of the first session, it became apparent that a new client was having difficulty communicating in a coherent fashion. With probing, the psychologist learned that the client had a history of schizophrenia and had recently gone off his medications because of its intolerable side effects. The psychologist postponed discussion relevant to informed consent and spent the rest of the session working with the client to determine the best course of action to deal with the immediate situation.

Nature of the Therapy

The *nature* of the therapy refers to information about the therapeutic process that would reasonably be expected to affect clients'/patients' decisions to enter into therapy with the psychologist. Informed consent should include discussion of the duration of each session (e.g., 50 minutes), appointment schedule (e.g., weekly), and the general objectives of treatment (e.g., crisis management, symptom reduction). Depending on the treatment modality, the consent process might inform clients/patients that therapy entails participating in biofeedback sessions, relaxation exercises, behavioral contracts, homework assignments, discussion of dreams and developmental history, collateral treatments, or other aspects of the therapeutic process relevant to an informed consent decision. Psychologists should not assume that all clients/patients are familiar with the nature of psychotherapy.

- ✓ A new patient who had recently immigrated to the United States from West Africa told a psychologist that his general practitioner had recommended that he see the psychologist because of headaches that had not responded to traditional medications. The psychologist explained her cognitive therapy approach to working with such problems, standard confidentiality procedures, and issues relevant to the patient's health plan and then turned to a discussion of issues relevant to the patient's presenting problem. Toward the end of the session, the psychologist asked the patient if he had any additional questions. The patient asked the psychologist if she was ready to give him a prescription for a medication that would cure his headaches. The psychologist then carefully explained in great detail the nature of cognitive therapy and the difference between such therapy and psychopharmacological approaches.

Anticipated Course of the Therapy

The *anticipated course* of therapy refers to the number of sessions expected, given the psychologist's current knowledge of the client's/patient's presenting problem and, when applicable, the company, institutional, or health plan policies that may affect the number of sessions. Depending on the treatment modality, consent discussions would also include expectable modifications such as the evolving nature of systematic desensitization or exposure therapy, the uncovering of as yet unidentified treatment issues, or, if the practitioner is a prescribing psychologist, adjustments in dosage levels of psychopharmacological medications.

Need to Know: Informed Consent With Suicidal Patients

For certain disorders and treatment contexts, informed consent will include discussion of empirically documented risks inherent in psychotherapy. Following a review of the literature, Rudd, Joiner, et al. (2009) concluded that given the available data on increased suicide risk during treatment involving multiple attempters, there is a need to include potential risks of death or suicide in the informed consent process. As a comparison, they noted the FDA black box warning label for antidepressant use with adolescents (Rudd, Cordero, & Bryan, 2009). According to the authors, frank discussions about suicide risk during informed consent offer the following benefits: (a) assisting clients/patients and their families to understand the true nature of suicide risk during the treatment process and to recognize shared responsibility to reduce its likelihood, (b) helping to clarify the importance of treatment compliance and crisis management to treatment effectiveness, (c) providing an opportunity to emphasize the need for effective self-management during outpatient care, (d) helping the psychologist to identify and target for treatment skill deficits that might limit the patient's willingness or ability to access emergency services, and (e) facilitating a frank exchange about the responsibilities of provider and client/patient.

In many instances, informed consent to therapy will be an ongoing process determined, for example, by the extent to which the nature of a client's/patient's treatment needs are immediately diagnosed or gradually identified over a series of sessions, cognitive and social maturation in child clients/patients, or functional declines in clients/patients with progressive disorders. Providing clients/patients with an honest evaluation of the anticipated and unanticipated factors that may determine the course of therapy demonstrates respect for their right to self-determination and can promote trust in the therapeutic alliance (Pomerantz, 2005; Principle C: Integrity; Principle E: Respect for People's Rights and Dignity).

- ✗ A psychologist saw a new client whose presenting problems appeared to be related to a debilitating social phobia. The client was to pay privately for treatment because her health plan did not cover psychotherapy. The client asked the psychologist how long she might have to be in therapy before she saw some relief from her symptoms. The psychologist responded, "We'll just see how it goes."
- ✓ A psychologist saw a new patient who appeared to be suffering from a mild form of agoraphobia. The psychologist explained his cognitive-behavioral approach to this type of problem and the average number of sessions after which patients often feel some relief from their symptoms. The psychologist stressed that each individual responds differently and that together they would reassess the patient's progress after a specific number of sessions.

Fees

Discussion of *fees* must include the cost of the therapy, the types of reimbursement accepted (e.g., checks, credit card payments, direct payment from insurance companies), the payment schedule (e.g., weekly, monthly), when fees are reevaluated (e.g., annual raise in rates), and policies regarding late payments and missed appointments.

When appropriate and as soon as such information can be verified, psychologists should also discuss with clients/patients the percentage of therapy costs reimbursed under the client's/patient's health plan and limitations on the number of sessions that can be anticipated because of limitations in insurance or other sources of client/patient financing (see also Standard 6.04, Fees and Financial Arrangements). Psychologists directly contracted with HMOs may have capitated or other types of business agreements that provide financial incentives to limit the number of treatment sessions. When permitted by law and contractual agreement, psychologists should inform clients/patients about such arrangements (Acuff et al., 1999; Barnett & Walfish, 2012) see also Standard 3.06, Conflict of Interest, and the Hot Topic in Chapter 9, "Managing the Ethics of Managed Care").

- ✗ On the initial visit, a psychologist told a client her fee for each session and mentioned that she was an approved provider for some HMOs. At the end of the first month in treatment, when the client asked the psychologist to fill out an insurance form, the client was shocked to learn that the psychologist was not an approved provider for his particular HMO plan, that she had not called the HMO to inquire about her eligibility for reimbursement, and that she had not informed him during the first session of the possibility that she was not an approved provider.

Involvement of Third Parties

The term *third parties*, as used in this standard, refers to legal guardians, health insurance companies, employers, organizations, and legal or other governing authorities that may be involved in the therapy. Psychologists should inform clients/patients if such parties have requested or ordered mental health treatment, are paying for the therapy, and are entitled to receive diagnostic information or details of the therapy based on law or contractual agreement—and to whom information may be provided—contingent on the client's/patient's appropriate written release or authorization (see section below on implications of HIPAA). Psychologists asked to evaluate a child by one parent should clarify, when appropriate, custody issues to determine if the other parent must also give permission.

- ✓ A psychologist was assigned to see a couple for court-ordered therapy following a finding of child abuse and neglect resulting in the removal of the children from their home. The psychologist informed the couple that the treatment was mandatory, that it was paid for by a court-affiliated child protective services agency, and that the psychologist would be providing to the court a summary of the couple's compliance with and progress in therapy.

Confidentiality

Informed consent to therapy must provide a clear explanation of the extent and limits of *confidentiality*, including (a) when the psychologist must comply with reporting requirements, such as mandated child abuse reporting or duty-to-warn laws, and (b) guardian access to records in the case of therapy involving minors or individuals with impaired consent capacities. Psychologists who provide therapy over the Internet must inform clients/patients about the procedures that will be used to protect confidentiality and the threats to confidentiality unique to this form of electronic transmission of information (see also Standard 4.02c, *Discussing the Limits of Confidentiality*). Clients/patients enrolled in health plans must be informed about the extent to which treatment plans, diagnosis, or other sensitive information must be disclosed to case managers for precertification or continuing authorization for treatment (Acuff et al., 1999; Fisher & Oransky, 2008). When appropriate, psychologists providing treatment in forensic settings should inform clients/patients of the possibility that the psychologist may be obligated to disclose statements made in therapy in court testimony.

- ✓ A psychologist had an initial appointment with an adolescent and his parents to discuss the 14-year-old's entry into individual psychotherapy for depression. The psychologist discussed with both the prospective patient

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and his parents what information concerning the adolescent's treatment would and would not be shared with the parents, including her confidentiality and disclosure policies regarding adolescent risk behaviors such as sexual activity and use of illegal drugs. She also informed them about her legal obligations to report suspected child abuse or neglect and her own policy regarding disclosure of information pertaining to client/patient imminent self-harm or harm to others. In addition, she described the parents' right to access the adolescent's health records under HIPAA (see also the Hot Topic "Confidentiality and Involvement of Parents in Mental Health Services for Children and Adolescents" in Chapter 7).

Digital Ethics: Discussion of Confidentiality Risks in Telepsychology

The APA Telepsychology Task Force (APA, 2013d) identified the critical need to ensure clients'/patients' full understanding of the increased risks to security and confidentiality when using telecommunication technologies. During informed consent, psychologists should explain the steps they have taken to protect client/patient confidentiality and the web-based security risks that might still exist within a professional health care setting or private or group practice (Standard 4.02, Discussing the Limits of Confidentiality). They should also use the consent conference to help clients/patients evaluate the remote environment in which they will receive and send electronically mediated services (e.g., home computer, mobile phone) to determine what steps clients/patients can take to address technical issues and protect the privacy of their information and safety. In addition, the informed consent discussion provides an opportunity to discuss how to avoid interruptions and distractions during sessions, establish a setting conducive to effective delivery of services, and arrange for contacting emergency personnel or other supports.

- ☒ A psychologist began therapy with a client over the Internet. The psychologist failed to inform the client of the need for a password to protect the home computer from which the client would be interacting with the psychologist. The client's spouse opened the files in which therapeutic communications had been saved and printed them out to use against the client in petitioning for divorce.

Implications of HIPAA

Psychologists who are *covered entities* under HIPAA must inform clients/patients about their rights regarding the uses and disclosures of their PHI. This includes

providing clients/patients with a Notice of Privacy Practices that explains the uses and disclosures of PHI that may be made by the covered entity, as well as the individual's rights and covered entity's legal duties with respect to PHI (see the discussions regarding HIPAA under Standard 3.01, Informed Consent, and in "A Word About HIPAA" in the preface of this book for definitions and discussion of these terms). Remember, the designation "covered entity" is not specific to an individual client/patient but to the psychologist's practice. Thus, even if a psychologist is not electronically transmitting health information about a particular client/patient, HIPAA is triggered if the psychologist or business associate (including clients'/patients' health insurer) has conducted any such transactions for others who are the psychologist's clients/patients. Readers may also wish to review HIPAA regulations governing the protection of psychotherapy notes discussed in Chapter 12.

Digital Ethics: Setting an Internet Search and Social Media Policy During Informed Consent

As discussed in Chapter 6, the continued growth, popularity, and accessibility of personal information online raises issues regarding appropriate privacy protections and personal/professional boundary setting in psychotherapy (Standards 3.05, Multiple Relationships; 4.01, Maintaining Confidentiality; 4.02, Discussing the Limits of Confidentiality). Situations may arise when it is ethically responsible to search online for client/patient information, for example, for an emergency contact or, in rare instances, to corroborate client/patient clinically relevant statements (Lehavot et al., 2010). As Internet searches become even more ubiquitous in personal and professional life, discussing the psychologist's policy for such web-based searches during informed consent may become another important contributor to the therapeutic alliance. The psychologist's restrictions on interaction with the client/patient through social networks or other online outlets should also be a part of the consent process. During informed consent, psychologists should also clarify policies against "friending" and "fanning" by clients/patients if the psychologist has a professional Facebook page, security concerns for clients/patients who might choose to follow a psychologist's professional Twitter posts or blog, policies on client/patient testimonials, and restriction of email for appointment purposes only.

Informed Consent Involving Children and Adolescent Clients/Patients

Psychologists providing therapy and counseling to children and adolescents face unique informed consent challenges tied to (a) state and federal laws governing the rights of minors to autonomous health care decisions; (b) laws related to the rights and obligations of minors' legal guardians; and (c) developmental changes in children's ability to understand their rights, the nature of their disorder, and the purpose of treatment (Standard 3.10b, Informed Consent). When working with children and adolescents, psychologists must constantly balance ethical obligations to protect

client/patient welfare with respect for the client's/patient's development of autonomy and privacy (Principle A: Beneficence and Nonmaleficence; Principle E: Respect for People's Rights and Dignity).

When Guardian Consent Is Required by Law

According to Standard 3.10b, Informed Consent, for persons who are legally ineligible to provide informed consent, psychologists must obtain guardian permission, provide the client/patient with an appropriate explanation, seek the client's/patient's assent, and consider such person's preferences and best interests. This standard respects the developing autonomy needs and rights of minor children by requiring that they receive developmentally appropriate information regarding the reason for and nature of the treatment and, with some exceptions, are given the right to refuse treatment.

Exceptions to the requirement for child assent arise when children are too young or too impaired at the time treatment is initiated to appreciate their disorder or understand the nature of therapy, especially when treatment is necessary for their well-being. When children's mental health needs indicate that their dissent will not determine whether they will receive treatment, psychologists should provide them with an appropriate explanation but not seek their assent (Fedewa, Prout, & Prout, 2015; Fisher & Mastey, 2006; Mastey & Fisher, 2008).

When Guardian Consent Is Not Permitted or Required by Law

Parents are given significant responsibilities and rights to consent to health care treatments for their children who are below 18 years of age (*Parham v. J. R.*, 1979; Weithorn, 2006; *Wisconsin v. Yoder*, 1972). Psychologists should be familiar with relevant state and federal laws before they consider treating a minor client/patient without guardian permission (for a review of state laws, see English & Kenney, 2003). Psychologists providing counseling services in schools should also be aware of district rules and state and federal laws restricting services to children without parental consent (Fedewa et al., 2015; Jacob & Hartshorne, 2007). As outlined in Chapter 6, Standard 3.10b, Informed Consent, exceptions to requirements for parental permission to treatment include state laws defining (a) *emancipated minors*, (b) *mature minors*, and (c) minors for whom there is evidence that their guardians' decisions may not be in their best interests.

According to Standard 3.10b, Informed Consent, when consent by a legally authorized person is not permitted or required by law, psychologists must take reasonable steps to protect the child's rights and welfare. A first step in complying with this standard is to be familiar with research on developmental differences in children's understanding of consent information and clinical methods to evaluate the consent capacity of individual clients/patients. For example, research on children's ability to consent to medical treatment and clinical research suggests that between the ages of 12 and 14, many children understand treatment-relevant

consent information as well as adults, although their relative lack of experience with independent health care decision making and power differentials with adult authorities may place them at a consent disadvantage (Alderson, Sutcliffe, & Curtis, 2006; Bluebond-Langner, DiCicco, & Belasco, 2005; Broome, Kodish, Geller, & Siminoff, 2003; Bruzzese & Fisher, 2003; Field & Behrman, 2004; Gormley-Fleming & Campbell, 2011; Hein et al., 2015; Mastly & Fisher, 2008).

The next step is to tailor the consent information to the child's level of understanding of both the nature of treatment and their rights under law and ethics. This may include educating clients/patients about treatment terminology, the nature of treatment, and their right to refuse or withdraw from treatment. Finally, as detailed in the Hot Topic in Chapter 7, even when adolescents have the legal right to consent to their own treatment, parents may have legal access to their child's psychotherapy records. For example, in many instances, if parents are responsible for paying their child's health care costs directly or through insurers, they will have access to the records irrespective of whether a child has been designated a mature or emancipated minor. Psychologists working with adolescents in the absence of parental consent need to be familiar with state and federal laws governing parental access to records and include this information during informed consent (see "A Word About HIPAA" in the preface of this book).

Digital Ethics: Child Assent and Parental Permission for Online Therapies

As discussed throughout this book, the Internet has increased the availability of psychological services as well as the ethical issues that must be addressed. Since minors constitute a substantial portion of Internet users (Kaiser Family Foundation, 2001), psychologists need to have a method for verifying client/patient age and obtaining guardian permission if required by state law. Since state laws vary in these requirements, psychologists also need to verify the state in which the minor resides. When feasible, some practitioners choose to have an initial face-to-face meeting with clients/patients before initiating web-based treatments. When this is not feasible, an initial videoconference, phone call, or exchange of identifying documents may be useful. Compliance with law and ethics protecting minors' participation in treatment requires documenting the validity of parental permission when it is required. An initial in-person visit if feasible, a web-based video consent conference, or telephone discussion with the client's/patient's legal guardian can ensure that appropriate permission has been obtained, provide an opportunity to discuss with guardians specific confidentiality and disclosure policies, and initiate a collaborative relationship that will be beneficial to the child's treatment. Psychologists also need to verify to the best of their ability that the individual they are corresponding with is the same person from whom consent was obtained. Some psychologists have used personalized code names that clients/patients include in their exchanges to address this potential problem.

(b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation. (See also Standards 2.01e, Boundaries of Competence, and 3.10, Informed Consent.)



Most techniques that are now accepted practice in the profession of psychology emerged from treatment needs unmet by existing therapies. Standard 10.01b recognizes that innovation in mental health services is critical if a profession is to continue to adequately serve a diverse and dynamic public. The standard also recognizes that during the development and refinement of new therapeutic techniques, the risks and benefits to clients/patients are unknown. Consequently, respect for a client's/patient's right to informed, rational, and voluntary consent requires that when the treatment needs of a client/patient call for innovative techniques, during informed consent, psychologists have the obligation to explain the relatively new and untried nature of the therapy. Furthermore, they must clearly describe alternative established treatments and clarify the client's/patient's right to dissent in favor of more established treatments, whether they are offered by the psychologist obtaining the consent or other mental health professionals.

Telepsychology

Telepsychology has been described as a new modality for helping people resolve life and relationship issues using the power and convenience of telecommunication technologies to allow synchronous (simultaneous) and asynchronous (time-delayed) communication between client/patient and therapist (APA, 2013d; Godine & Barnett, 2013; Grohol, 2001; Maheu & Gordon, 2000). As detailed in the *APA Guidelines for the Practice of Telepsychology* (APA, 2013d), such technologies may augment in-person care (e.g., mobile phone behavioral management reminders, online psychoeducational materials) or be used as stand-alone services (e.g., therapy over video conferencing). A primary advantage of telepsychology is that through remote communication, it can provide clients/patients access to qualified mental health professionals regardless of geographical proximity.

To date, telepsychology does not represent a new theoretical approach to psychotherapy in the same vein as cognitive, psychodynamic, behavioral, or other theoretically driven approaches to treatment. Rather, it represents a new modality or process by which these forms of therapy can be provided. While great strides have been made, electronically mediated therapies (e.g., email, chat rooms, videoconferencing) have yet to emerge as "established" treatments in many contexts in which they are conducted (Pietrzak, Pullman, Campbell, & Cotea, 2010). This is due in part to continuously changing technology, use of different web-based modes of treatment, variability in which treatment techniques are viewed as compatible with web-based approaches, the range of disorders treated, and difficulty in obtaining empirical data on the demographics and other characteristics of

individuals using web-based therapies (Cooper & Cody, 2015; Heinlen et al., 2003). For these reasons, psychologists providing web-based services should carefully consider the extent to which their services are considered “established” within the profession and whether their informed consent procedures need to comply with Standard 10.01b.

- ✓ A psychologist working in a large, underserved rural community found that a number of his clients could not afford to make the 100-mile trip to his office on a weekly basis. After attending an intensive workshop on email therapy and developing a network of colleagues to consult with on behavioral telehealth techniques, the psychologist decided to use this form of therapy. He adopted the procedure of having an initial in-person meeting with each client who might be appropriate for email therapy. During the informed consent provided at this session, he explained the following: (a) Email therapy is a new and still-developing form of therapy; (b) although there was reason to believe this form of therapy would serve the client’s mental health needs, the extent of such benefits was still largely unknown; (c) current risks associated with email therapy include confidentiality concerns and lack of immediacy; (d) there are traditional treatments available for the client’s presenting problem; and (e) if the client preferred to receive a more traditional therapy, the psychologist would try to work out a schedule that could accommodate the client’s travel difficulties.

Digital Ethics: State Laws Regulating Use of Telehealth Services

According to the most recent survey of state licensing laws, only a few states currently regulate the use of telehealth-related services by licensed psychologists (American Psychological Association Practice Organization, 2013; Webb & Orwig, 2015). Psychologists seeking to practice telehealth services need to be up-to-date on whether the state in which they are licensed (a) has specific statutes or regulations pertaining to telepsychology; (b) includes telepsychology in the statutory definition of psychological practice; or (c) includes psychologists as providers under a general telemedicine act. Psychologists providing telehealth services to clients residing in or visiting a state in which the practitioner is not licensed need to be similarly vigilant in understanding whether telepsychology is included in the state’s temporary/guest provision act. States that have begun to regulate electronically communicated health care services require certain information to be disclosed during informed consent, largely focused on risks inherent in providing services via the Internet or other electronic media, including how records are stored and protected and communication alternatives in the event of technology failure (Baker & Bufka, 2011).

The Ongoing Nature of Consent

Informed consent should be conceptualized as a continuing process in which the clinically determined need to shift to treatment strategies distinctly different from those that were originally agreed upon during informed consent are discussed with the client/patient at appropriate points during the course of psychotherapy. If, after several sessions, a client's/patient's treatment needs call for a shift to innovative techniques that have not been widely used or accepted by practitioners in the field, psychologists should follow the requirements of Standard 10.01b. The following case illustrates a potential violation of this standard.

- ☒ A psychologist had just returned from a professional meeting in which she heard several other practitioners discuss a new technique for anxiety disorders that involved viewing video clips of people reacting to natural or human-made catastrophes. She decided to try this untested technique with one of her patients who had not been responding to traditional interpersonal approaches to anxiety. At the next session, rather than discussing with the patient the option of trying this new type of approach, she told the patient that as part of his ongoing treatment, they would look at a video together. The patient experienced an anxiety attack following exposure to the video and apologized to the therapist for failing to improve after so many sessions.

Need to Know: Expanded Informed Consent for Psychologists With Prescriptive Authority

Guideline 12 of the APA Practice Guidelines regarding Psychologists' Involvement in Pharmacological Issues (APA, 2011a, pp. 844–845) encourages psychologists with prescriptive authority to use an expanded informed consent process to incorporate additional issues specific to prescribing, including the following:

- The agent to be used
- Symptoms it is intended to address
- Potential adverse side effects, potential contraindications if the patient is taking other medications, and risks associated with sudden unilateral discontinuation
- Rationale for treatment relative to other treatments, including other medications, and, when appropriate, why psychotherapy and psychopharmacology are used together
- The estimated duration and cost of treatment, including any indicated physical or laboratory examinations and therapeutic monitoring of drug levels
- The potential reasons for reducing dosage or discontinuing medication

(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.

Standard 10.01c applies to therapy conducted and supervised as part of practice, internships, or other training experiences in which the legal responsibility for treatment resides with the supervisor. In these contexts, clients/patients must be informed that the therapist is a trainee and that the therapy is supervised and be given the name and contact information of the supervisor. Both the trainee and the supervisor would be in potential violation of this standard if the supervisee failed to include this information during informed consent. This standard does not apply to therapy conducted by licensed psychologists obtaining postdoctoral training and supervision because, in such contexts, the legal responsibility most often resides with the psychologist (Barnett & Molzon, 2014).

- ☒ A student interning at a veterans hospital was concerned that her ability to help patients would be compromised if she told them that she was a trainee. When she discussed this with her supervisor, the supervisor told her the decision was up to her.

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.)



Steps required to inform prospective clients/patients in couples or family therapy about the nature of treatment go beyond those described in Standards 3.10, Informed Consent, and 10.01, Informed Consent to Therapy. In some couples or family treatment modalities, the client/patient is the multiperson unit, and the primary obligation of the psychologist is to the parties as a whole. Under Standard 10.02, psychologists must identify and explain which members of the couple or family are the primary client/patient. They should also discuss issues related to termination, including whether treatment will continue if a member of the couple or family decides to discontinue (Knauss & Knauss, 2012). In other family or couple therapy modalities, the primary client/patient is a single individual, with family members involved only to provide collateral support for the client's/patient's treatment. While the psychologist does not have the same legal obligations to these

individuals because they are not clients/patients (Younggren, 2009), they should be told how the information will be used and the therapist's confidentiality policy, including mandated reporting requirements.

- ✓ A divorced couple with joint custody of their children began family therapy to help their 10-year-old son, who had been having problems in school and with adjusting to living in two different homes. The father indicated that he was just attending sessions to support his son's therapy. The psychologist explained to the father, mother, and child that she offered family therapy in which all members are clients and their feelings and behaviors are equally explored during the treatment sessions. She also told them that if there were some indication that the son needed individual therapy, she would recommend an appropriate practitioner specializing in childhood disorders (see also Standard 2.01, Boundaries of Competence).

During informed consent, psychologists also need to ensure that all family members understand the nature of psychotherapy and are voluntarily agreeing to participate. If a family member joins the process at a later time, the informed consent process should be repeated (Knauss & Knauss, 2012).

- ✓ A 40-year-old woman sought family therapy for herself and her elderly mother. At the initial session, the psychologist learned that the daughter had given up her job to care for her mother and was frustrated by her mother's refusal to do simple chores around the house and their constant arguments. During the informed consent process, the mother appeared anxious. When the psychologist asked her whether she had any questions, she burst into tears and said she found it humiliating to speak to a stranger about family problems. The psychologist explained his role and his obligation to keep whatever he learned in therapy confidential. As the consent discussion continued, the mother became increasingly more agitated about sharing her personal thoughts and feelings. The psychologist concluded that her participation in the therapy would not be voluntary. He discussed his observations with the mother and daughter and recommended they consider seeing a pastoral counselor affiliated with their church as an alternative that might be more acceptable to the mother. He also let them know that he would be available if the mother changed her mind.

Clarifying the Psychologist's Role and Goals of Therapy

In addition to identifying who is the client/patient, discussions at the outset of couples or family therapy must clarify (a) the psychologist's responsibilities in balancing the interests of different individuals, (b) whether the psychologist will

conduct individual or conjoint sessions, and (c) how often the psychologist will meet with each party (Principle B: Fidelity and Responsibility). The modifier *reasonable* indicates that a violation of this standard is limited to instances when psychologists do not take steps to clarify information in a manner that would be considered appropriate in the prevailing judgment of other similarly engaged psychologists. Clients'/patients' failure to understand the full implications of this information is not in itself sufficient evidence of violation.

- ✓ An elderly couple entered therapy to help them address feelings and conflicts arising from the husband's terminal illness. Upon initial assessment of their situation, the psychologist determined that the wife's and husband's emotional reactions to the illness should be explored in individual sessions before it would be helpful for the couple to meet with the therapist together. The therapist outlined a treatment plan that included scheduling of individual and joint sessions.

In many instances, the goals of treatment may be different for the individuals involved. For example, one member of a couple may see therapy as a means of strengthening the relationship, whereas the other sees it as a means of ending the relationship. Conflicting perspectives on the goals of therapy may also reflect conflicting value systems, for example, different beliefs about the importance of religion or different emphases on the well-being of the family as a whole versus the well-being of individual family members, and individuals may believe the psychologist shares and will promote their values (Lebow, 2014). Psychologists must take reasonable steps to correct such misimpressions.

- ✓ An interfaith couple began premarital counseling to help resolve conflicts regarding issues such as which clergy should perform their wedding ceremony and the religious upbringing of their children. In the first 10 minutes of the initial session, it became clear that one member of the couple believed the purpose of counseling was to convince his fiancée to agree to have the wedding ceremony performed and their children raised in his faith. During the process of informed consent and in subsequent sessions, the psychologist continued to clarify that involvement in premarital counseling could not predict the direction the couple's relationship would take.

Confidentiality

Psychologists working with couples and families must take reasonable steps to clarify how confidential information will be handled. Will the psychologist keep information received from one party secret from the other? Or will all information

be shared (see Margolin, 1982; Snyder & Doss, 2005)? Psychologists must also clearly articulate their legal obligations and policies regarding confidentiality and disclosure of information about child abuse, domestic abuse, HIV status, high-risk behaviors of adolescent clients/patients, and other instances of potential harm.

- ☒ A gay couple had been in couples counseling for several sessions. One member of the couple called the psychologist and revealed that, without the knowledge of his significant other, he had begun seeing his former wife in what was progressing toward a renewal of their sexual relationship. The client asked the psychologist to keep the information secret. Although the psychologist had communicated a general confidentiality policy to the couple at the outset of therapy, she had not specifically discussed with them her policy regarding secrets between her and one member of the couple. She now felt in a terrible bind. If she refused to keep the information secret, she would violate the presumption of confidentiality held by the client who had called. If she respected the request for secrecy, she might be violating the other client's trust and expectation of openness.

Digital Ethics: Telepsychology Involving Family Members

For clients/patients living in underserved rural areas, comprehensive treatment of mental health disorders such as anorexia nervosa and schizophrenia requiring inpatient medical care is often only available in urban centers, which are not easily accessible to family members who may be critical to treatment effectiveness. In these settings, psychologists are increasingly using Internet-mediated services to involve families in the treatment plan. In addition to clarifying which individual is the client/patient, psychologists need to provide remote family members with all essential information regarding who will have access to electronically mediated sessions and information, the security protections in place (and their limitations when appropriate) at the psychologist's site, and how family members can protect their own privacy and security on their personal electronic media.



- (b) If it becomes apparent that psychologists may be called on to perform potentially conflicting roles (such as family therapist and then witness for one party in divorce proceedings), psychologists take reasonable steps to clarify and modify, or withdraw from, roles appropriately. (See also Standard 3.05c, Multiple Relationships.)

It is not unusual for individuals who have sought couples or family therapy to become involved in litigation involving divorce, child custody, child abuse allegations, petitions for child or family services, or mental competency hearings. In such

situations, psychologists may be asked by one party to testify on his or her behalf or receive a court order to serve as a fact witness for the legal matter at issue. When such situations arise, under Standard 10.02b, psychologists must first take steps to clarify to clients/patients the nature of the two roles and the potential effect on each party involved in the therapy. To comply with this standard, psychologists will need to be aware of and communicate to their patients/clients the extent to which state law defines as public or private the information revealed in couples or family therapy and whether one or all parties must agree to disclosure of information in court.

As with other forms of multiple relationships, sometimes the request to serve in a dual capacity risks impairing performance of one or both professional roles. In such cases, psychologists are required to take reasonable steps to modify or withdraw from one of the roles to ensure that services continue to be objective and effective and to avoid exploitation or harm to parties involved (Standard 3.05b and 3.05c, Multiple Relationships).

- ✓ A psychologist providing therapy for a family with a terminally ill child received a court order to serve as a fact witness for a case against the couple alleging child neglect. The psychologist informed the parents of the court's request and took steps to clarify to them the nature of this role. The psychologist was concerned that testifying in court would harm the therapeutic relationship achieved with this family and informed the judge in writing of these concerns. The judge refused to comply with the psychologist's request not to testify. The psychologist discussed the situation further with the family, and they mutually agreed to a referral to another therapist (see also Standard 1.02, Conflicts Between Ethics and Law, Regulations, and Other Governing Legal Authority).

10.03 Group Therapy

When psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality.



In addition to responsibilities described in Standards 3.10, Informed Consent, and 10.01, Informed Consent to Therapy, psychologists conducting group therapy must describe at the outset of treatment the unique roles and responsibilities of both therapist and clients/patients in multiperson therapies. Such information may include discussion of (a) differences between the exclusivity of the therapist's attention in individual therapy and the attention to group dynamics in multiperson treatments; (b) group member responsibilities, including turn taking and prohibitions against group members socializing outside sessions; and (c) policies regarding such client/patient responsibilities as acceptance of diverse opinions, abusive language, coercive or aggressive behaviors, or member scapegoating. As in couple and

family therapy, informed consent regarding termination policies is critical (e.g., disruptive group members; Knauss & Knauss, 2012). Group members need to know they have the right to voluntarily withdraw from the group as well as the consequences of member dropouts for the continuation of the group as a whole.

Digital Ethics: Setting Internet Use Policies for Group Therapy

When describing group member responsibilities, psychologists should develop guidelines for members' use of social media such as Facebook, Twitter, and Instagram and mobile phone technology. For example, Dombo, Kays, and Weller (2014) described an incident in which during a session, one group member pulled out his phone and stated, "I'm going to tweet that!" He then snapped and posted a picture of the therapist and another group member before the therapist could intervene. Psychologists should also discuss appropriate use of social media platforms to "friend" or discover background information about other group members.

Confidentiality

A frequently misunderstood aspect of group therapy concerns the limits of confidentiality. Although psychologists are professionally obligated to maintain the confidentiality of most statements made during group therapy sessions, decisions by members of a therapy group to disclose confidential information are neither bound by professional codes nor subject to legal liability. At the outset of group therapy, and each time a new member enters an ongoing group, psychologists must take reasonable steps to clarify that they can request, but not guarantee, that all group members maintain the confidentiality of statements made during sessions. Psychologists should also be familiar with and inform group members about state laws protecting or denying client/patient privilege (the right to limit the psychologist's disclosures to courts) for information shared during group therapy. When group therapy is conducted in response to court-ordered counseling, psychologists must also clarify to group members the parties in the justice system who will receive information learned during group therapy and how such information may be used.

Clients/Patients in Concurrent Single and Group Therapy

Psychologists who see clients/patients concurrently in individual and group therapy must take special precautions to ensure that they do not inadvertently reveal during a group session confidential information gained about a client/patient during an individual session. Psychologists must also clarify in advance to such clients differences between the goals, processes, and therapist-client relationships

in single versus group therapy. When recommending that a client/patient seen in individual therapy also participate in group therapy conducted by the psychologist, steps should be taken to ensure that clients/patients understand that such a decision is voluntary and that reluctance to participate in the group will not compromise the current therapeutic relationship. This does not prohibit psychologists from having a policy of only accepting individuals as clients/patients if they participate in group therapy if (a) such multimodal treatment is clinically indicated and (b) clients/patients are informed of this requirement prior to or at the outset of therapy. For additional discussion, see Standards 3.05, Multiple Relationships, and 3.06, Conflict of Interest.

10.04 Providing Therapy to Those Served by Others

In deciding whether to offer or provide services to those already receiving mental health services elsewhere, psychologists carefully consider the treatment issues and the potential client's/ patient's welfare. Psychologists discuss these issues with the client/patient or another legally authorized person on behalf of the client/patient in order to minimize the risk of confusion and conflict, consult with the other service providers when appropriate, and proceed with caution and sensitivity to the therapeutic issues.



There may be instances when psychologists professionally encounter an individual already receiving mental health services from another professional who might benefit from or is requesting additional therapy with the psychologist. Standard 10.04 recognizes the rights of clients/patients to seek additional services and the potential benefits of collateral therapy, as well as the potential harm that can result from client/patient involvement in concurrent therapies.

Under this standard, careful consideration of the client's/patient's welfare and treatment needs determines the ethical appropriateness of providing therapy to those served by others. In some instances, clients/patients may benefit from consultation with a psychologist when they are uncertain about the effectiveness of their current therapy or uncomfortable with what they perceive as their current provider's boundary violations. In other instances, the expertise of the psychologist may provide needed collateral treatment, for example, when a client/patient who is under the care of a psychiatrist for psychopharmacological treatment of depression would also benefit from psychosocial or behavioral treatment. On the other hand, provision of concurrent services may be harmful if clients/patients consciously or unconsciously seek to use a second therapist as a means of triangulating issues arising in their current therapy, if they begin to receive conflicting therapeutic messages from the two service providers, or if the psychologist's choice to see the patient is governed by the psychologist's own financial interests rather than client/patient welfare (see also Standards 3.04, Avoiding Harm; 3.06, Conflict of Interest; 3.08, Exploitative Relationships; 5.06, In-Person Solicitation).

- ✓ A psychologist had an initial consultation with an individual who was currently in treatment with another provider. During the consultation, the patient frequently asked questions about the appropriateness of certain therapeutic styles. The psychologist asked the patient why he sought the consultation. The patient stated that he liked his current therapist but thought he would benefit from two different perspectives on his problems. During further discussions, there was no evidence that the patient's current treatment was inadequate or that the psychologist could provide collateral therapy that would be helpful. The psychologist explained this to the patient and told him that under such circumstances, it would not be appropriate for her to see him as a regular patient.

In addition to careful consideration of the treatment issues and client/patient harm, under Standard 10.04, psychologists should take steps to minimize the risk that providing therapy to an individual already receiving mental health services will lead to confusion and conflicts that could jeopardize client/patient welfare. Such steps include discussing with the client/patient or his or her legally authorized representative the potential consequences of entering into a second therapeutic relationship and obtaining authorization from the client/patient to consult with the other service provider about the appropriateness and effectiveness of conjoint services.

- ✓ An individual met with a psychologist to discuss joining one of the psychologist's therapy groups. The client was currently in individual psychotherapy with another practitioner and informed the psychologist that her current therapist had suggested that concurrent participation in group therapy might be helpful in addressing some of the social anxiety issues they had been discussing in treatment. The psychologist explained the differences in goals and modalities of group and single therapy and received written authorization from the client to discuss the treatment recommendation with her current therapist. After a conversation with the current therapist, the psychologist agreed that the client could be further helped through participation in group therapy.

Because conflicts and issues associated with providing therapy to those served by others may continue to emerge over the course of treatment, Standard 10.04 also requires that psychologists who decide to offer such services continue to monitor and proceed cautiously and sensitively in response to therapeutic issues that may arise.

10.05 Sexual Intimacies With Current Therapy Clients/Patients

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

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Sexual intimacies of any kind with a current therapy client/patient are harmful and prohibited by Standard 10.05. The term *sexual intimacies* is broadly interpreted and includes fondling, intercourse, kissing, masturbation in front of a client, telephone sex, touching of genitals, erotic hugging, verbal invitations to engage in sexual relationships, or communications (in person or via electronic transmission) intended to erotically arouse the patient. The ethical obligation to avoid sexual intimacies with clients/patients lies solely with the therapist, not with the client/patient. Any sexual intimacy between psychologists and clients/patients represents a violation of this standard regardless of whether clients/patients initiated sexual contact or voluntarily or involuntarily responded to therapists' overtures.

Sexual intimacies with current clients/patients exploit the explicit power differential and influence that psychologists have over those they treat in therapy and the vulnerabilities that led clients/patients to treatment in the first place. Sexual intimacies further harm clients/patients by impairing the provider's ability to objectively evaluate treatment issues and the client's/patient's ability to trust and respond to the psychologist in his or her professional role. In many cases, therapist–client sex exacerbates the client's/patient's symptoms or leads to more serious mental disorders (Pope, 2013).

Nonsexual physical contact with clients/patients such as handshakes or nonerotic hugging is not a violation of Standard 10.05. However, the nonerotic intentions of a therapist, such as meetings outside the therapist's office, are often misperceived as sexualized by clients/patients. Blurring of boundaries and self-disclosures can be misperceived as minimizing the client's mental health problems, and they may shift the identity of the therapist between hero and victim in a way that generates a false sense of equivalent responsibilities between the psychologist and client (Lamb & Catanzaro, 1998; McNulty, Ogden, & Warren, 2013). In addition, research indicates that for some psychologists, such seemingly minor blurring of boundaries as self-disclosures are often precursors of sexual misconduct, (Pope, Keith-Spiegel, & Tabachnick, 2006; see also the section on unforeseen potentially harmful multiple relationships in Chapter 6 under Standard 3.05a and 3.05b, Multiple Relationships).

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

Psychologists do not engage in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of current clients/patients. Psychologists do not terminate therapy to circumvent this standard.

Engaging in sexual intimacies with another person who is related to or in a significant relationship with a current client/patient is prohibited. Sexual intimacies with such persons harm the client/patient by impairing the psychologist's treatment objectivity, blurring the therapist–client roles and relationships, and risking exploitation of the client/patient to attain or maintain a sexual relationship with a third party. This standard applies to a client's/patient's parents, siblings, children, legal guardians, and significant others. It may also apply to other relatives if they are emotionally or otherwise close to the client/patient. The phrase *they know to be* applies to the rare instance when psychologists are unaware that someone they are seeing romantically is a close relative, guardian, or significant other of a current client/patient. Standard 10.06 also prohibits psychologists from terminating therapy to circumvent the prohibition.

- ☒ A psychologist began dating the mother of a child who was currently in therapy with the psychologist.
- ☒ A psychologist terminated marriage therapy with a couple with the intent to begin a sexual relationship with one of the spouses.

10.07 Therapy With Former Sexual Partners

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

Under Standard 10.07, psychologists are prohibited from providing therapy to former sexual partners. Conducting therapy with individuals with whom psychologists have had a previous sexual relationship risks compromising the effectiveness of professional services. The knowledge gained about the individual from former sexual relationships and romantic and sexualized feelings that may reemerge during therapy can impair the psychologist's ability to objectively evaluate the client's/patient's treatment needs and response to treatment. In addition, intimate and personal knowledge about the psychologist that the client/patient gained during the former relationship can create role confusion and interfere with the client's/patient's ability to benefit from the psychologist's professional communications.

- ☒ A psychologist received a call from a man with whom she'd had a sexual relationship during college. The man asked if he could see her professionally to discuss some serious problems that had recently

arisen in his life. The psychologist told him that she did not think it was a good idea for her to see him professionally because they had been in a previous personal relationship. The man started crying and told the psychologist that he had just moved to the town in which the psychologist practiced and she was the only person he could trust with his problems. The psychologist agreed to see him for just one session.

10.08 Sexual Intimacies With Former Therapy Clients/Patients

(a) Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy.



Standard 10.08a prohibits psychologists from engaging in sexual intimacies for at least 2 years after the therapy has ended. Posttherapy sexual relationships can be harmful to clients/patients in many ways, including (a) depriving former clients/patients of future services with a practitioner who is familiar with their mental history and with whom they had a good therapeutic rapport, (b) threatening client/patient privilege when the blurring of personal and professional boundaries allows a court to require the psychologist to testify about the former client/patient in his or her personal role, (c) compromising the credibility of previous professional reports written by the psychologist about the client/patient and jeopardizing the credibility of court testimony that may be needed regarding the client's/patient's past mental status, and (d) client/patient exploitation and psychological deterioration.

Two-Year Moratorium

Under Standard 10.08a, any sexual intimacies with a former client/patient within 2 years following the last professional contact are an ethical violation. The standard has a 2-year moratorium period rather than a permanent prohibition against sex with former clients/patients because most complaints involving sexual intimacies with former clients/patients received by the APA Ethics Committee and licensing boards pertain to relationships that began during the first year following the cessation of therapy, and complaints about relationships that began 2 years posttherapy are infrequent. However, as discussed below under Standard 10.08b, such behavior is not unconditionally acceptable after 2 years.

- ☒ A year after therapy ended, a traumatic event in a former patient's life created a need for additional treatment. The patient had begun a sexual relationship with his psychologist a few months following termination of treatment and thus could not reenter therapy with the psychologist. The former patient, fearful that another psychologist would be critical of his relationship with his former therapist, chose not to seek needed treatment.
- ☒ A year after therapy terminated, a client entered into a sexual extramarital relationship with her former therapist and continued to discuss her mental health problems in this nonprofessional relationship. During this period, her husband sued her for divorce, naming the therapist as his wife's extramarital partner. The former client wanted to exert her privilege to keep her mental status and thus her involvement in therapy confidential. Due to the blurring of personal and professional boundaries, the judge issued a court order to call the psychologist as a witness.
- ☒ A psychologist began a sexual relationship with a former patient soon after therapy was terminated. Several months later, the former patient was injured on the job, and his attorney advised him to pursue a disability insurance claim for mental distress created by the accident. The patient needed the psychologist to testify regarding his mental status prior to the injury. However, the psychologist–client sexual relationship compromised the psychologist's ability to provide or appear to provide objective information to the court.
- ☒ A client with a history of child sexual abuse had transferred to the psychologist the feelings of both powerlessness and eroticism that she felt for her childhood abuser. The psychologist took advantage of these feelings and told the client that she could overcome the mental health consequences of this early trauma by terminating therapy and becoming his lover. The patient agreed to end therapy. A few weeks into the posttherapy sexual relationship with the psychologist, her depression escalated and she attempted suicide.

(b) Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient bear the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated; (2) the nature, duration, and intensity of the therapy; (3) the circumstances of termination; (4) the client's/patient's personal history; (5) the client's/patient's current mental status; (6) the likelihood of adverse impact on the client/patient; and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a

posttermination sexual or romantic relationship with the client/patient. (See also Standard 3.05, Multiple Relationships.)

Standard 10.08a prohibits psychologists from engaging in a sexual relationship with a former client/patient for at least 2 years following the termination of therapy. However, sexual intimacies with former clients/patients even 2 years following the cessation of therapy can result in exploitation and harm. If an ethics complaint is made against the psychologist regarding a 2-year posttermination sexual relationship, Standard 10.08b places the ethical burden on the psychologist to demonstrate that the sexual relationship is not exploitative. The standard describes seven relevant factors that could be applied to determine such exploitation. These seven factors are listed along with examples of how they might be applied to a finding of violation of this standard for a psychologist who engaged in sexual relationships with a former client/patient after the 2-year period:

1. *The amount of time that has passed since therapy terminated.* Following the termination of therapy, the psychologist frequently met a former client/patient for lunch. A sexual relationship was initiated immediately following the 24-month period.
2. *The nature, duration, and intensity of the therapy.* The client/patient was seen by the psychologist three times a week for several years in intensive psychodynamic psychotherapy.
3. *The circumstances of termination.* The client/patient abruptly stopped coming to therapy after expressing strong erotic fantasies for the psychologist.
4. *The client's/patient's personal history.* During the therapy, the client/patient had been diagnosed with bipolar disorder marked by periods of mania involving promiscuous and high-risk sexual activity.
5. *The client's/patient's current mental status.* When the posttermination sexual relationship with the psychologist began, the patient was being treated by another psychologist for major depression.
6. *The likelihood of adverse impact on the client/patient.* Based on a family history of sexual abuse, borderline diagnosis, and current major depression, it was reasonable to assume that a client/patient would be extremely vulnerable to reexperiencing some of the early trauma if engaged in a sexual relationship with his or her former therapist, whom he or she perceived as a powerful parent figure.
7. *Any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a posttermination sexual or romantic relationship with the client/patient.* The psychologist had a habit of hugging the client/patient at the end of each therapy session.

10.09 Interruption of Therapy



When entering into employment or contractual relationships, psychologists make reasonable efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the client/patient. (See also Standard 3.12, Interruption of Psychological Services.)

This standard applies to ethical obligations of psychologists at the time they enter into employment or contractual agreements with other providers, group practices, managed care providers, institutions, or agencies. Employment or contractual agreements can end when psychologists have a time-limited contract or employment period, when they elect to leave for professional or personal reasons, or when the employer or company terminates their position or contract. Under Standard 10.09, psychologists must make reasonable efforts to ensure at the outset that the employment agreement or contract provides for an orderly and appropriate resolution of responsibility in the event that the employment or contractual arrangement ends (Principle B: Fidelity and Responsibility).

Psychologists can comply with Standard 10.09 by determining through pre-employment discussions whether the organization, group practice, or other entity in which a work arrangement is being considered has policies designed to ensure continuity of care when a practitioner can no longer provide services. If no such policies exist, psychologists can help develop such policies or include in their employment or contractual agreements permission to resolve treatment responsibility appropriately in the event their employment or contract ends (see Standard 1.03, Conflicts Between Ethics and Organizational Demands). Steps the psychologist can recommend be taken to protect client/patient welfare when treatment can no longer be provided by the psychologist include providing pretermination counseling and referrals, supervising appropriate transfer and storage of client/patient records, assisting in the transition of the client/patient to a new treatment provider if clinically indicated, or continuing treatment with the client/patient in a different venue. The phrase *make reasonable efforts* recognizes that in some situations, despite a psychologist's efforts, employers, organizations, group practices, or other providers will refuse to promise or follow through on promises to protect client/patient welfare through an orderly and appropriate resolution of care when there is a change in staff.

- ✓ A school psychologist was hired on a 9-month (October through June) contract to provide counseling services for grade school students who had lost parents in the September 11, 2001, attack on the World Trade

Center. It was reasonable to assume that some children might need continued care during the summer. The school psychologist raised this issue when asked to take the position. The school superintendent responded that such services were not available through the schools during the summer. The psychologist worked with the superintendent to develop an agreement with a social services agency to provide treatment for students who needed continued care over the summer. The superintendent agreed to set up a system that facilitated the appropriate transfer of student records to the social service agency, and the psychologist laid out a plan for identifying children who would need summer services and for informing their guardians about the availability of such services.

Standard 10.09 does not prohibit psychologists from signing a noncompetes clause barring the psychologist from continuing to see specific clients/patients after the employment or contractual agreement has ended as long as other provisions for protecting client/patient welfare are in place.

10.10 Terminating Therapy

(a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.

Psychologists are committed to improving the condition of individuals with whom they work and to do no harm (Preamble; Principle A: Beneficence and Nonmaleficence). In some instances, continued therapy with a client/patient may be nonbeneficial or harmful. Standard 10.10a requires psychologists to terminate therapy under three conditions in which therapy may either fail to benefit clients/patients or could be harmful if continued. Although the need to continue or terminate a therapeutic relationship requires professional judgment based on knowledge of the specific treatment context, the phrase *reasonably clear* in this standard indicates that it is ethically inappropriate for a psychologist to continue therapy under conditions in which most psychologists engaged in similar activities in similar circumstances would judge it unnecessary, nonbeneficial, or harmful.

Services Are No Longer Needed

Psychologists who continue to see clients/patients professionally after they no longer need mental health services are in violation of this standard. The need for continued services depends on the nature of the client's/patient's disorder and the

goals of treatment as identified during the initial informed consent and throughout the therapeutic process. Psychologists who continue to treat clients/patients when the problems associated with entering treatment have been adequately addressed violate this standard. The standard does not prohibit psychologists and clients/patients from reevaluating treatment needs and continuing in a therapeutic relationship to address additional mental health needs. However, failure to reevaluate the need for continued therapy after treatment goals are met would violate the standard. Psychologists who continue to see clients/patients solely to fulfill the psychologists' own training requirements or for financial gain violate this standard and also risk violating Standards 3.06, Conflict of Interest, and 3.08, Exploitative Relationships. Psychologists who continue to bill a third-party payor for mental health services when the services are no longer required place themselves at risk for accusations of insurance fraud and are in potential violation of Standards 6.04b, Fees and Financial Arrangements, and 6.06, Accuracy in Reports to Payors and Funding Sources.

- ✗ A licensed psychologist in independent practice had sought additional training at a prestigious postgraduate psychotherapy institute. The institute required a certain number of hours of supervision with clients with specific disorders to obtain a certificate of completion. The psychologist needed to complete 8 more hours of supervision for treatment of anxiety disorders before he could qualify for the certificate. The client who met the diagnostic criteria for supervision had been doing very well in treatment. She had resolved most of the problems at work and at home that had brought her to therapy and viewed terminating treatment with eagerness and a sense of pride. She asked the therapist whether they could have one final session to complete the therapy. The psychologist told her that although she had been doing well, there were a few unresolved issues that would take about eight more sessions to address adequately. The client reluctantly agreed.

The Client/Patient Is Not Likely to Benefit

Psychologists must also terminate therapy when the client/patient is not likely to benefit from the treatment. This criterion applies when, during the course of therapy, it becomes reasonably clear that the client/patient is not responding to treatment, a newly uncovered aspect of the client's/patient's disorder is not amenable to the type of treatment modality in which the psychologist has been trained (see also Standard 2.01a, Boundaries of Competence), or a client/patient is unwilling or unable to comply with treatment (e.g., when a client/patient continuously refuses to follow the terms of a behavioral contract).

- ✓ A psychologist was providing psychoanalytic therapy to a patient with narcissistic personality disorder. The treatment appeared to be going well until the patient began to discuss in detail a traumatic rape experience that had

occurred when she was a young adult. In the weeks that followed, the patient kept putting herself in dangerous situations that appeared to be reenactments of the earlier event. She was engaging in sexual relationships with men she barely knew, having unprotected sex, and frequenting dangerous areas of the city. In therapy during the next 5 weeks, the psychologist continued to explore with the patient her feelings and behaviors associated with the initial trauma. Instead of abating the risky behavior, each session appeared to lead to more extreme behaviors. The psychologist was concerned that the patient might again be raped, assaulted, or contract HIV and consulted with several colleagues regarding continuation of services. On the basis of these consultations, he concluded that continuing the therapy would be harmful to this patient and that she might benefit from a different therapeutic approach. He discussed this with the patient over several sessions and referred her to a group practice specializing in treatments for rape trauma.

The Client/Patient Is Being Harmed by Continued Service

Psychologists are prohibited from continuing therapy if it is reasonably clear that the client/patient is being harmed by the treatment (Principle A: Beneficence and Nonmaleficence, Standard 3.04, Avoiding Harm). For example, in some instances clients/patients may unexpectedly react to a specific treatment modality with major depression, a psychotic episode, or an exacerbation of impulsive or addictive behaviors that do not respond to continued efforts by the psychologist. The phrase *reasonably clear* indicates that the criteria for determining whether a client/patient is being harmed by continued services are determined by what would be the prevailing judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time. Psychologists who find that a client's/patient's mental health is deteriorating may find it helpful therefore to consult with colleagues regarding whether services should be continued. When it is appropriate to terminate, patients should be referred to alternative treatments that may be more effective.

- ✓ A counseling psychologist had been seeing a client for career counseling who was recently fired from a management position that he had held for 10 years. The client was angry and believed that the termination was undeserved. After three sessions, the psychologist determined that there was a clinically paranoid feature to the client's distress and that more intensive psychotherapy was needed before career counseling could be beneficial. The psychologist discussed her concerns with the client and referred him to another practitioner who worked with more seriously disturbed clients. The psychologist also informed the client that her services would be available to him when he was ready to resume career counseling.

Need to Know: Abandonment Considerations

Although neither the APA Ethics Code nor case law defines termination of mental health services as “abandonment,” and the terms *termination* and *abandonment* are often confused by the public and psychologists alike. Termination based on reasonable professional judgment and proper pretermination counseling is not abandonment. Abandonment occurs when a client/patient in imminent need of treatment is harmed by termination of services in the absence of a clinically and ethically appropriate process (Younggren, Fisher, Foote, & Hjelt, 2011; Younggren & Gottlieb, 2008; Standard 3.04, Avoiding Harm). Conducting appropriate terminations requires keeping up-to-date with the empirical and professional literature and consulting colleagues when necessary (Standards 2.03, Maintaining Competence; 2.04, Bases for Scientific and Professional Judgment). Davis and Younggren (2009) suggested the following additional steps to foster appropriate and client–therapist collaborative terminations:

- Develop plans for termination at the outset of psychotherapy and include a discussion of factors influencing the length of treatment during informed consent.
- Continuously evaluate client/patient progress.
- Review ethical and legal duties.
- Develop a well-conceptualized rationale for termination based on clinical, relational, and situational factors and consult with the client/patient on these factors when clinically feasible.
- Construct a timeline for termination and be responsive to client/patient responses.
- Create a record documenting key components of the termination rationale and process.

Clinicians should also proceed cautiously when considering persistence in contacting a client/patient who abruptly drops out of treatment. To avoid the necessity for potentially intrusive follow-up letters or other contacts, psychologists should consider inclusion during informed consent of the psychologist's policies for client/patient nonattendance (Davis & Younggren, 2009).

Digital Ethics: Terminating Telepsychology Services

The American Psychological Association's *Guidelines for the Practice of Telepsychology* (APA, 2013d) urges psychologists providing therapy through telecommunication services to monitor and assess regularly the progress of clients/patients to determine whether the provision of telepsychology services continues to be appropriate and beneficial. When psychologists become aware of a significant negative change in the therapeutic interaction or the client's/patient's functioning, they should take steps to adjust the treatment plan and

reassess the appropriateness of delivering services through remote services. When it becomes reasonably clear that continuing to provide telepsychology services is no longer beneficial or presents a risk to the client's/patient's emotional or physical well-being, the Guidelines encourage psychologists to discuss these concerns with the client/patient and appropriately terminate remote services with adequate notice, care for client/patient well-being, and referral to any needed alternative services.

(b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.

Standard 10.10b permits psychologists to terminate therapy abruptly if they are threatened or endangered by a client/patient or another person with whom the client/patient has a relationship, such as a family member, significant other, friend, employer, or employee. Such situations can include verbal or physical threats or any other evidence that the psychologist is endangered (see Carr, Goranson, & Drummond, 2014, for guidance on reducing risk and managing stalking behavior by patients). In such situations, neither advance notification of termination nor pretermination counseling as described in Standard 10.10c is required. Psychologists may also request a protective order against clients/patients or others whom they suspect will threaten or harm them. Prohibitions against revealing confidential information do not apply when psychologists must call on authorities or others to protect them from threats or harm (see Standard 4.05b, Disclosures).

(c) Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate.

Termination based on reasonable professional judgment and proper pretermination counseling is ethically appropriate. In addition to the situations described in Standard 10.10a and 10.10b above, ethically permissible and professionally appropriate reasons to end a therapeutic relationship include the following: (a) an organized system of health or managed care company rejects a psychologist's recommendations for additional therapy sessions; (b) an unforeseen potentially harmful multiple relationship arises (Standards 3.05b, Multiple Relationships; 10.02b, Therapy Involving Couples or Families); (c) a client/patient repeatedly refuses to pay for services (Standard 6.04e, Fees and Financial Arrangements); (d) a psychologist becomes ill or finds therapy with a particular client/patient stressful in a manner that risks compromising professional services (Standard 2.06b, Personal Problems and Conflicts); (e) during the course of therapy, unexpected treatment needs arise that are outside the psychologist's area of expertise (Standard 2.01, Boundaries of Competence); or (f) the psychologist is relocating or retiring.

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Under Standard 10.10c, psychologists must provide pretermination counseling prior to ending a therapeutic relationship. Pretermination counseling includes (a) providing clients/patients sufficient advance notice of termination (when possible), (b) discussing with the client/patient the reasons for the termination, (c) encouraging the client/patient to ask questions regarding termination, and (d) providing referrals to alternate service providers when appropriate. Psychologists need to plan for pretermination counseling for group as well as individual therapies (Davis & Younggren, 2009; Mangione, Forti, & Iacuzzi, 2007). Psychologists are not in violation of this standard if pretermination counseling is precluded by client/patient or third-party payor actions. For example, parents may abruptly end their child's therapy, making further contact with the child inappropriate or unfeasible, or health plans may prohibit or place restrictions on provider referrals. When clients/patients who have paid for services abruptly cease coming to sessions, psychologists should carefully balance their concern with client/patient well-being with the client's/patient's right to privacy and exert caution in pursuing them through email, letters, phone calls, or other forms of contact (see Standards 3.06, Conflict of Interest; 3.08, Exploitation).

- ⑦ A psychotherapy patient changed to a health plan that she later realized would not reimburse her current psychologist's services. She told the psychologist that she would not be able to come to any more sessions because she could not afford to pay for therapy out of pocket and thus would be continuing services with a provider covered by her new health plan. The psychologist discussed the patient's concerns about leaving therapy. The patient appeared ready to terminate the relationship. The psychologist told her that he was not familiar with any of her new health plan's approved providers but, with her written authorization, would be willing to speak with her new therapist if the need arose.
- ⑦ A psychologist in independent practice accepted a job offer from a treatment center in another state. The psychologist agreed to start the new position in 4 weeks. At their next sessions, the psychologist told each of her clients that she would be relocating at the end of the month and that they would have time to discuss over the next few weeks their feelings about terminating therapy and their plans for the future. At each of the remaining sessions, she encouraged clients to discuss any concerns they might have about the termination. The psychologist provided appropriate referrals to those who wished to continue in therapy with another professional. She told the other clients how to contact her if they wished a referral in the future. One client had serious difficulty adjusting to the termination. The psychologist offered to have phone sessions with this client until a suitable referral could be found.
- ⑦ A patient who recently lost his job had not paid his last two monthly bills for psychotherapy. The psychologist had discussed the issue of nonpayment with the patient several times during the past month. Neither a reduced fee nor payment plan was economically feasible for the patient.

The psychologist told the patient that she would not be able to continue to see him pro bono indefinitely and that they would have two more sessions to discuss any questions he might have and his plans for the future. She also provided the patient with a list of several free clinics in the area that offered therapy.

- ☒ During the fourth session, a client who had begun cognitive-behavioral therapy for a mild case of anxiety disorder expressed frustration with the progress of treatment. Several days later, she left a phone message for the psychologist letting him know she had decided to seek services elsewhere. The psychologist sent the client an email suggesting that her mental health might be jeopardized by the abrupt termination and strongly urging her to attend the next session to obtain closure.

HOT TOPIC

Ethical Issues for the Integration of Religion and Spirituality in Therapy

The past decade has witnessed increased attention to the importance of understanding and respecting client/patient spirituality and religiosity to psychological assessment and treatment, as well as recognition that religious and spiritual factors remain underexamined in research and practice (APA, 2007d). Advances in addressing the clinical relevance of faith in the lives of clients/patients have raised new ethical dilemmas rooted in theoretical models of personality historically isolated from client/patient faith beliefs, the paucity of research on the clinical benefits or harms of injecting faith concepts into treatment practices, group differences in religious practices and values, and individual differences in the salience of religion to mental health (Rose, Westefeld, & Ansley, 2008; Shafranske & Sperry, 2005; Tan, 2003).

The Secular–Theistic Therapy Continuum

Integration of religion/spirituality in therapy can be characterized on a secular–theistic continuum (Fisher, 2009). Toward the secular end of the continuum are “religiously sensitive therapies” that blend traditional treatment approaches with sensitivity to the relationship of diverse religious/spiritual beliefs and behaviors to mental health. Midway on the continuum are “religiously accommodative therapies” that do not promote faith beliefs but, when clinically relevant, use religious/spiritual language and interventions consistent with clients’/patients’ faith values to foster mental health. Toward the other end of the continuum are “theistic therapies” that draw on psychologists’ own religious beliefs and use sacred texts and techniques (prayer, forgiveness, and meditation) to promote spiritual health.

The sections that follow highlight ethical challenges that emerge along all points of the secular–theistic therapy continuum.

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Competence

All psychologists should have the training and experience necessary to identify when a mental health problem is related to or grounded in religious beliefs (Standards 2.01b, Boundaries of Competence, and 2.03, Maintaining Competence; see also Plante, 2014; Raiya & Pargament, 2010; Vieten et al., 2013). Personal faith and religious experience are neither sufficient nor necessary for competence (Gonsiorek, Richards, Pargament, & McMinn, 2009). There is no substitute for familiarity with the foundational empirical and professional mental health knowledge base and treatment techniques. While personal familiarity with a client's/patient's religious affiliation can be informative, religious/spiritual therapeutic competencies for mental health treatment include

- an understanding of how religion presents itself in mental health and psychopathology;
- the ability to identify internal and external spiritual and religious resources that may support psychological well-being and recovery from psychological disorders;
- techniques to inquire about spiritual and/or religious practices, beliefs, and experience as part of standard client history;
- self-awareness of religious bias that may impair therapeutic effectiveness, including awareness that being a member of a faith tradition is not evidence of expertise in the integration of religion/spirituality into mental health treatment;
- techniques to assess and treat clinically relevant religious/spiritual beliefs and emotional reactions; and
- knowledge of data on mental health effectiveness of religious imagery, prayer, or other religious techniques.

Collaboration With Clergy

Collaborations with clergy can help inform psychologists about the origins of the client's beliefs, demonstrate respect for the client's religion, and avoid trespassing into theological domains by increasing the probability that a client's incorrect religious interpretations will be addressed appropriately within his or her faith community (W. B. Johnson, Redley, & Nielson, 2000; Plante, 2014; Richards & Bergin, 2005; Standard 3.09, Cooperation With Other Professionals). For example, Hathaway (2013) described the case of a 15-year-old Catholic boy whose obsessive-compulsive disorder included a variety of religious practices to ward off reoccurring "blasphemous thoughts about cursing God" (p. 24). The boy's therapist asked permission to have a Catholic priest he had worked with professionally to participate in some sessions. The priest was able to successfully challenge the boy's beliefs about the spiritual necessity of the compulsive behaviors. The priest's continued participation assisted in the eventual success of the treatment.

When cooperation with clergy will be clinically helpful to a client/patient, psychologists should

- obtain written permission/authorization from the client/patient to speak with a specific identified member of the clergy,
- share only information needed for both to be of optimal assistance to the client/patient (Standard 4.04, Minimizing Intrusions on Privacy),
- discuss with the clergy where roles might overlap (e.g., family counseling, sexual issues), and
- determine ways in which the client/patient can get the best assistance.

Avoiding Secular–Theistic Bias

Psychologists must ensure that their professional and personal biases do not interfere with the provision of appropriate and effective mental health services for persons of diverse religious beliefs (Principle D: Justice and Principle E: Respect for People's Rights and Dignity; Standards 2.06, Personal Problems and Conflicts, and 3.01, Unfair Discrimination).

Disputation or Unquestioned Acceptance of Client/Patient Faith Beliefs

Trivializing or disputing religious values and beliefs can undermine the goals of therapy by threatening those aspects of life that some clients/patients hold sacred, that provide supportive family and community connections, and that form an integral part of their identity (Pargament, Murray-Swank, Magyar, & Ano, 2005; Standard 3.04, Avoiding Harm). Similarly, some religious coping styles can be deleterious to client/patient mental health (Sood, Fisher, & Sulmasy, 2006), and uncritical acceptance of theistic beliefs, when they indicate misunderstandings or distortions of religious teachings and values, can undercut treatment goals by reinforcing maladaptive ways of thinking or by ignoring signs of psychopathology. In addition, psychologists should not assume that religious or spiritual beliefs are static and be prepared to help clients/patients identify changes reflecting spiritual maturity positively tied to treatment goals (Knapp, Lemoncelli, & VandeCreek, 2010). To identify whether clients'/patients' religious beliefs are having a deleterious effect on their mental health, psychologists should explore whether their beliefs (a) create or exacerbate clinical distress, (b) provide a way to avoid reality and responsibility, (c) lead to self-destructive behavior, or (d) create false expectations of God (W. B. Johnson et al., 2000). When appropriate, psychologists should consider consulting with clergy to determine whether a clients'/patients' religious beliefs are distortions or misconceptions of religious doctrine.

Imposing Religious Values

Using the therapist's authority to indoctrinate clients/patients to the psychologists' religious beliefs violates their value autonomy and exploits their vulnerability to coercion (Principle E: Respect for People's Rights and Dignity; Standard 3.08, Exploitative Relationships). When clients/patients are grappling with decisions in areas in which religious and secular moral perspectives may conflict (e.g., divorce, sexual orientation, abortion, acceptance of transfusions, end-of-life decisions), therapy needs to distinguish between those religious values that have positive or destructive influences on each individual client's/patient's mental health—not the religious or secular values of the psychologist. Professional license to practice psychology demands that psychologists provide competent professional services and does not give them license to preach (Plante, 2014). Psychologists should guard against discussing religious doctrine when it is irrelevant to the clients'/patients' mental health needs (Richards & Bergin, 2005).

Confusing Religious Values With Psychological Diagnoses

The revised Guidelines for Psychological Practice With Lesbian, Gay, and Bisexual Clients (APA, 2012c) encourages psychologists to consider the influences of religion and spirituality on the lives of lesbian, gay, and bisexual clients specifically and transgender, gender-nonconforming, and

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questioning clients in general. The linking of religious values and psychotherapies involving LGBT clients/patients has drawn a considerable amount of public attention. Spiritually sensitive, accommodative, and theistic therapies have a lot to offer LGBT clients/patients (Lease, Horne, & Noffsinger-Frazier, 2005). LGBT persons vary in their religious backgrounds and the extent to which faith affects their psychological well-being.

Ethical problems arise, however, when psychologists confuse a client's/patient's conflicted feelings about sexual orientation and religious values with psychological diagnoses (Page, Lindahl, & Malik, 2013). For example, psychologists must be sensitive to the fact that rejection by one's religious institution does not mean LGBTQ clients are not deeply religious or spiritual or seeking to be so. Competencies in addressing religion and spirituality among LGBTQ clients include training in therapeutic techniques to effectively address the following (see also Entengoff & Daiute, 2014; Magaldi-Dopman & Park-Taylor, 2010; Matthews & Salazar, 2012; Sherry, Adelman, & Whilde, 2010):

- Religious beliefs that may lead to higher levels of shame, guilt, and internalized homophobia
- Emotions associated with loss, grief, anger, reconciliation, or change in religious or spiritual identity
- Skills clients may need to separate spirituality from religion and to explore diversity of opinion within their faith community
- The liabilities and benefits of coming out to family members and others who endorse religious biases against LGBTQ individuals

Conversion Therapy

Ethical challenges around the application of conversion therapies to alter sexual orientation have stimulated considerable professional dialogue. All major professional mental health organizations have affirmed that variations in sexual orientation and gender identity are normative and not pathological (APA, 2009, 2015c; <http://www.apa.org/pi/lgbt/resources/just-the-facts.aspx>). In addition, empirical data indicate that conversion therapies or other efforts to change sexual orientation or gender identity are ineffective, harmful, and not appropriate for the delivery of mental health services (SAMHSA, 2015).

Based on the evidence, psychologists who offer such therapies to LGBT clients/patients are violating Standard 2.04, Bases for Scientific and Professional Judgments. Moreover, when psychologists offer "cures" for homosexuality, they falsely imply that there is established knowledge in the profession that LGBT sexual orientation is a mental disorder. This, in turn, may deprive clients/patients of exploring internalized reactions to a hostile society and risks perpetuating societal prejudices and stereotypes (Cramer, Golom, LoPresto, & Kirkley, 2008; Haldeman, 1994, 2004; Simons, Leibowitz, & Hidalgo, 2014; Vance, Ehrensaft, & Rosenthal, 2014; Principle A: Beneficence and Nonmaleficence; Principle B: Fidelity and Responsibility; Principle D: Justice; Standard 3.04, Avoiding Harm). In addition, when psychologists base their diagnosis and treatment on religious doctrines that view homosexual behavior as a "sin," they can be in violation of Standard 9.01, Bases for Assessments, and may be practicing outside the boundaries of their profession. (See also discussion of conversion therapy involving children and adolescents in Chapter 6 under Standard 3.04, Avoiding Harm).

Multiple Relationships

Multiple relationship challenges arise when clergy who have doctoral degrees in psychology provide mental health services to congregants or nonclergy psychologists treat members of their faith communities (Standard 3.05, Multiple Relationships).

Clergy–Psychologists

Clergy–psychologists providing therapy for members of their faith over whom they may have ecclesiastical authority should take steps to ensure they and their clients/patients are both aware of and respect the boundaries between their roles as a psychologist and as a religious leader. Distinguishing role functions becomes particularly important in addressing issues of confidentiality. Psychologists and clergy have different legal and professional obligations when it comes to mandated reporting of abuse and ethically permitted disclosures of information to protect clients/patients and others from harm (Standard 4.05, Disclosures).

Therapists at all points along the secular–theistic continuum who share the faith beliefs of clients/patients or work with fellow congregants must take steps to ensure that clients do not misperceive them as having religious or ecclesiastical authority and understand that the psychologists do not act on behalf of the church or its leaders (Gubi, 2001; Richards & Potts, 1995). This may be especially challenging for nonclergy religious psychologists working in faith-based environments (Sanders, Swenson, & Schneller, 2011). Psychologists also need to take steps to ensure that their knowledge of their joint faith community does not interfere with their objectivity and that clients/patients feel safe disclosing and exploring concerns about religion or behaviors that might ostracize them from this community.

Fee-for-Service Quandaries

While psychologists can discuss spiritual issues in therapy, when services are provided as a licensed psychologist eligible for third-party payments, the primary focus must be psychological (Plante, 2007). A focus on religious/spiritual rather than therapeutic goals may risk inappropriately charging third-party payors for non-mental health services not covered by insurance policies (Tan, 2003; see also Principle C: Integrity, and Standard 6.04, Fees and Financial Arrangements). Clergy and nonclergy psychologists practicing theistic therapies may find it difficult to clearly differentiate in reports to third-party payors those goals and therapeutic techniques that are accepted mental health practices and those that are spiritually based. In most instances, clergy–psychologists should encourage their congregants to seek mental health services from other providers in the community and refrain from encouraging their congregants to see them for fee-for-service therapy (Standard 3.06, Conflict of Interest). When clergy or nonclergy psychologists provide spiritual counseling free of charge in religious settings, they should clarify they are counseling in their ecclesiastical role and that content will be specific to pastoral issues (Richards & Bergin, 2005).

Informed Consent

The role of religion/spirituality in clients'/patients' worldviews may determine their willingness to participate in therapies along the secular–theistic continuum. Some may find the interjection of

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religion into therapy discomforting or coercive, while others may find the absence of religion from therapy alienating.

When scientific or professional knowledge indicates that discussion of religion may be essential for effective treatment (Standards 2.01b, Boundaries of Competence; 2.04, Bases for Scientific and Professional Judgments), informed consent discussions can help the client/patient and psychologist identify and limit for treatment those religious beliefs and practices that facilitate or interfere with treatment goals (Rosenfeld, 2011; Shumway & Waldo, 2012). In some contexts, it may be ethically appropriate to discuss the risks involved in exploration of the client's religious beliefs, including loss of current coping mechanisms, stress produced by self-questioning of religious beliefs, and diminished capacity to seek support from one's religious community (Rosenfeld, 2011). The goal of such discussions is to enhance the therapeutic alliance and treatment context through client–therapist mutual understanding and respect.

When treatments diverge from established psychological practice, clients/patients have a right to consider this information in their consent decisions. Consequently, informed consent for theistic therapies should explain the religious doctrine and values upon which the treatment is based, the religious methods that will be employed (e.g., prayers, reading of scripture, forgiveness), and the relative emphasis on spiritual versus mental health goals. In addition, since theistic therapies are relatively new and currently lack empirical evidence or disciplinary consensus regarding their use (Plante & Sherman, 2001; Richards & Bergin, 2005), psychologists practicing these therapies should consider whether informed consent requirements for “treatments for which generally recognized techniques and procedures have not been established,” described in Standard 10.01b, apply.

Conclusion

There is a welcome increase in research examining the positive and negative influences of religious beliefs and practices on mental health and the clinical outcomes of treatment approaches along the secular–theistic therapy continuum. Ethical commitment to do what is right for each client/patient and well-informed approaches to treatment will reduce, but not eliminate, ethical challenges, which will continue to emerge as scientific and professional knowledge advances. Psychologists conducting psychotherapy with individuals of diverse religious backgrounds and values will need to keep abreast of new knowledge and emerging ethical guidelines, continuously monitor the consequences of spirituality and religiously sensitive treatment decisions on client/patient well-being, and have the flexibility and sensitivity to religious contexts, role responsibilities, and client/patient expectations required for effective ethical decision making.

Chapter Cases and Ethics Discussion Questions

Amos, a devout Mormon whose company has just transferred him from Salt Lake City to New York City, identified Dr. Gail Main as a potential therapist by cross-listing psychologists with members of the Mormon Church in the city. In their initial interview, he describes his anxiety working with openly gay employees. He states

that he has never known anyone personally who is gay and because the Church forbids "homosexual acts," he is afraid to go the men's room or be alone in an elevator with these employees because he is afraid they will make sexual advances toward him and try to "turn him gay." He tells Dr. Main that he chose her as a therapist because as a fellow Mormon, she will help him protect himself from "sinning." Discuss the steps Dr. Main should take to fulfill her ethical responsibility to provide Amos with the best treatment in a manner that clarifies the professional nature of her therapeutic services, is sensitive to Amos's religious values, and avoids blurring her own religious values with her professional standards.

Dr. Mizaki, a clinical psychologist working in a psychiatric facility, was preparing his patient, Donna, for discharge from the hospital. Donna had been diagnosed with schizophrenia. Donna lives in a rural area 500 miles from the hospital, and there are no mental health professionals in the area. The only way to provide Donna with outpatient services is through telepsychology. Dr. Mizaki wants to initiate a new telehealth procedure that has been developed by a colleague at the hospital for individuals in rural areas with serious mental disorders. The new treatment involves individual sessions with clients and family members via computer-based video chat to educate them about the medication and other supports Donna will need. Discuss the informed consent and confidentiality procedures that Dr. Mizaki will need to ethically implement this new treatment approach.

Susan is completing her clinical internship at an outpatient clinic of a veterans hospital and is supervised by the director of the clinic. She has been treating Alan, a 30-year-old military officer who fought in Afghanistan, for posttraumatic stress disorder (PTSD). After 4 sessions, she believes she sees some reduction in Alan's sleep disturbance and symptoms of anxiety. She has noticed that he is often in the waiting room on days in which he does not have a scheduled appointment. At least twice during the past 2 weeks, she has also noticed him outside the café where she gets coffee every morning. She raises this during the next session, and he responds very angrily, telling her that he needs to see her more than once a week. Given his progress, she believes that the once-weekly frequency of sessions is sufficient and encourages him to discuss what he believes would be the advantages of additional sessions. He has difficulty explaining why he wants more sessions and kicks the door as he leaves the office. Susan discusses the situation with her supervisor, who suggests some interventions, but these are met with increased anger by Alan, along with reports of increased PTSD symptoms. In addition, Alan is now waiting outside the café every morning when Susan gets her coffee. Discuss the ethical challenges raised by this scenario and solutions that Susan and her supervisor might consider.