

ETHICS: CASE STUDIES I

Presented by

CONTINUING PSYCHOLOGY EDUCATION INC.

6 CONTINUING EDUCATION CONTACT HOURS

“What makes an action right is the principle that guides it.”
T. Remley and B. Herlihy (2007)

Course Objective

The purpose of this course is to provide an understanding of the concept of ethics as related to therapists. Major topics include: competence, therapist impairment and burnout, client termination, informed consent, client right to refuse treatment, and legal/ethics case studies.

Accreditation

This course is accepted for 6 continuing education contact hours by the Michigan Board of Social Work for Michigan social workers via approval by the National Association of Social Workers (NASW Provider ID # 886398989), and the California (PCE 2156), Texas (Provider # 3329), New Jersey, Illinois (Provider # 159-000806), and Florida (Provider # 50-446) State Social Work Boards.

Mission Statement

Continuing Psychology Education Inc. provides the highest quality continuing education designed to fulfill the professional needs and interests of mental health professionals. Resources are offered to improve professional competency, maintain knowledge of the latest advancements, and meet continuing education requirements mandated by the profession.

Learning Objectives

Upon completion, the participant will be able to:

1. Explain the meaning and purpose of ethical behavior.
2. Understand the ethics of therapist competence.
3. Recognize therapist impairment and burnout.
4. Discuss ethical standards pertaining to client termination.
5. Comprehend the historical development of informed consent.
6. Expound upon information to be included in informed consent material.
7. Interpret various Codes of Ethics.
8. Apply ethical standards to case studies.

Faculty

Neil Eddington, Ph.D.
Richard Shuman, MFT

Copyright © 2016 Continuing Psychology Education Inc.

INTRODUCTION

The Codes of Ethics of the professional mental health organizations, including the National Association of Social Workers (NASW, 1999), American Association for Marriage and Family Therapy (AAMFT, 2001), and American Psychological Association (APA, 2002), serve to educate members about sound ethical conduct, professional accountability, and improved practice through mandatory and aspirational ethics. Mandatory ethics describes compliance with the “musts” and “must nots” of the ethical standards and are enforceable whereas aspirational ethics involves the highest standards of conduct to which one can aspire, implies one understands the moral fiber behind the code, suggests doing more than the minimum requirement and they are not enforceable. NASW (1999) promotes the following aspirational ethics, termed “Ethical Principles” as ideals to which social workers may aspire:

- Service – Helps people in need and addresses social problems
- Social Justice – Challenges social injustice
- Dignity and Worth of the Person – Respects the inherent dignity and worth of the person
- Importance of Human Relationships – Recognizes the central importance of human relationships
- Integrity – Acts in a trustworthy manner
- Competence – Practices within established areas of competence and evolves professional expertise

Professionals assume a fiduciary obligation with their clients, implying a “special duty to care for the welfare of one’s clients or patients” (Haas & Malouf, 1995, p. 2), therefore, the professional’s standard relative to moral principles is much higher than the ordinary citizen’s. Meara, Schmidt and Day (1996) believe that a virtuous professional upholding a fiduciary relationship would: a) be motivated to do what is good, b) have vision and discernment, c) realize the function of emotion in judging proper conduct, d) possess a high degree of self-understanding and awareness, and e) comprehend the mores of his or her community and the legitimacy of client diversity (pp. 28-29). Contrarily, Koocher and Keith-Spiegel (2008) list characteristics of practitioners who demonstrate questionable, unethical or unprofessional behavior:

1. Are unaware or misinformed of the ethical standards
2. Offer treatment outside the scope of their practice
3. Display insensitivity to the needs of others or to situational dynamics
4. Exploit clients by putting their own needs first
5. Act irresponsibly due to stress, laziness, non-awareness, or inattention
6. React with vengeance against clients for perceived harm
7. Experience burn-out or other emotional impairment
8. Reveal interpersonal boundary issues
9. Are self-serving
10. Generally, are ethical but occasionally blunder resulting from oversight or distraction

Herlihy and Corey (1996) advise therapists to be wary of unethical or questionable behavior such as extending the number of therapy sessions to fulfill their own emotional or financial needs; being unaware of countertransference reactions to a client thereby heightening resistance and slowing growth; impressing values on clients incongruent with their cultural background; utilizing techniques or strategies comfortable for therapist but not necessarily functional for client; and practicing with apathy and little enthusiasm. Golden (1992) observed that many ambiguities may abound during therapy, thus “When we find ourselves navigating in waters that are not clearly charted by our profession’s ethical codes, we must be guided by an internal ethical compass.”

This course uses cases that have been adapted from actual incidents to illustrate realistic and common ethical issues facing practitioners; the names have been omitted to protect the privacy of those involved except when cases are already public information through books, newspapers, or media. Codes of ethics, which represent moral principles created by the various mental health organizations to provide guidance for right conduct and are binding on their members, and key literature, are utilized to assist practitioners in making sound ethical decisions promoting the welfare and best interests of their clients and to avoid ethical conflicts.

COMPETENCE

Clients disclose their most personal secrets and struggles during therapy thus placing themselves in a vulnerable position requiring therapist competence. “When clients put their trust in us as professionals, one of their most fundamental expectations is that we will be competent” (Pope & Vasquez, 1991, p. 51). Competent professionals uphold two essential ethical principles: beneficence, which is attempting to do only good for the client, and nonmaleficence, which is never doing harm. Welfel (2006) believes that competence includes a combination of knowledge, skill, and diligence. Effective practice requires intellectual and emotional competence (Pope & Brown, 1996). The intellectual component consists of attaining a knowledge base, assessing and planning effective treatment for a client or issue, and understanding one’s therapeutic limitations (i.e., a child specialist may lack skills required for older adults). Emotional competence relates to managing clinical information, personal biases, and self-care (Pope, Sonne, & Greene, 2006; Welfel, 2006). The concept of competence has been difficult to define, though many efforts have manifested through the development of ethics codes, standards of practice and practice guidelines, third-party-payer quality assurance programs, state licensing and certification boards (Packard, Simon, & Vaughn, 2006), and specialized credentialing authorities. Nonetheless, uniform agreement within the mental health field on the definition of competence is lacking (Claiborn, 1982; Kaslow, 2004). Additionally, incompetence is often difficult to prove given

the legal requirements of due process and supportive evidence.

Peterson and Bry (1980) studied competence by examining appraisals of 126 Ph.D. students by 102 faculty and supervisors. The dominant characteristic for “outstanding” trainees was “high intelligence” and “lack of knowledge” for incompetent trainees. Supervisors rated students the following year and determined the following four factors as central to competence: professional responsibility, interpersonal warmth, intelligence, and experience.

The minimum competence standards for therapists are based on academic training and supervised experience culminating in professional licensure. The counselor’s license does not specify the type of clients, issues, or interventions he or she may address, instead, the practitioner is ethically obligated to restrict practice to areas of qualification based on training and experience. Attorneys and physicians are not competent to practice in every aspect of law and medicine, likewise, psychotherapists are not competent to treat all people for all issues (Brenner, 2006; Halderman, 2006; Maxie, Arnold, & Stephenson, 2006). The ethical codes of the mental health organizations cite the following regarding competence:

Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience (NASW, 1999, 1.04.a.).

Marriage and family therapists... maintain competence in marriage and family therapy through education, training, or supervised experience (AAMFT, 2001, 3.1).

Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience (APA, 2002, 2.01.a.).

Competence also has legal implications because society expects practitioners to be competent and it upholds these high standards through licensing boards and the court system. Counselor incompetence is the second most often reported area of ethical complaint (dual relationships is first) as indicated by Neukrug, Millikin, & Walden (2001). Given client harm, a therapist is open to lawsuit for malpractice and can be legally responsible in a court of law; many such lawsuits focus on competence. Therapists are encouraged to be cognizant of guidelines or standards applicable to their areas of specialization as a best practice for demonstrating professional competence and lowering liability risks (Bennett et al., 2007).

Koocher & Keith-Spiegel (2008) present the following five cases:

Case 1-1: Therapist had practiced individual psychoanalysis for ten years. After completion of a four-hour continuing education workshop on family therapy, she offered family therapy sessions to some clients while reading books in this field in her spare time.

Case 1-2: Counselor treated a woman for six months with various adjustment issues following a separation and upcoming divorce. Client’s attorney asked therapist to testify that client should receive child custody of her 7 year-old. Therapist lacked previous forensic experience or training but

from the witness stand he offered opinions about the adjustment of client and her child. Client’s husband filed an ethical complaint against therapist on the grounds that he lacked training in child work and he never interviewed the child, thus he was negligent in offering an opinion. Furthermore, this therapist did not attain information from another therapist who was seeing the child, nor from the child’s father.

Case 1-3: Practitioner completed graduate training in the 1970s, before clinical neuropsychology evolved as a specialty with more advanced assessment tools. She has not studied neuroanatomy and her practice is mainly in psychotherapy. She accepted an attorney’s referral to assess a client who sustained a closed head injury and resulting language, memory, and perceptual sequelae and she used her 1970s techniques.

Analysis: In each case, therapist did not identify the limit or scope of his or her practice and training which led to crossing ethical boundaries. The first case reveals a counselor lacking in minimum competence levels, training and experience. Her efficacy would only come into question if a formal complaint was filed, nonetheless, therapists have an ethical responsibility to practice in specialty areas that are new to them only after obtaining suitable education, training and supervised experience, and precautions must be taken to ensure competent work during the learning process. In the second case, practitioner was not cognizant of forensic practice or expert witness requirements that could have created negative outcomes for all involved. He violated APA’s ethic code (APA 02: 9.01.a) which states, “Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings” and ethics code (APA 02: 9.01.b) that professes, “... Psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions.” The therapist in the third instance had not kept current with newer neuropsychological assessment techniques and appeared unaware of expert witness ethical responsibilities. In such situations, practitioners are advised to seek formal education, training, consultation or supervision with an expert in that specialty. Considering that competence is difficult to define and assess, self-monitoring is an effective method to ensure quality therapeutic service as reflected in these ethics codes:

Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study (APA, 2002, 2.01.c.).

While developing new skills in specialty areas, marriage and family therapists take steps to ensure the competence of their work and to protect clients from possible harm. Marriage and family therapists practice in specialty areas new to them only after appropriate education, training, or supervised experience (AAMFT, 2001, 3.7).

Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from

ETHICS: CASE STUDIES I

people who are competent in those interventions or techniques (NASW, 1999, 1.04.b.).

Case 1-4: Therapist performed a cognitive evaluation of an adult utilizing the Wechsler Adult Intelligence Scale-Revised (WAIS-R), four years after the revised WAIS-III was published. He responded, “They’re about the same, and the new kit is too expensive.”

Case 1-5: Counselor continued treating his child clients with long-term psychotherapy for secondary reactive enuresis despite significant evidence that certain behavioral treatments are very effective in a brief time. When confronted with this information, he seemed surprised and then researched the professional literature.

Analysis: Both therapists are offering below-standard treatment resulting from failure to keep abreast with advancements in the field. The first therapist rationalized his performance, combining ignorance and arrogance. The second practitioner was completely unaware but at least interested in updating his knowledge base; even if the new technique poses professional or theoretical concerns from this counselor’s view, he has the ethical responsibility to inform clients of this alternative while offering recommendations. Ethically, practitioners must maintain current skills and vigilance of progress within their areas of practice.

Case 1-6: Mr. Austin hired Dr. Dale in a child custody case in the hope of taking custody of his two sons, aged 9 and 11, from his ex-wife, Mrs. Romero, who held custody. Dr. Dale evaluated Mr. Austin, his current wife and the two children. In court, Dr. Dale testified that Mr. Austin and his wife would be better parents and should have custody of the children and Mrs. Romero should have limited visitation rights. He said the boys preferred their father over their mother. Dr. Dale never evaluated Mrs. Romero or her current husband, rather, all such information was gained secondhand. The psychologist for Mrs. Romero highlighted that she had custody of the children before the current trial, Mr. Austin infrequently saw the children, and he infrequently paid his child support. Dr. Dale ignored hospital records sent to him by Mrs. Romero indicating the fact that Mr. Austin was an alcoholic and was probably still drinking. Mrs. Romero lost custody of the children at the trial. She then received letters from her children stating that their father was drinking heavily and beating his second wife – the same reasons why Mrs. Romero divorced Mr. Austin. Mrs. Romero is Anglo but her current husband is Mexican American; she wondered if that tainted Dr. Dale’s evaluation. Analysis: Dr. Dale appears to have violated the same two ethics codes as in Case 1-2, demonstrated by his conclusions about Mrs. Romero and her current husband without previous evaluation. He also chose to ignore Mr. Austin’s history of alcoholism. Whether he lacked forensic experience, was lazy in collecting information, or was biased against certain groups, the displayed incompetence produced dismal consequences for Mrs. Romero and her family (Kitchener, 2000).

4 Continuing Psychology Education Inc.

Successful graduation from an accredited graduate program does not necessitate or guarantee competence (Kitzow, 2002). Determining competence with respect to various types of clients and issues is a decision requiring ethical and professional integrity often made by the individual professional. The ethics codes indicate the following concerning developing new skills:

(AAMFT, 2001, 3.7 – already cited).

When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm (NASW, 1999, 1.04.c.). (APA, 2002, 2.01.c – already cited.).

Case 1-7: A 35 year-old woman with a diagnosis of psychomotor epilepsy and multiple personality disorder filed a complaint with the APA Ethics Committee against her psychologist of four years for practicing outside her areas of competence. Client claimed that she discovered that her psychologist did not have prior training or supervised experience in her multiplicity of issues; client’s condition worsened during treatment leading to hospitalization. Psychologist informed the Ethics Committee that she began treatment as an employee of a community mental health center and was under supervision of two clinic consultants: a neurologist who controlled client’s medication and a psychiatrist experienced in multiple personality disorders. Psychologist started a private practice during the third year of therapy with client and was advised by psychiatrist to allow client to remain with the clinic while the clinic administrator, who was not a psychologist, recommended psychologist to work with client in private practice to avoid disruption of treatment. Psychologist continued therapy with client in private practice and kept the same psychiatrist for consultation as needed. After six months of therapy proceeding well, client began decompensating. Client called psychologist late one night threatening suicide because she felt hopeless and she blamed psychologist for not being more helpful. Psychologist called the police who took client to the county psychiatric hospital emergency room where psychologist met her and stayed with her until she was admitted. Psychologist continued therapy with client at the hospital until client refused to see psychologist. Client ultimately returned to the community mental health center for therapy with a different practitioner.

Psychologist informed the APA Ethics Committee that she acted professionally and responsibly as evidenced by her consultations with the psychiatrist and that the clinic administrator recommended she take client into her private practice.

Adjudication: The APA Ethics Committee found psychologist in violation of the principles of competence and responsibility. She tried to operate beyond the limits of her competence and used mistaken judgment in seeing the client in private practice as opposed to allowing client to continue in the more structured environment of the clinic where trained staff to deal with this issue was extant – as the

psychiatrist had advised. Further, she did not take full responsibility for the consequences of her actions by transferring responsibility for her decisions to other parties – who were not psychologists. Psychologist was censured with stipulation to take two advanced courses: organic disturbances and diagnosis and treatment of borderline personality and multiple personality disorders. Psychologist accepted the censure and stipulations (APA, 1987).

Case 1-8: Psychologist A charged Psychologist B, a new Ph.D. in social psychology, with performing duties beyond his level of competence. B received a license based on two years experience performing research in a private mental hospital, and he then opened a psychotherapy practice. The private mental hospital's administrator was a businesswoman, not licensed in psychology, and she designated B as chief psychologist, a title that B used as a credential. B informed the APA Ethics Committee that his state psychology license was generic, thereby, having no limits on practice, and his two-year work experience at the mental hospital trained him to practice psychotherapy and act as chief psychologist. He claimed psychologist A was simply professionally jealous.

Adjudication: The APA Ethics Committee declared Psychologist B was practicing outside his area of competence and was not accurately representing his education, training and experience. He was censured with the stipulation that he cease and desist from practicing psychotherapy and from utilizing the title of chief psychologist. Psychologist B did not reply to the censure and stipulation, consequently, the Committee voted that he be dropped from Association membership for violation of the above ethics standards and for failure to cooperate (APA, 1987).

Case 1-9: Mrs. A filed a complaint against her husband's therapist, Psychologist C, charging that he was disseminating outdated ideas and values regarding women and marriage. Mrs. A's husband was in therapy for a depressive reaction after the death of his father. After six months, the couple experienced marital difficulties and the husband requested his wife attend several sessions. Mrs. A suspected that Psychologist C's "old-fashioned" and patriarchal marital views were causing the marital strife. She informed the APA Ethics Committee of C's views on marriage as follows: the woman is to be subservient and obedient, only "radical feminists" believe in the women's movement, a woman's career is a marital handicap, and she quoted C's statements toward sexual relations indicating insufficient knowledge of female sexuality. The complainant reported that C helped her husband with the loss of his father but his antiquated marriage views almost destroyed her marriage and she was concerned for the welfare of future marital clients. The Ethics Committee questioned Psychologist C about his initial training and continued exposure to the themes of marriage and women. He expressed a lack of contemplating the issues, but the current situation led him to appreciate Mrs.

A's criticisms culminating in his reading current books on the topics and planning to attend workshops.

Adjudication: The APA Ethics Committee found Psychologist C in technical violation of the need to undertake relevant education, training, and study yielding competence. In light of his response that he was striving to update his knowledge of these issues, a majority voted to close the case with an educative letter and no further action (APA, 1987).

In response to the awareness that society has historically misunderstood, minimized or ignored women's issues, the APA (1975) launched a task force to study potential gender-bias and gender-role stereotyping of women in psychotherapy. These four general areas of bias were recognized: a) often, therapists values were sexist and their understanding of female biology and psychological process was lacking; b) generally, therapy promoted traditional gender roles; c) therapists commonly utilized out-dated psychoanalytic concepts that devalued women; and d) therapists occasionally treated women as sex objects. Ultimately, principles for competent practice for women were endorsed by several APA divisions, including counseling, clinical, and psychotherapy stressing therapists' awareness of their personal values and ways biases limit options of female clients. The resulting "Counseling and Therapy of Women Preamble" (1979) states the following:

Although competent counseling/therapy processes are essentially the same for all counselor/therapist interactions, special subgroups require specialized skills, abilities and knowledge. Women constitute a special subgroup.

Competent counseling/therapy requires recognition and appreciation that contemporary society is not sex fair. Many institutions, test standards and attitudes of mental health professionals limit the options of women clients. Counselors/therapists should sensitize women clients to these real-world limitations, confront them with both the external and their own internalized limitations and explore with them their reactions to these constraints.

Case 1-10: Therapist D was effective in offering workshops on diagnosis and treatment planning for practitioners seeking third-party reimbursement from insurance companies. Through a referral, she agreed to provide a series of in-service consultation sessions on the above topic with ten counselors at a community mental health agency. D did not have formal training or supervision in agency consultation but she resolved that a little self-instruction would suffice. D signed a 6-month contract with the agency director to offer bi-weekly consultation with staff members to discuss cases and increase likelihood that the agency was creating diagnosis and treatment plans resulting in third-party reimbursement. D and the director did not address how D would be evaluated or how she would report to the director. D instituted a written contract with the agency indicating that staff participation was voluntary and confidential; further, agency clients were informed of D's involvement thereby addressing client confidentiality issues. All involved were pleased with D's performance but at the conclusion of the contract, D was surprised when the director asked her to evaluate the quality of each staff member's treatment plans. He said the agency was going to decrease its staff size and her opinion would be valuable in making staffing decisions. Therapist complied with this request due to feeling obligated

for his hiring her, the staff reduction was to inevitably occur anyway, and she potentially might save the jobs of the most competent staff clinicians. Several months thereafter, two former employees who participated in the consultation group filed a complaint with the ACA Ethics Committee, charging ethical misconduct for disclosing to the director individual staff members' ratings of performance (Herlihy & Corey, 1996).

Analysis: Therapist complied with the ethical responsibility of having agency clients informed of her consultant role with staff members and her access to confidential client information. Codes of Ethics on informed consent reveal:

When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons... (APA, 2002, 3.10.a.).

Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a thirdparty payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent (NASW, 1999, 1.03.a.).

The content of informed consent may vary depending upon the client and treatment plan; however, informed consent generally necessitates that the client: ...b) has been adequately informed of significant information concerning treatment processes and procedures (AAMFT, 2001, 1.2.b.).

Consultees are afforded similar rights, thus, informed consent pertaining to goals of the consultation and potential disclosure of shared information is critical, especially when a third party such as a supervisor is involved.

Therapist D declared that disclosed information during consultation meetings was confidential for clients and consultees, further, the possibility of a consultee evaluation was not mentioned. Consultees were not given the choice to participate or not with the understanding that their clinical performance might be disclosed to and evaluated by the agency director. Therapist D violated the consultees' privacy rights by disclosing information not essential to the purpose of the consultation to the director. Privacy issues are illustrated in the following codes:

Social workers should respect clients' right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply (NASW, 1999, 1.07.a.).

Information may be shared only to the extent necessary to achieve the purposes of the consultation (AAMFT, 2001, 2.6).

Psychologists include in written and oral reports and consultations, only information germane to the purpose for which the communication is made (APA, 2002, 4.04.a.).

Although therapists possess broad training and experience, they have the ethical responsibility to seek education, supervision, and consultation when entering into new specialty areas. Therapist D was experienced in treatment planning and insurance reimbursement but not in agency consultation. Her attempts to study consultation on her own proved ineffective regarding consultee confidentiality and informed consent whereas having sought consultation may have prepared her to address the agency director's staff evaluation request. She unintentionally violated her consultees' rights and did not promote their welfare by divulging information that adversely affected their

employment. Codes of Ethics highlighting therapist responsibility to promote client welfare state the following: Marriage and family therapists advance the welfare of families and individuals. They respect the rights of those seeking their assistance, and make reasonable efforts to ensure that their services are used appropriately (AAMFT, 2001, Principle 1).

Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination (APA, 2002, Principle E).

Social workers' primary responsibility is to promote the wellbeing of clients. In general, clients' interests are primary (NASW, 1999, 1.01).

Case 1-11: Therapist E was newly licensed and motivated to begin private practice. His marketing efforts were not attracting referral sources or clients but his pursuit of becoming a network provider with XYZ Corp., a managed care company, led to referrals. E was not cognizant of the impact of managed care upon private practice but he agreed to conform with XYZ Corp.'s approach to managed care. He was referred a client presenting with depression but he needed to refer client upon assessing that client was also anorexic and he lacked training and supervised experience in this disorder. E called his case manager with XYZ Corp. who arranged a referral to another provider in the network.

Over time, Therapist E became somewhat uncomfortable with several of XYZ Corp.'s policies, including having to communicate with numerous case managers (who only gave their first name) rather than only one when requesting authorization for client sessions and needing to disclose much information about the clients above and beyond the diagnosis. He understood the additional request of information was legal because clients signed XYZ Corp.'s disclosure form but E wondered if it was ethical and just what happened with this information such as clients' childhood traumas, marital concerns, addictions and other issues.

One of Therapist E's clients exhausted her insurance benefits before therapy was complete and the case manager advised E to space out the remaining three of the twenty allocated sessions over several months and to initiate a referral to a community mental health center. Therapist E informed the case manager that he disagreed with this plan because client needed continuity of care for an extended time. The case manager was not convinced which led E to see the client pro bono (with resentment toward the managed care company) and to wonder if XYZ Corp.'s case managers were qualified to make psychotherapy decisions.

Therapist E, shortly thereafter, was referred an 11 year-old boy, under the boy's father's company insurance plan administered by XYZ Corp., for fighting at school. E assessed that the boy's misbehavior resulted from conflict between the parents so therapist recommended marital counseling but this specific XYZ Corp. plan did not cover marital counseling. Therapist E felt frustrated with managed care, commenced marital counseling with the parents of the boy, and billed the sessions under the boy's name. E internally reasoned that improvement in the marital relationship would benefit the boy (Herlihy & Corey, 1996).

Analysis: Upon determining client was anorexic, Therapist E appropriately arranged for a referral to a qualified provider, thus not practicing beyond his boundaries of competence.

Codes of Ethics relating to referral state:

Marriage and family therapists assist persons in obtaining other therapeutic services if the therapist is unable or unwilling, for appropriate reasons, to provide professional help (AAMFT, 2001, 1.10).

... psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals... (APA, 2002, 2.01.b).

Social workers should refer clients to other professionals when the other professionals' specialized knowledge or expertise is needed to serve clients fully or when social workers believe that they are not being effective or making reasonable progress with clients and that additional service is required (NASW, 1999, 2.06.a.).

Therapist E developed confidentiality concerns for his clients due to XYZ Corp.'s anonymous and multiple case managers and their requirement for disclosure of much client information. The limits of confidentiality are generally discussed with clients during the intake session and ethical standards respond to this issue as follows:

Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality. Social workers should review with clients circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. This discussion should occur as soon as possible in the social worker-client relationship and as needed throughout the course of the relationship (NASW, 1999, 1.07.e.).

Social workers should not disclose confidential information to thirdparty payers unless clients have authorized such disclosure (NASW, 1999, 1.07.h.).

Psychologists discuss with persons... and organizations with whom they establish a scientific or professional relationship 1) the relevant limits of confidentiality and 2) the foreseeable uses of the information generated through their psychological activities (APA, 2002, 4.02.a.).

This therapist was responsible to know the type of client information that was required before agreeing to become an XYZ Corp. provider, something he may have overlooked given his frustrations and financial needs. He will need to address his concerns with XYZ Corp. and then decide whether to continue as their network provider. Upon continuing, he has an ethical responsibility to inform his clients of the information to be shared with the company because he cannot depend totally on the fact that clients have signed the company's disclosure form.

As Therapist E's concerns about XYZ Corp.'s policies and procedures progress, he is advised to decide if he can continue being their provider and also adhere to these "conflicts between ethics and organizational demands" ethical standards:

If the demands of an organization with which psychologists are affiliated or for whom they are working conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and to the extent feasible, resolve the conflict in a way that permits adherence to the Ethics Code (APA, 2002, 1.03).

Marriage and family therapists remain accountable to the standards of the profession when acting as members or employees of organizations. If the mandates of an organization with which a marriage and family therapist is affiliated, through employment, contract or otherwise, conflict with the AAMFT Code of Ethics, marriage and family therapists make known to the organization their commitment to the AAMFT Code of Ethics and attempt to resolve the conflict in a way that allows the fullest adherence to the Code of Ethics (AAMFT, 2001, 6.1).

Social workers should not allow an employing organization's policies, procedures, regulations, or administrative orders to interfere with their

ethical practice of social work. Social workers should take reasonable steps to ensure that their employing organizations' practices are consistent with the NASW Code of Ethics (NASW, 1999, 3.09.d.).

With resentment, Therapist E continued therapy with the client whose benefits ended, hence, E upheld the following "termination of services" ethics code:

Social workers should take reasonable steps to avoid abandoning clients who are still in need of services. Social workers should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects. Social workers should assist in making appropriate arrangements for continuation of services when necessary (NASW, 1999, 1.16.b.).

Nonetheless, therapist may need to self-assess his ability to offer clinical objectivity and effectiveness despite resentment toward the managed care company.

Therapist E's decision to see the parents of the 11 year-old boy and to bill the therapy under the boy's name suggests insurance fraud – a legal and ethical issue. His rationalizations may represent the onset of an "ethical slippery slope" meaning that he might continually disregard rules and condone dishonest practices in the future.

Although Therapist E was qualified to establish a private practice according to state licensure laws, his actions suggest being uninformed and naïve pertaining to managed care issues, thus questioning his level of competence to begin an independent private practice. Practitioners are advised to consult their association's Code of Ethics and their state licensure laws when confronted with managed care issues. In this case, E could have emphasized his rationale to XYZ Corp.'s case manager that seeing the parents may offer the quickest and most effective way to treat the boy – instead, the therapist violated these ethics codes:

Marriage and family therapists represent facts truthfully to clients, third-party payors, and supervisees regarding services rendered (AAMFT, 2001, 7.4).

When psychologists agree to provide services to a person or entity at the request of a third party, psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations involved. This clarification includes the role of the psychologist... an identification of who is the client, the probable uses of the services provided or the information obtained... (APA, 2002, 3.07).

Psychologists do not misrepresent their fees (APA, 2002, 6.04.c.).

In their reports to payors for services or sources of research funding, psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided or research conducted, the fees, charges, or payments, and where applicable, the identity of the provider, the findings, and the diagnosis (APA, 2002, 6.06).

Social workers should establish and maintain billing practices that accurately reflect the nature and extent of services provided... (NASW, 1999, 3.05).

Social workers should ensure that their representations to clients, agencies, and the public of professional qualifications, credentials, education, competence, affiliations, services provided, or results to be achieved are accurate (NASW, 1999, 4.06.c.).

THERAPIST IMPAIRMENT and BURNOUT

Therapist impairment is a deterioration of professional abilities from a previous competent level (Kutz, 1986; Nathan, 1986; Schwebel, Skorina, Schoener, 1994) and occurs when therapists personal problems overflow into their professional activity and decreases therapeutic effectiveness. Impairment is often caused by personal vulnerabilities such as burnout, drug or alcohol abuse, depression, loneliness,

etc., and it can lead to unethical behavior, defined as causing injury or harm to a consumer during performance of a professional role (Stromberg & Dellinger, 1993). A lonely and depressed therapist, for example, may lose sight of professional boundaries and become sexually involved with a client. Therapists are obligated to identify personal emotional or physical concerns affecting professional effectiveness and to seek help for resolution. Concern for the welfare of one's clients is recommended over hesitancy to accept help. Remley and Herlihey (2007) note the following common symptoms of impairment:

1. Deterioration in personal relationships, for example, marital concerns and family dysfunction
2. Isolation and withdrawal from others
3. Sensing disillusionment with the profession
4. Exhibiting emotional distance during therapy sessions
5. Alcohol and/or drug abuse
6. Displaying changes in work style such as tardiness and absenteeism
7. Becoming moody, depressed or anxious
8. Demonstrating procedural mistakes and poor record keeping

Between 26% and 43% of practicing psychologists indicate struggling sometimes with work effectiveness issues (Guy et al., 1989; Mahoney, 1997), including episodes of emotional exhaustion, distress over the size and severity of their caseload, doubts about their therapeutic effectiveness, and disillusionment feelings (Mahoney, 1997). One study revealed 26% of psychologists identified themselves as having been impaired at a given time (Coster & Schwebel, 1997). A study of APA psychotherapy division members discovered that 71.2% disclosed having worked when too distressed to be effective and 5.9% performed therapy under the influence of alcohol (Pope et al. 1987). A similar study of academic psychologists found that 77.2% had taught while feeling too distressed to be effective and 4.6% had taught under the influence of alcohol (Tabachnick et al., 1991). The data suggest that psychologists are similar to other groups pertaining to sometimes being too emotionally upset to be effective in work or in other areas of life.

In contrast, psychologists exhibit significant amounts of self-care behavior. Mahoney (1997) indicated that 80% of practicing psychologists read for pleasure, participate in a hobby, take vacations, and attend movies, museums or concerts for enjoyment while 75% physically exercise and socialize with peers for support. This research concluded that the average practitioner is healthy, happy, enjoys work, and takes active measures to cope with personal problems (including seeking personal therapy when appropriate). Coster and Schwebel (1997) determined that 74% of psychologists are well-functioning and Thoreson et al. (1989) found that the majority of psychologists they surveyed were healthy and satisfied with work and their interpersonal relationships.

Coster and Schwebel (1997) and Mahoney (1997) reveal the following psychologist-recommended coping

mechanisms to protect psychological well-being, avoid impairment and promote client welfare:

- Maintain a strong interpersonal support system of family, friends and companions which will help buffer work-related stressors.
- Interact with a peer group facilitating exchange of objective feedback, stress-reduction, and problem-solving. Learning that your peers are challenged in similar ways as yourself and listening to their solutions can be stress-reducing.
- Spend time nurturing your personal well-being by living a balanced lifestyle encouraging fun and physical activity along with work.
- Enjoy professional development activities that foster remaining current with the field.
- Monitor your personal weaknesses and impairment danger signals such as dissatisfaction, withdrawal, depression, loss of energy, unjustified anger toward others, alcohol/drug dependence, or impulses to act on sexual feelings. Pursue self-help behavior or therapy when necessary.
- Remove yourself from professional work activities if personal issues remain unresolved that could harm consumers.

Burnout is defined as a type of emotional exhaustion due to extreme demands on energy, strength, and personal resources in the workplace (Baker, 2003; Maslach, Schaufeli, & Leiter, 2001; Shiron, 2006). Therapist burnout yields symptoms of emotional exhaustion, depersonalization, and a sense of limited personal accomplishment and "may manifest itself in a loss of empathy, respect, and positive feelings for their clients" (Skorupa & Agresti, p.281, 1993). Therapist may become withdrawn, bad-tempered and uncooperative with clients and colleagues (Mills & Huebner, 1998) which can lead to poor decision-making and disrespect of one's clients (Pope & Vasquez, 2005). Burnout is more likely for therapists with less control over work activities, excessive work hours, and many administrative tasks (Rupert & Morgan, 2005). Practitioners with smaller caseloads are less susceptible to burnout (Skorupa & Agresti, 1993). Age of therapist is inversely related to burnout (Vredenburgh et al., 1999) presumably because younger counselors experience more stress as they are developing competence and professional security.

The warning signs of burnout include the following: inappropriate anger outbursts, feeling apathetic, continual frustration, feeling depersonalized, depression, emotional and physical exhaustion, being hostile, experiencing malice or aversion toward clients, and reduced productivity or work effectiveness. Predisposing factors that can lead to burnout include: ambiguous work roles such as unclear or changing demands and expectations, work environment conflict and tension, incongruity between ideal and real job activities, unrealistic pre-employment expectations, insufficient social support at work, being a perfectionist with a feeling of being externally controlled, experiencing death or divorce in the family, consistent helplessness, permeable emotional

boundaries, substance abuse, and maintaining excessively high self-expectations (Dupree & Day, 1995; Jenkins & Maslach, 1994; Koeske & Kelly, 1995; Koocher, 1980; Lee & Ashforth, 1996; Maslach, 1993; Maslach et al., 2001; McKnight & Glass, 1995; Shiron, 2006).

Therapists can minimize burnout risk by receiving supervision and social support, especially for those working with difficult populations, feeling a strong purpose and mission in work activities, and seeking help if professional or personal stressors mount (Acker, 1999; Miller, 1998). Joining an informal peer support group can foster ventilation of pent-up stress and promote exposure to professional support and problem-solving ideas. Additional self-care strategies include taking a break or vacation from work, regular exercise, meditation, and engaging in hobbies. Work environment factors that protect therapists from burnout include: understanding your expected role, receiving positive feedback, work autonomy, opportunities to relieve stress at work, social support at the worksite, experiencing personal accomplishment, maintaining realistic criteria for client outcome, being cognizant of personal strengths and weaknesses, and remaining under internal-control (Koocher & Keith-Spiegel, 2008).

The following two cases are presented by Koocher and Keith-Spiegel (2008):

Case 1-12: Therapist F worked full-time at a cancer treatment facility for several years and due to concern for his clients, made himself available “on call” beyond normal hours. His performance lessened after the death of a liked client and a personal marriage concern. F stopped returning calls to clients and staff in a timely way, sometimes missed appointments without giving notice, and exhibited distance from his clients. He was fired by the facility but performed well at his next therapeutic setting.

Case 1-13: Therapist G worked as a school psychologist in a large urban public school system. She felt under-appreciated and over-worked by clients and administrators coupled with an inability to effectively manage her work situation culminating in dislike of her position. G resigned from the job after securing another position elsewhere but she failed to give adequate notice and left several student evaluations incomplete.

Analysis: Both therapists experienced burnout resulting from stress in their jobs, personal lives, various client issues dealt with daily, and other factors. Each was subjected to learned helplessness and depression, in turn, their clients were affected. Therapist F’s detachment and withdrawal was not professional and Therapist G’s immediate departure probably negatively impacted several students and staff.

The Codes of Ethics express the requirement of acknowledgment and resolution of personal problems as follows:

Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have a professional responsibility (NASW, 1999, 4.05.a.).

Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their

professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others (NASW, 1999, 4.05.b.). Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner (APA, 2002, 2.06.a.).

When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties (APA, 2002, 2.06.b.).

Marriage and family therapists seek appropriate professional assistance for their personal problems or conflicts that may impair work performance or clinical judgment (AAMFT, 2001, 3.3).

Marriage and family therapists are in violation of this Code and subject to termination of membership or other appropriate action if they continue to practice marriage and family therapy while no longer competent to do so because they are impaired by physical or mental causes or the abuse of alcohol or other substances (AAMFT, 2001, 3.15.f.).

TERMINATION

Termination or referral of a client is generally based on three conditions. First, when therapy has successfully resolved client’s presenting issues and treatment is no longer required. Second, if client is not gaining any benefit from therapy but is willing to continue given dependency upon the therapist. A referral is possible if therapist senses client would benefit from a different practitioner. Third, upon therapist belief that therapy continuation could be harmful to client – a referral is also possible. Additionally, therapists discuss the issue of termination with clients thoroughly along with clarifying the reasons. The decision to terminate therapy is based on the best interest of the client, hence, therapists do not abandon their clients. Codes of Ethics on terminating therapy emphasize the following:

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 (APA, 2002, 10.10.a.).

Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship (APA, 2002, 10.10.b.).

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 (APA, 2002, 10.10.c.).

Marriage and family therapists do not abandon or neglect clients in treatment without making reasonable arrangements for the continuation of such treatment (AAMFT, 2001, 1.11; 1.10 already mentioned).

Social workers should terminate services to clients and professional relationships with them when such services and relationships are no longer required or no longer serve the clients’ needs or interests (NASW, 1999, 1.16.a.).

Case 1-14: Client has been in therapy with Therapist H weekly for six years and has already resolved her presenting issues. Her emotional status has not changed in approximately four years except she has developed a growing attachment to therapist. H has not strongly recommended termination, rather, his attitude is “If the client thinks she needs to see me, then she does” (Koocher & Keith-Spiegel, 2008).

Analysis: Therapist H failed to ethically terminate treatment at the time client did not need continued services or therapy

was no longer beneficial. The possibility exists that Therapist H facilitated client's dependency, prolonged needless therapy, thereby suggesting exploitation for financial or emotional fulfillment. He is wise to periodically, critically evaluate the therapy process with client and refer client to a different therapist for consultation regarding need for further therapy. The best interest of client, not therapist, determines termination and referral.

Case 1-15: Therapist I treated client for escalating anger toward his employer but therapist observed client becoming paranoid and deeply troubled. Therapist I recommended hospitalization to client several times but client rejected the thought. Therapist continued treating client, eventually developing into the object of client's paranoid anger (Koocher & Keith-Spiegel, 2008).

Analysis: Therapist I practiced beyond the scope of his competency. Upon recognition that client needed a higher level of care, possibly inpatient treatment, therapist could have refused therapy until client sought appropriate assistance. If client's behavior would have escalated to being a danger to self or others, or suggested involuntary hospitalization then therapist would be responsible to consider an effective course of action.

Case 1-16: A corporation hired Therapist J to assist in improvement of employee morale and lower product defects. Effectiveness data acquired by therapist himself validated unsuccessful results, however, Therapist J disregarded the outcome information, informed the company that a longer trial was required, and persisted to offer the unproductive services at a high fee for several more months until the corporation finally cancelled the contract (Koocher & Keith-Spiegel, 2008).

Analysis: Therapist J willfully chose to overlook his data and continue providing ineffective services rather than re-evaluating treatment plans and constructing an alternative course of action. The ethical obligation to inform management of the absence of benefit was not timely demonstrated.

Corey et al. (2007) believe that even highly experienced therapists will occasionally question whether their personal and professional competence is sufficient with some of their clients. Encountering difficulties with some clients does not necessarily imply incompetence or the need to immediately refer, instead, it is wise to balance between expanding areas of competence and referring when appropriate. Professional growth, extended competence, and avoidance of stagnation may arise by accepting clients with new issues. While learning new skills and implementing new competencies, practitioners must ensure that clients are not harmed. Broadening boundaries of competence can occur through reading, professional development activities, consultation, co-counseling with experienced colleagues in a specialty area, and receiving supervision. Whether administering experienced or inexperienced therapeutic skills, therapists

would benefit by self-appraisal through peer consultation and client evaluation.

INFORMED CONSENT

The process of informed consent is a legal and ethical obligation to provide relevant information to clients regarding expectations of therapy before onset of assessment or treatment. Therapists should discuss goals, expectations, procedures, and potential risks (Becker-Blease & Freyd, 2006; Bennett et al., 2007; Everstein et al., 1980; Hare-Mustin et al., 1979; Vogel & Wester, 2003) enabling clients to make intelligent choices such as whether to receive therapy, with whom, and how the process will transpire. The essence of informed consent is designed to anticipate questions of reasonable clients thus preventing future misunderstanding and frustration yielding a "culture of safety" (Knapp & VandeCreek, 2006). Informing clients how therapy works demystifies the relationship and empowers their active involvement. Clients, generally, must rely upon and trust their practitioner to disclose information necessary to make wise treatment decisions (Handelsman, 2001). Sullivan, Martin, and Handelsman (1993) note that "clients may be more favorably disposed to therapists who take the time and effort to provide (informed consent) information" (p. 162). Further, Tryon and Winograd (2001) propose that therapist-client agreement on goals is positively correlated with improved patient outcomes and satisfaction and they advise, "to maximize the possibility of achieving a positive treatment outcome, therapist and patient should be involved throughout therapy in a process of shared decision-making, where goals are frequently discussed and agreed upon" (p. 387). Supportively, informed consent is a recurrent process because the treatment plan may be altered due to assessment results, client's reactions and his or her changing needs. The client should be informed of treatment plan changes and voluntarily agree with them. Marczyk and Wertheimer (2001) acknowledged the difficulty of mental health practitioners historically to offer comprehensive treatment choices because the discipline of counseling and psychology was "still very much a philosophy and not a science" (p. 33). They believe that mental health practitioners should be required to offer clients success rates of various mental health treatment based on empirical research-based evidence similar to physicians treating patients with conditions as cancer.

The requirement for health professionals to secure informed consent from their clientele prior to rendering services started in the field of medicine (Appelbaum, Lidz, & Meisel, 1987). Historically, in 1767, a court in England established that physicians were responsible to acquire consent from their patients before touching them or offering treatment (*Slater v. Baker & Stapleton*). This requirement was founded on the basic tort principle of battery emphasizing that members of a society are entitled to personal privacy, including not having their bodies touched without permission. Through history, the health care professions maintained an authoritarian

position in terms of the patient's needs as it was assumed that the physician knew the best course of action and the patient lacked such knowledge – the principle of informed consent is absent from the Hippocratic Oath. This authoritarian approach was challenged in a New York case, in 1914, when Judge Benjamin Cordozo (he later became a U.S. Supreme Court Justice) wrote, “every human being of adult years and sound mind has a right to determine what shall be done with his own body” (*Schloendorff v. Society of New York Hospital*, 1914, p. 93). The principle that the patient and not the doctor had the right to decide whether to undergo a specific treatment approach was dormant for decades. The first case in the United States to uphold the requirement that patients must be educated or informed about their medical treatment options and consequences before being able to give a valid consent to treatment that is legally binding was *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees* (1957).

Appelbaum, Lidz & Meisel (1987, p. 41) conclude the Salgo case stressed that physicians must provide patients the following: “disclosure of the nature of the ailment, the nature of the proposed treatment, the probability of success, and possible alternative treatments.”

In 1960, in the Kansas case of *Nathanson v. Kline*, the court endorsed the Judge Cordozo principle by stating, “Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man is considered to be master of his own body” (p. 1104). The court expressed that the patient needs relevant information to make this determination, however, it was left to the doctors to determine what information was relevant: “The duty ... to disclose ... is limited to those disclosures which a reasonable ... practitioner would make under the same or similar circumstances.... So long as the disclosure is sufficient to assure an informed consent, the physician's choice of plausible courses should not be called into question if it appears, all circumstances considered, that the physician was motivated only by the patient's best therapeutic interests and he proceeded as competent medical men would have done in a similar situation” (1960, p. 1106). This case demonstrates the “community standard” rule whereby informed consent procedures must represent that which the general community of doctors customarily do.

The case of *Canterbury v. Spence* (1972) resolved that physicians must disclose information pertaining to a proposed treatment that a reasonable person, such as the patient being treated, would require to render a decision to accept or refuse treatment. The court conveyed, “The root premise is the concept, fundamental in American jurisprudence, that ‘every human being of adult years and sound mind has a right to determine what shall be done with his own body.’ True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision.

From these almost axiomatic considerations springs the need, and in turn the requirement, of a reasonable divulgence by physician to patient to make such a decision possible” (*Canterbury v. Spence*, 1972, p. 780). The patient, not the doctor, therefore, makes the final decision and the decision is based upon relevant information supplied by the doctor: “It is the prerogative of the patient, not the physician, to determine for himself the direction in which he believes his interests lie. To enable the patient to chart his course knowledgeably, reasonable familiarity with the therapeutic alternatives and their hazards becomes essential” (*Cobbs v. Grant*, 1972, p. 514).

This rationale illustrated the vital importance of trust and dependence in the delivery of health care and differentiated such trust and dependence from the less profound and intimate general marketplace transactions often reflective of the caveat emptor policy: “A reasonable revelation in these aspects is not only a necessity but, as we see it, is as much a matter of the physician's duty. It is a duty to warn of the dangers lurking in the proposed treatment, and that is surely a facet of due care. It is, too, a duty to impart information which the patient has every right to expect. The patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms-length transactions. His dependence upon the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject” (*Canterbury v. Spence*, 1972, p. 782).

The *Canterbury v. Spence* case rejected the notion that doctors, resulting from their “community standards,” could regulate the type of information patients should receive. It was resolved that doctors could not determine the informed consent rights of the patient or those rights indirectly by creating “customary” standards concerning the type of information to be provided. Contrarily, patients were determined to have a right to make an informed decision and the courts would guarantee patients were privy to relevant information to make the decision. The court noted, “We do not agree that the patient's cause of action is dependent upon the existence and nonperformance of a relevant professional tradition.... Respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves” (*Canterbury v. Spence*, 1972, pp. 783—784). Furthermore, this case requires doctors to provide relevant information whether or not patients ask the “right” questions in each area, hence, doctors could not withhold information because a patient did not inquire. Doctors have a duty to render a sufficient full disclosure: “We discard the thought that the patient should ask for information before the physician is required to disclose. Caveat emptor is not the norm for the consumer of medical services. Duty to disclose is more than a call to speak merely on the patient's request, or merely to answer the patient's questions: it is a duty to volunteer, if necessary, the information the patient needs for intelligent decision. The patient may be ignorant, confused, overawed by the

physician or frightened by the hospital, or even ashamed to inquire.... Perhaps relatively few patients could in any event identify the relevant questions in the absence of prior explanation by the physician. Physicians and hospitals have patients of widely divergent socioeconomic backgrounds, and a rule which presumes a degree of sophistication which many members of society lack is likely to breed gross inequalities” (*Canterbury v. Spence*, 1972, p. 783).

The courts also deliberated on the possibility of patients refusing a specific assessment or treatment and concluded that patients have a right to be informed of the possible consequences of rejecting such assessment or treatment procedures. The California Supreme Court, in 1980, reaffirmed the principles of *Canterbury v. Spence* and *Cobbs v. Grant* and affirmed that patients have a right to informed refusal of treatment along with the right of informed consent to treatment: “The rule applies whether the procedure involves treatment or a diagnostic test.... If a patient indicates that he or she is going to decline a risk-free test or treatment, then the doctor has the additional duty of advising of all the material risks of which a reasonable person would want to be informed before deciding not to undergo the procedure. On the other hand, if the recommended test or treatment is itself risky, then the physician should always explain the potential consequences of declining to follow the recommended course of action” (*Truman v. Thomas*, 1980, p. 312).

The court clarified that doctors need not inform patients of everything they learned during their training because patients probably would not understand such complexities, instead, patients only need relevant information presented in understandable and straightforward language so to make an informed decision: “The patient’s interest in information does not extend to a lengthy polysyllabic discourse on all possible complications. A mini-course in medical science is not required” (*Cobbs v. Grant*, 1972, p. 515).

The courts changed the locus of control in decision-making to the patient and the duty of ensuring the decision for assessment or treatment being a result of clear and relevant doctor disclosed information. The California Supreme Court explained the derivation of informed consent as follows: “We employ several postulates. The first is that patients are generally persons unlearned in the medical sciences and therefore, except in rare cases, courts may safely assume the knowledge of patient and physician are not in parity. The second is that a person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment. The third is that the patient’s consent to treatment, to be effective, must be an informed consent. And the fourth is that the patient, being unlearned in medical sciences, has an abject dependence upon and trust in his physician for the information upon which he relies during the decisional process, thus raising an obligation in the physician that transcends arm-length transactions. From the foregoing axiomatic ingredients emerges a necessity, and a resultant requirement, for divulgence by the physician to his patient of

all information relevant to a meaningful decisional process” (*Cobbs v. Grant*, 1972, p. 513). Berner (1998) suggests that two key elements are involved with the informed consent legal standard. First, the “professional element” pertains to information which a reasonable physician would have offered a patient in similar circumstances, and “materiality,” defined as the amount of information the average patient would deem adequate to decide whether to accept or reject treatment. Given Berner’s interpretation, the courts will predictably require physicians to provide basic information to all patients and the information must be understandable to the particular patient.

One example of informed consent principles passing from case law into legislation is Indiana’s House Enrolled Act of 1984, which articulates, “All patients or clients are entitled to be informed of the nature of treatment or habilitation program proposed, the known effect of receiving and of not receiving such treatment or habilitation, and alternative treatment or habilitation programs, if any. An adult voluntary patient or client, if not adjudicated incompetent, is entitled to refuse to submit to treatment or to a habilitation program and is entitled to be informed of this right” (section F). These informed consent principles are also clearly communicated in the ethical standards and principles of the mental health associations. Though a large portion of case law pertains to medical practice, examination of Codes of Ethics for mental health practitioners illuminates the relevance and positive transfer to clinical assessment and psychotherapy:

Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a thirdparty payer, relevant costs, reasonable alternatives, clients’ right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions (NASW, 1999, 1.03.a.). Marriage and family therapists obtain appropriate informed consent to therapy or related procedures as early as feasible in the therapeutic relationship, and use language that is reasonably understandable to clients. The content of informed consent may vary depending upon the client and treatment plan; however, informed consent generally necessitates that the client: a) has the capacity to consent; b) has been adequately informed of significant information concerning treatment processes and procedures; c) has been adequately informed of potential risks and benefits of treatments for which generally recognized standards do not yet exist; d) has freely and without undue influence expressed consent; and e) has provided consent that is appropriately documented. When persons, due to age or mental status, are legally incapable of giving informed consent, marriage and family therapists obtain informed permission from a legally authorized person, if such substitute consent is legally permissible (AAMFT, 2001, 1.2). When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons... (APA, 2002, 3.10.a.).

Pondering how we would feel in the role of a client who was not given adequate information to make a decision on an informed basis can increase our sensitivity and appreciation of the ethical responsibility to provide informed consent. The following three examples of failure to provide informed consent illustrate its importance: One of the most frightening cases involved the U.S. government offering free medical

care to hundreds of U.S. citizens from 1932 to 1972 in the Tuskegee syphilis study through what ultimately became the U.S. Public Health Service (J. H. Jones, 1981; Rivers, Schuman, Simpson & Olansky, 1953; U.S. Public Health Service, 1973). The participants of the study were not told that they were used to research the effects of syphilis given nontreatment. Research procedures were utilized as treatment, for example, painful spinal taps were explained to the subjects as a form of medical treatment. The Public Health Service denied any racism in this research, however, only male African Americans were admitted to the program. A second example is when hospitals may perform AIDS tests on patients without their knowledge or permission, sometimes in violation of state law (Pope & Morin, 1990). In a third case, Stevens (1990) revealed a testing center that administered the Stanford-Binet Intelligence Scale facilitating placement of students into appropriate classes at school. The schools received different information than the child's parents. One report, for example, stated the boy should be placed in a class for average students while the parents received a report stating, "David should be placed in a class for superior students" (p. 15). The testing center justified their position expressing, "The report we send to the school is accurate. The report for the parents is more soothing and positive" (p. 15).

The concern that providing relevant therapy information may yield negative client consequences has not been research-supported, instead, an array of studies demonstrate that informed consent procedures increase likelihood that clients will become less anxious, follow the treatment plan, recover more quickly, and be more alert to unanticipated negative treatment outcomes (Handler, 1990).

Therapists must strive to inform clients in understandable and unbiased language during their decision process to participate in assessment or treatment as the following Harvard University hospital study illustrates. McNeil et al. (1982) gave subjects the choice of surgical versus radiological treatment based on actuarial data of outcomes of lung cancer patients. For those who chose surgery, 10% died during the operation itself, 22% died within the first year after surgery, and another 34% died within five years. For radiation therapy, none died during the radiation treatments, 23% died within the first year, and an additional 55% died within five years. When this data was presented in terms of mortality (percentage of patients who died), 42% of participants in the study chose radiation. Given the same actuarial data presented in terms of percentage of patients who survived at each stage – for radiation, 100% survived the treatments, 77% survived the first year, and 22% survived five years – only 25% chose radiation. A shift from a mortality to survivability presentation produced a significant change in subject's perception and ultimate decision.

An informed consent form may have been composed with intimidating legalese and bureaucratic terminology to protect the organization from lawsuit, therefore, a therapist ethical responsibility exists to explain the information to client. Grundner (1980, p. 900) observed that "consent forms have

valid content, but little effort has been made to ensure that the average person can read and understand them." He analyzed five forms, with two standardized readability tests, and concluded that "the readability of all five was approximately equivalent to that of material intended for upper division undergraduates or graduate school students. Four of the five forms were written at the level of a scientific journal, and a fifth at the level of a specialized academic magazine" (p. 900).

Comprehension as well as recall of information is not guaranteed by client simply reading an informed consent form. Robinson & Merav (1976) re-interviewed twenty patients four to six months after they read and signed an informed consent form and underwent therapy. All patients exhibited poor recall of all aspects of the information on the form, including the diagnosis, possible negative outcomes, and alternate types of management. Cassileth, Zupkis, Sutton-Smith, & March (1980) discovered that only 60% of patients who read and signed an informed consent form understood the purpose and nature of the procedures one day later. A mechanical and obligatory response from clients that they understand is not always reliable (Irwin et al., 1985).

Remley and Herlihey (2007) recommend the following to be included in informed consent material:

1. The purposes, goals, techniques, procedures, limitations, potential risks, and benefits of the proposed therapy
2. Therapist qualifications, including degrees, licenses and certifications, areas of specialization, and experience
3. Plans for continuation of therapy services if therapist becomes incapacitated or dies
4. Implications of the diagnosis and planned utilization of tests and reports
5. Billing information and fees
6. Confidentiality and its limitations
7. Clients' rights to receive information about their records and to participate in therapy plans
8. Clients' rights to refuse any recommended treatment services or changes and to be informed of potential consequences of refusal

Moreover, the following topics are also recommended to be included:

- a) The therapist's theoretical orientation expressed in understandable language (Corey et al., 2007) or therapist's philosophy of the therapy process
- b) Logistics of therapy, including length and frequency of sessions, how to make and cancel sessions, policy about telephone contact between appointments, method of contacting therapist or an alternative service in case of emergency (Haas & Malouf, 1995)
- c) Insurance reimbursement information, including how client's diagnosis becomes part of client's permanent health record; description of information to be provided to insurance carriers and the resulting limits on confidentiality (Welfel, 2006); and, if appropriate, explanation of how managed care will affect the therapy process (Corey et al., 2007; Glosoff et al., 1999)
- d) Information on alternatives to therapy, for example,

ETHICS: CASE STUDIES I

- 12-step groups, self-help groups, bibliotherapy, medications, nutritional or exercise therapy, or other pertinent options (Bray, Shepherd, & Hays, 1985)
- e) If the case may be discussed with a supervisor or consultant, or videotaped/audiotaped (Corey et al., 2007)
 - f) Client's options if dissatisfied with therapy such as names/contact information of supervisors, and contact information of licensing boards and professional organizations (Welfel, 2006)

Furthermore, the eight potential legal concerns listed below are recommended to be discussed in informed consent material because they could lead to lawsuit if client believes therapist has enacted any of the following (Remley & Herlihy, 2007):

- Failure to include HIPAA elements – For example, not informing clients of their right to look at their therapy records.
- Providing a guarantee of an outcome resulting from therapy – Therapist states, “Therapy will save your marriage” but divorce ensues leading to a breach of contract lawsuit.
- Offering a guarantee of privacy without exceptions – Therapist explains the ethical and legal responsibility of protecting privacy to a client who is concerned about privacy issues. Client perceives that therapist will not disclose any information under any circumstance. Soon after, therapist breaks confidentiality by informing client's wife that client reveals suicidal ideation. Client sues therapist for breach of contract, malpractice, and deliberately inflicting emotional distress.
- Agreeing to a fee that is changed later – Agreement of a \$50 per hour rate is raised to \$75 after several months. Client expresses that the new rate is excessive and therapist replies that therapy will be terminated without the new fee. Client sues for breach of contract and abandonment.
- Touching a client without implied or actual permission – During group therapy, therapist directs clients to catch one another as they fall backward as a sign of trust. A female client with various sexual issues reluctantly participates but leaves session early and visibly distraught. Client sues therapist for breach of contract, breach of fiduciary duty, assault, battery, and sexual assault.
- Misrepresenting one's credentials – Client receives therapy from a master's level licensed therapist and writes the checks to “Dr. Smith” while noting fee is for “psychological services” and the checks are cashed. After eight sessions, client calls therapist “Dr. Smith” and is corrected by therapist. Client is upset to learn he is seeing a master's level therapist and not a psychologist. Client sues for breach of contract and fraudulent misrepresentation.
- Failure to indicate the nature of therapy – Client initiates therapy to overcome public-speaking anxiety. Therapist assesses the anxiety results from low self-esteem and treatment targets the delivery of positive reinforcement of client's positive attributes. After five sessions yielding no change, client conveyed she expected to learn ways to give public presentations without feeling anxious through

receiving advice on managing anxiety, reading books on the subject, and practicing speaking with therapist. Client sues for breach of contract and malpractice.

→ Failure to warn client about possible stigma – Therapist completes an insurance form after first session, at client's request, indicating client had a single episode of depression and designated the appropriate diagnosis. Therapy continued for ten sessions and terminated due to client moving away. Client called therapist two years later complaining that he was denied security clearance for a job he applied for because therapist diagnosed him with a mental disorder, without his knowledge or agreement. Client sues for breach of contract, malpractice, and defamation.

These situations demonstrate the significance of therapist and client understanding expectations of therapy before the process begins. The above issues were avoidable given therapists fully informing clients of the therapy relationship.

The Health Insurance Portability and Accountability Act (HIPAA) became effective on April 15, 2003, in turn, therapists must give their clients written informed consent documents to sign. HIPAA requires all health care providers who transmit records electronically (which probably includes all providers) to conform with procedures that will ensure consumer privacy. Practitioners must inform health care recipients in detail of their established rights regarding privacy and records. This federal law has evolved a previous vague notion of informed consent to a concrete format, including steps taken to ensure client privacy and clients' signature of a document that they were informed of their rights. Some essential HIPAA elements for informed consent documents indicating clients have been informed about proposed treatment and agreeing to the arrangements and treatment are illustrated below (Remley & Herlihy, 2007):

- Indicate that your client's personal information may be used and disclosed in order to complete treatment, and information may be presented to health care companies in relation to payment of your services.
- Have a complete written description of your procedures for keeping and disclosing your clients' personal information.
- Advise your client that you have a more complete description of how you will keep or disclose their personal information and it is available to view. Inform that client has a right to see the complete description before signing the consent form. State that your practice may change over time and client can review those revisions by requesting such in writing.
- Explain to clients that they may request that you restrict how their personal information is used or disclosed, that you will consider their requests, and will inform them whether you have agreed to them.
- Acknowledge that client has the right to revoke his or her consent in writing, except for actions that you have already taken which were based on prior consent.
- Have client sign and date the form.
- Keep the form for a minimum of six years.

CLIENT RIGHT TO REFUSE TREATMENT

Clients who disapprove of a therapist's proposed treatment plans may generally choose to not receive treatment or to pursue alternative care, however, clients confined in mental hospitals, and minors brought to therapy by their parents or guardians may not have such a choice. Several court rulings have offered direction in this area, for example, in the landmark case of *O'Connor v. Donaldson* (1975), the U.S. Supreme Court identified, for the first time, a constitutional basis for the "right to treatment" for the nondangerous mentally ill patient. Mr. Donaldson was schizophrenic and his father committed him to a hospital for psychiatric care. Mr. Donaldson refused somatic treatments due to his Christian Science religious beliefs. He was not deemed a danger to self or others, yet, he was confined in the hospital for refusing medication. Mr. Donaldson was not offered alternative treatment such as verbal or behavioral therapy. The ruling indicated that the state could not confine such patients without treatment being provided.

Case 2-1: Charles Sell, a dentist, practiced in Missouri and had a long history of mental illness. He was hospitalized, treated with antipsychotic medication, and discharged, in 1982, after advising doctors that the gold used in his fillings was contaminated by communists. Through the years, Dr. Sell experienced several documented episodes of visual and auditory hallucinations followed by a U.S. government charge, in 1997, of Medicaid, insurance, and mail fraud, alleging he submitted multiple false claims. A court-ordered psychiatric examination assessed Dr. Sell "currently competent" but stated "a psychotic episode" was possible in the future. In 1998, during a bail revocation hearing, the judge said Dr. Sell was "totally out of control" as he yelled, insulted and ultimately spat in the judge's face. Several months later, the grand jury charged Dr. Sell with attempted murder of the Federal Bureau of Investigation agent who arrested him and a past employee who was to testify against him in the fraud case. While incarcerated before trial, another court-ordered examination found Dr. Sell "mentally incompetent to stand trial," hence, the judge ordered him "hospitalized for treatment" up to four months "to determine whether there was a substantial probability that Sell would attain the capacity to allow his trial to proceed." After two months, the medical staff recommended Dr. Sell take antipsychotic medication but he refused. The medical staff pursued permission to administer the medication against Dr. Sell's will.

In a 6-3 vote, the U.S. Supreme Court ruled that the government can involuntarily administer antipsychotic medications to a mentally ill defendant thus allowing the defendant to stand trial, "but only if the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the fairness of the trial and, taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests." The Supreme Court also stated that a) in deciding

if the government maintains an important interest in bringing a defendant to trial, a trial court must determine whether the defendant will be civilly committed or has been detained already for a lengthy period; b) the government must show that the intended medication is considerably likely to render the defendant competent to stand trial; c) the court must recognize the absence of a less intrusive approach or alternative as likely to attain the same result of leading a defendant to competency; and d) the medication must be in the patient's best interest, including efficacy and side effects (*Sell v. United States*, 2003). The Supreme Court's decision agreed with the American Psychological Association's request that courts should consider "alternative, less intrusive means" before forcibly treating mentally ill criminal defendants with medication. Nathalie F. P. Gilfoyle, General Counsel for the APA, stated, "The bottom line is that – the Court has specifically required that trial courts consider and rule out nondrug alternatives before ordering involuntary drug treatment."

Case 2-2: Nancy Hargrave had a history of paranoid schizophrenia and many admissions to the Vermont State Hospital. At a time of emotional stability, Ms. Hargrave completed an advance directive through a durable power of attorney (DPOA) designating a substitute decision maker if she again became psychotic and incompetent by reason of psychosis and she chose to reject "any and all anti-psychotic, neuroleptic, psychotropic, or psychoactive medications" upon any future involuntary commitment.

The 1998 Vermont state legislature, however, passed Act 114, a statute allowing hospital (or prison) personnel to seek court permission to treat incompetent involuntarily committed patients, despite any advance directives requesting otherwise. Ms. Hargrave argued that the new law violated her rights under the Americans With Disabilities Act. The U.S. District Court and the Second Circuit Court of Appeals agreed with Ms. Hargrave rather than with the state. Addressing the argument that Hargrave and other involuntarily committed patients represent a direct threat, the three-judge panel countered that all committed patients do not pose a threat to others, as required by the Americans With Disabilities Act, because many became hospitalized only due to danger to themselves. Additionally, the court stated that those people designated as dangerous to others at the time of commitment cannot still be presumed as dangerous when seeking to override their advance directives. The court resolved that the state statute violated the Americans With Disabilities Act (Appelbaum, 2004).

CASE STUDIES

Case 2-3: A 13 year-old walks into a Mental Health Center and asks to talk to someone. Therapist K sees client who indicates many personal and family problems, including severe physical abuse at home. Client asks therapist not to discuss the case with anyone, especially his parents.

Therapist explains his options with client, states that he cannot offer treatment to anyone under the age of 18 without parental consent, and expresses his duty to report suspected child abuse to Child Protective Services. Client feels betrayed.

Analysis: Generally, with the exception of a small number of states (i.e., the Commonwealth of Virginia), a parent's permission is needed to provide psychotherapy with a minor client (Koocher, 1995, 2003). In fact, a child generally cannot refuse treatment authorized by a parent, even if the proposed treatment is inpatient confinement (Koocher, 2003; Melton et al., 1983; Weithorn, 1987, 2006). The courts have assumed that the mental health practitioner treating the child at the parents request represents an unbiased third party capable of assessing that which is best for the child (J.L. v. Parham, 1976; Parham v. J.R., 1979).

Therapist K understood that he could not legally accept client's request for therapy and client could not provide competent informed consent with all such implications, including payment for services. Therapist did not, however, explain limits of confidentiality to client from the start, as required by HIPAA (Health Insurance Portability and Accountability Act, 1996). Practitioner knew of the need to report suspected child abuse to the proper authorities as is the statutory obligation in all states. He also respected child's rights as a person and client by discussing his action plan (Koocher & Keith-Spiegel, 2008).

Case 2-4: A 30 year-old woman called by phone and requested therapy for depression and marital dissatisfaction. In the first session, client disclosed that she was a victim of sexual trauma as an adolescent. It appeared that client's symptoms were linked to her adolescent trauma.

Analysis: It is recommended that the informed consent process address possible negative effects of therapy upon the marriage and the spouse. Common trauma symptoms include disrupted relationships with significant others such as emotional detachment, lack of intimacy, and impaired sexual functioning. Therapist wisely informed client that some of her negative feelings about her marriage may be caused by the impact of the trauma, unrelated to the marriage itself (Knapp & VandeCreek, 2006).

Case 2-5: Therapist, working in a mental health agency, gave client a personalized, pre-made informed consent form before the session began. During session, the client, a young mother, revealed that her husband gets angry when their infant daughter cries and severely shakes the child to stop the crying. Therapist advised client that he must report her husband's actions as possible child abuse, along with potential outcomes of the report, and that he will continue counseling her. Client responded that she would not have revealed this situation had she known it would be reported. Therapist reminded client that she signed the informed consent form which clearly stated therapists are legally obligated to report incidents of suspected child abuse. Client admitted to not having read the document, instead, she signed

it along with the other paperwork for insurance purposes. Client chose to discontinue therapy because she lost trust in therapist.

Analysis: Therapists should make the effort to ensure clients understand that which they have read in disclosure statements. Informed consent forms can be used to correct misunderstandings before therapy begins, additionally, written rather than verbal disclosure statements are more effective in addressing questions or issues because the intent of the parties is clearly expressed. Pope and Vasquez (1998) believe that counselors cannot rely exclusively on standard forms to complete the purpose of informed consent, regardless of the quality of the form. Dialogue is required to ensure client and therapist understand their upcoming shared encounter. In the case of clients who lack the capacity to give informed consent, for example, minors, developmentally disabled, severe thought-disorders, or those not speaking the primary language, therapists take additional steps to promote understanding as indicated in these Codes of Ethics:

For persons who are legally incapable of giving informed consent, psychologists nevertheless 1) provide an appropriate explanation, 2) seek the individual's assent, 3) consider such persons' preferences and best interests, and 4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare (APA, 2002, 3.10.b.).

...When persons, due to age or mental status, are legally incapable of giving informed consent, marriage and family therapists obtain informed permission from a legally authorized person, if such substitute consent is legally permissible (AAMFT, 2001, 1.2).

In instances when clients are not literate or have difficulty understanding the primary language used in the practice setting, social workers should take steps to ensure clients' comprehension. This may include providing clients with a detailed verbal explanation or arranging for a qualified interpreter or translator whenever possible (NASW, 1999, 1.03.b.).

In instances when clients lack the capacity to provide informed consent, social workers should protect clients' interests by seeking permission from an appropriate third party, informing clients consistent with the clients' level of understanding. In such instances social workers should seek to ensure that the third party acts in a manner consistent with the clients' wishes and interests. Social workers should take reasonable steps to enhance such clients' ability to give informed consent (NASW, 1999, 1.03.c.).

Case 2-6: A 38 year-old woman, experiencing postpartum depression, chronic pain in her lower back resulting from a two year-old injury, and worry over her infant's unusual health concerns, contacted therapist for psychotherapy and nonmedical interventions for her pain. Due to media misconceptions and a close friend who was experiencing very fast therapeutic progress, client expected relief from her back pain with one hypnotic session and only a few sessions to remedy her depression. In their first telephone contact, therapist clarified that the process would probably take longer than she anticipated, involving history taking, possible psychological testing, relaxation, biofeedback or self-hypnotic training, psychotherapy, and perhaps other interventions. He described the importance of each stage and how collectively they maximize treatment, and that other practitioners may work differently but his method has proven effective through years of experience with chronic pain and depression. Counselor explained that he used cognitive-

behavioral principles that are research-tested for improving pain disorders and associated symptoms, and he would coordinate treatment with her physician and specialists through consent forms to permit communication. Therapist addressed client's concern over fees and expected duration of therapy because she was previously told by another therapist that significant pain relief would occur in two or three sessions. Client felt enlightened by the discussion and appreciative of therapist taking time to explain fundamental issues and answer her questions, at no cost; she chose this therapist and was pleased with the outcome.

Upon arrival at her first session, therapist gave client a printed disclosure statement explaining other aspects of informed consent in detail, including confidentiality and its limitations, fees and third-party reimbursement, duration of therapy, cancellations and missed appointments, telephone availability and emergencies, collaboration with other health care professionals or psychologists, and interruptions to therapy such as vacations. Since therapist's practice was HIPAA compliant, he issued client a second handout indicating her rights and other relevant information required by law.

Analysis: Therapist effectively obtained informed consent before the onset of treatment and informed about the nature of the therapy and how it would likely proceed. He discussed financial matters, third-party involvement (which could include previous therapists, family members, and physicians), and confidentiality rules and exceptions. Therapists can view the informed consent process as though they are enlightening a friend or family member about the nature and expected path of treatment in an unhurried manner while addressing questions and concerns (Nagy, 2005).

Case 2-7: Therapist created a new program for overweight people to lose weight for which supporting research in the literature was scarce. The written informed consent material clearly described the procedure and the information was explained again at the first consultation. Counselor informed clients of very specific risks potentially associated with this protocol, that no weight loss might occur even with compliance to treatment, and the method was too new to assure long-term results. He reported the availability of many weight loss programs in the area, and in writing and verbally, expressed that participation was voluntary and could be withdrawn at any time; with such termination, he would refer to three other practitioners using different methods. Clients felt well informed about the novel approach given the printed handouts and verbal explanation provided at the outset.

Analysis: Therapist informed his clients about the novel techniques, interventions, strategies and procedures for which supportive research was lacking and not generally accepted by the mental health community. Informed consent regarding novel treatment includes these elements:

- Explain the experimental or evolving nature of the treatment, for example, that you have achieved good outcomes, if true, but the procedure is yet to be

scientifically researched.

- Inform clients of possible risks such as the treatment may not be successful, symptoms may increase, or new symptoms or side effects might develop.
- Enlighten clients of available alternative treatments for their issues, regardless of whether you will offer them.
- State that participation is completely voluntary and may be withdrawn at any time (Nagy, 2005).

The APAs Ethical Standard relating to informing clients of new methodology states:

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 (APA, 2002, 10.01.b.).

Case 2-8: By telephone, Therapist L told a prospective client, who was depressed and anorectic, that individual psychotherapy would rapidly relieve her symptoms and improve her work performance within nine sessions – coinciding with the number of managed care sessions allotted. Therapist L did not mention that: depression is sometimes exacerbated during therapy, treatment may last longer than expected, a managed care request for additional sessions may be needed, there may be a need for psychiatrist assessment for antidepressant medication or a need to coordinate treatment with her referring primary care physician. Therapist used complex terms in describing her theoretical orientation, which client did not comprehend, and she omitted discussion of confidentiality, possible need for hospitalization, fees or frequency of sessions. When client arrived for the first session, she was disappointed to learn that the fees were \$175.00 per session and three sessions per week was recommended. Client ended the encounter, felt betrayed and ashamed, and delayed contacting another therapist for several months.

Analysis: Therapist L did not inform client of the relevant aspects of the proposed treatment or the business arrangements, and she presented the therapy unrealistically through potentially false promises of efficacy and timeframe. Generally, clients should understand what therapist has planned through a) clear description of the proposed treatment, b) explanation of significant aspects of the services, c) a willing consent to services, and d) therapist documents the consent (Nagy, 2000).

Case 2-9: Psychologist M conducted a pre-sentencing psychological evaluation of Mr. A which would assist the court in determining whether to sentence Mr. A to death for conviction of murder of two children. Psychologist M informed Mr. A that the judge asked her to complete an evaluation to acquire information that might affect whether or not he would receive the death penalty. She clarified that in their state, the courts could deem certain psychological problems or histories as either mitigating or aggravating factors which would decrease or increase, respectively, the probability of the death penalty. The psychologist

illuminated that her job was to provide psychological data to the court which the judge would use to decide and that it was difficult to gauge the judge's interpretation of the data. Psychologist M stated that she would not administer projective tests because people may not be aware of how much they are revealing on such tests and she wanted Mr. A to choose the information to disclose in the evaluation. The district attorney, who referred the case to Psychologist M, was so upset that she disclosed such detailed information to Mr. A about the sentencing and evaluation procedures that he filed a complaint with the Ethics Committee.

Adjudication: The Ethics Committee determined that Psychologist M was ethical and actually exemplary in clarifying her role and offering fully informed consent. The Committee explained that informed consent obligations are always important but are intensified when vital and irrevocable consequences for the client's life are involved. Important civil and legal rights are involved when conducting an evaluation for the death penalty, a custody or competency hearing, therefore, therapists should fully inform clients of the practitioner's role and purpose of the evaluation (APA, 1987).

Case 2-10: Psychologist N performed a divorce mediation with a couple, Mr. and Mrs. B, regarding the custody of their child. Psychologist N informed the couple of the goals and methods of mediation such that they would meet for eight sessions to arrive at an agreeable custody arrangement. They did not reach an agreement as conflict mounted, hence, the case was returned to the court for adjudication. Psychologist N then voluntarily issued a psychological evaluation report to the court which recommended Mr. B to be granted custody of the child, partly due to his more acquiescent presentation during mediation, perhaps facilitating allowance of the child to have unobstructed visitation rights. Mrs. B filed a complaint about the report with the Ethics Committee. Psychologist N told the Committee that it was her general practice to submit evaluation reports to the court after failed mediation attempts and that there is nothing wrong with doing so.

Adjudication: The Ethics Committee declared Psychologist N violated informed consent standards by not clarifying her role in the process and not informing the couple of the purpose and nature of their eight sessions. She did not indicate, from the beginning, that her role was as mediator and evaluator, further, she failed to explain to the couple that the mediation evaluation information might be used in the custody adjudication, if needed. The Committee determined that Psychologist N also breached confidentiality by releasing information from the sessions without either a court order or the couple's permission. The Ethics Committee censured the psychologist and ordered her forensic practice under the supervision of a board-certified forensic psychologist, selected by the Committee (APA, 1987).

Case 2-11: The director of a firm referred an ineffective employee of the firm to Psychologist O for evaluation. The

firm director and psychologist agreed before the employee's first consultation that the psychologist would tell the director whether the evaluation suggested the employee's job continuation and if remedial training might improve his performance. Employee saw psychologist for several sessions involving interviews and testing, under the impression that all shared information was confidential. Psychologist O never informed employee of the arrangement with the firm. The director fired the employee upon receipt of psychologist's report. The employee deduced the psychologist's involvement and filed charges with the Ethics Committee. Psychologist O told the Committee that he thought the employer would advise employee of the purpose and possible implications of the evaluation, thus, he did not feel a need to raise the issue.

Adjudication: The Ethics Committee found Psychologist O in violation of informed consent standards based on his failure to clarify with client the nature of involvement between the three parties. Practitioner had the ethical responsibility to be explicit with client unrelated to psychologist's understanding of the employer's plans. The Committee censured Psychologist O (APA, 1987).

Case 2-12: A clinical agency hired Psychologist P as a researcher to design an evaluation study comparing the effectiveness of two depression-treatment therapeutic modalities: a behavioral group program and a psychotropic medication program with supportive psychotherapy. The clinic preferred to randomly assign clients to either treatment and psychologist expressed that informed consent is needed for randomization and participation in the intervention and evaluation process. The clinic director, not an APA member, countered that there was no need for the clinic to inform clients they were participating in a research study. Psychologist P was uncomfortable with this decision and with the thought of endangering her position; she requested guidance from the Ethics Committee.

Opinion: The Ethics Committee instructed Psychologist P of her responsibility to conform with the Ethical Principles and any relevant state or federal regulations. Continued involvement in the study was deemed contingent upon Psychologist P convincing the clinic to abide by informed consent obligations or forcing compliance through filing a complaint with APA or proper state body (APA, 1987).

Case 2-13: A psychologist began therapy with a client at the agreed-upon rate of \$70.00 per session. After several weeks of therapy, client called on the morning of a scheduled appointment stating he was in court and would have to miss that session. Client was very angry to see the missed session was charged on his monthly statement and upon questioning the psychologist was told that this is standard practice and that he, being an educated person, would understand this. Client filed a complaint with the Ethics Committee explaining he gave ample notice for the missed session and that no mutual agreement of required payment for cancelled

sessions was ever made. The psychologist issued the Committee the same rationale as given to the client. Adjudication: The Ethics Committee determined that the psychologist violated informed consent requirements by not ensuring all financial arrangements were clear to client before therapy began. The committee reprimanded the psychologist, authorized the missed session charge be cancelled, and required more open communication with her clients in the future (APA, 1987).

Weinrach (1989) suggested that the two most frequent problems for private practitioners involve fees and billing, and late cancellations or no-shows, thus, practitioners will want to be clear regarding payment methods and missed appointments.

Ethically, informed consent is a recurring process rather than a single event and documenting discussion of informed consent throughout the therapy process is advised. As therapy moves forward, goals, concerns, risks, and benefits may evolve to a different level, hence, logic dictates that clients require updated information to facilitate continued sound decisions (Handelsman, 2001).

Glosoff (1998) recommends therapists to expand informed consent information to clients in managed care systems compared to other clients; discussion would include how clients' specific plan will affect length of treatment, types of available treatment, confidentiality limits, development of treatment plans, and how diagnoses are made and used. Practitioners are encouraged to know the requirements of their clients' managed care company, but if this proves impractical, to advise their clients to understand the terms and limits of their coverage.

Obtaining informed consent is research validated to be a worthy endeavor. Studies show that clients want information about their prospective therapists (Braaten, Otto, & Handelsman, 1993; Hendrick, 1988); and they perceive therapists who offer informed consent information to be more professional and trustworthy (Sullivan, Martin, & Handelsman, 1993). Moreover, informed consent forms can help prevent some legal problems if allegations of nondisclosure occur as the client-signed disclosure statement may exonerate a falsely accused therapist.

REFERENCES

- Acker, G. M. (1999). The impact of clients' mental illness on social workers' job satisfaction and burnout. *Health and Social Work, 24*, 112-119.
- American Association for Marriage and Family Therapy. (2001). Code of ethics. Alexandria, VA.
- American Counseling Association. (2005). Code of ethics. Alexandria, VA: author.
- American Psychological Association. (1975). Report on the Task Force on Sex Bias and Sex-Role Stereotyping in Psychotherapeutic Practice. *American Psychologist, 30*, 1169-1175.
- American Psychological Association. (1987). *Casebook on ethical principles of psychologists*. Washington, DC.
- American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47*, 1597-1611.
- American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57*, (12), 1060-1073.
- Appelbaum, P. S., Lidz, C. W., & Meisel, A. (1987). *Informed consent: Legal theory and clinical practice*. New York: Oxford University Press.
- Appelbaum, P. S. (2004). Law and psychiatry: Psychiatric advance directives and the treatment of committed patients. *Psychiatric Services, 55*, 751-763.
- Baker, E. K. (2003). *Caring for ourselves: A therapist's guide to personal and professional well-being*. Washington, DC: American Psychological Association.
- Becker-Blease, K. A., & Freyd, J. H. (2006). Research participants telling the truth about their lives: The ethics of asking and not asking about abuse. *American Psychologist, 61*, 218-226.
- Bennett, B. E., Bricklin, P. M., Harris, E. A., Knapp, S., VandeCreek, L., & Younggren, J. N. (2007). *Assessing and managing risk in psychological practice: An individualized approach*. Rockville, MD: American Psychological Association Insurance Trust.
- Berner, M. (1998). Informed consent. In L. E. Lifson, & R. I. Simon (Eds.), *The mental health practitioner and the law* (pp. 23-43). Cambridge, MA: Harvard University Press.
- Braaten, E. E., Otto, S., & Handelsman, M. M. (1993). What do people want to know about psychotherapy? *Psychotherapy, 30*, 565-570.
- Bray, J. H., Shepherd, H. N., & Hays, J. R. (1985). Legal and ethical issues in informed consent to psychotherapy. *American Journal of Family Therapy, 13*, 50-60.
- Brenner, A. M. (2006). The role of personal psychodynamic psychotherapy in becoming a competent psychiatrist. *Harvard Review of Psychiatry, 14*, 268-272.
- Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir 1972).
- Cassileth, B. R., Zupkis, R. V., Sutton-Smith, K., & March, V. (1980). Informed consent – Why are its goals imperfectly realized? *New England Journal of Medicine, 323*, 896-900.
- Claiborn, W. L. (1982). The problem of professional incompetence. *Professional Psychology, 13*, 153-158.
- Cobbs v. Grant*, 502 P.2d 1,8 Cal.3d.229 (1972).
- Corey, G., Corey, M., & Callahan, P. (1998). *Issues and ethics in the helping professions*. Pacific Grove, CA: Brooks/Cole.
- Corey, G., Corey, M., & Callahan, P. (2007). *Issues and ethics in the helping professions* (7th ed.). Pacific Grove, CA: Brooks/Cole.
- Coster, J. S., & Schwebel, M. (1997). Well-functioning in professional psychologists. *Professional Psychology: Research and Practice, 28*, 5-13.
- Dupree, P. I., & Day, H. D. (1995). Psychotherapists' job satisfaction and job burnout as a function of work setting and percentage of managed care clients. *Psychotherapy in Private Practice, 14*, 77-93.
- Everstein, L., Everstein, D. S., Heymann, G. M., True, R. H., Frey, D. H., Johnson, H. G., et al. (1980). Privacy and confidentiality in psychotherapy. *American Psychologist, 35*, 828-840.
- Fisher, C. B. (2003). *Decoding the ethics code: A practical guide for psychologists*. Thousand Oaks, CA: Sage Publications.
- Ford, G. G. (2001). *Ethical reasoning in the mental health professions*. Boca Raton, FL: CRC Press.
- Glosoff, H. L., Garcia, J., Herlihy, B., & Remley, T. P., Jr. (1999). Managed care: Ethical considerations for counselors. *Counseling and Values, 44*, 8-16.
- Glosoff, H. L. (1998). Managed care: A critical ethical issue for counselors. *Counseling and Human Development, 31*(2), 1-16.
- Golden, L. (1992). Dual role relationships in private practice. In B. Herlihy & G. Corey, *Dual relationships in counseling* (pp. 130-133). Alexandria, VA: American Association for Counseling and Development.
- Grundner, T. M. (1980). On the readability of surgical consent forms. *New England Journal of Medicine, 302*, 900-902.
- Guy, J. D., Poelstra, P. L., & Stark, M. J. (1989). Personal distress and therapeutic effectiveness: National survey of psychologists practicing psychotherapy. *Professional Psychology: Research and Practice, 20*, 48-50.
- Haas, L. J., & Malouf, J. L. (1995). *Keeping up the good work: A practitioner's guide to mental health ethics* (2nd ed.). Sarasota, FL: Professional Resource Exchange.
- Halderman, D. E. (2006). Queer eye on the straight guy: A case of male heterophobia. In M. Englar-Carlson & M. A. Stevens (Eds.), *In the room with men: A casebook of therapeutic change* (pp. 301-317). Washington, DC: American Psychological Association.

ETHICS: CASE STUDIES I

- Handler, J. F. (1990). *Law and the search for community*. Philadelphia: University of Pennsylvania Press.
- Handelsman, M. M. (2001). Accurate and effective informed consent. In E. R. Welfel & R. E. Engersoll (Eds.), *The mental health desk reference* (pp. 453-458). New York: Wiley.
- Hare-Mustin, R. T., Marecek, J., Kaplan, A. G., & Liss-Levenson, N. (1979). Rights of clients, responsibilities of therapists. *American Psychologist*, 34, 3-16.
- Health Insurance Portability and Accountability Act, Pub. L. No. 104-191 (1996).
- Hendrick, S. S. (1988). Counselor self-disclosure. *Journal of Counseling and Development*, 66, 419-424.
- Herlihy, B., & Corey, G. (1996). *ACA ethical standards casebook* (5th Ed.). American Counseling Association. Alexandria, VA:
- Irwin, M., Lovitz, A., Marder, S. R., Mintz, J., Winslade, W. J., Van Putten, T., & Mills, M. J. (1985). Psychotic patients' understanding of informed consent. *American Journal of Psychiatry*, 142, 1351-1354.
- J...L. v. Parham*, 412 112 (M.D. Ga. 1976).
- Jenkins, S. R., & Maslach, C. (1994). Psychological health and involvement in interpersonally demanding occupations. A longitudinal perspective. *Journal of Organizational Behavior*, 15, 101-127.
- Jones, J. H. (1981). *Bad blood: The Tuskegee syphilis experiment – A tragedy of race and medicine*. New York: Free Press.
- Kaslow, N. J. (Ed.). (2004). Competencies conference – Future directions in education and credentialing in professional psychology (Special issue). *Journal of Clinical Psychology*, 60.
- Kitchener, K. S. (2000). *Foundations of ethical practice, research, and teaching in psychology*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Kitzrow, M. A. (2002). Survey of CACREP-accredited programs: Training counselors to provide treatment for sexual abuse. *Counselor Education and Supervision*, 42, 107-118.
- Knapp, S. & VandeCreek, L. (2006). *Practical ethics for psychologists: A positive approach*. Washington, DC: American Psychological Association.
- Koeske, G. G., & Kelly, T. (1995). The impact of overinvolvement on burnout and job satisfaction. *American Journal of Orthopsychiatry*, 65, 282-292.
- Koocher, G. P. (1980). Pediatric cancer: Psychosocial problems and the high costs of helping. *Journal of Clinical Child Psychology*, 9, 2-5.
- Koocher, G. P. (1995). Ethics in child psychotherapy. *Child and Adolescent Psychiatric Clinics of North America*, 4, 779-791.
- Koocher, G. P. (2003). Ethical issues in psychotherapy with adolescents. *Journal of Clinical Psychology*, 59, 1247-1256.
- Koocher, G. P., & Keith-Spiegel, P. (2008). *Ethics in psychology and the mental health professions: Standards and cases* (3rd Ed.). New York: Oxford University Press.
- Kutz, S. I. (1986). Defining "impaired psychologists." *American Psychologist*, 41, 220.
- Lee, R. T., & Ashforth, B. E. (1996). A meta-analytic examination of the correlates of the three dimensions of job burnout. *Journal of Applied Psychology*, 81, 123-133.
- Mahoney, M. J. (1997). Psychotherapists' personal problems and self-care patterns. *Professional Psychology: Research and Practice*, 28, 14-16.
- Marczyk, G. R., & Wertheimer, E. (2001). The bitter pill of empiricism: Health maintenance organizations, informed consent and the reasonable psychotherapist standard of care. *Villanova Law Review*, 46, 33. Retrieved October 11, 2003, from http://seg802.ocs.lsu.edu:2077/universe/document?_m=195e04421e4f907ab553bdcf3alfaf13&_docnum=7&wchp=dGLbVzz-zSkVb&_md5=37660fdcd2980a347aef6ae3153e475
- Maslach, C. (1993). Burnout: A multidimensional perspective. In W. B. Schaufeli, C. Maslach, & T. Marek (Eds.), *Professional burnout: Recent developments in theory and research*. (pp. 19-32). Philadelphia: Taylor & Francis.
- Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology*, 52, 397-422.
- Maxie, A. C., Arnold, D. H., & Stephenson, M. (2006). Do therapists address ethnic and racial differences in cross-cultural psychotherapy? *Psychotherapy: Theory, Research, Practice, Training*, 43, 85-98.
- McKnight, J. D., & Glass, D. C., (1995). Perceptions of control, burnout, and depressive symptomatology: A replication and extension. *Journal of Consulting and Clinical Psychology*, 63, 490-494.
- McNeil, B., Pauker, S. G., Sox, H. C., & Tversky, A. (1982). On the elucidation of preferences for alternative therapies. *New England Journal of Medicine*, 306, 1259-1262.
- Meara, N. M., Schmidt, L. D., & Day, J. D. (1996). Principles and virtues: A foundation for ethical decisions, policies and character. *The Counseling Psychologist*, 24(1), 4-77.
- Melton, G. B., Koocher, G. P., & Saks, M. J. (1983). *Children's competence to consent*. New York: Plenum Press.
- Miller, L. (1998). Our own medicine: Traumatized psychotherapists and the stresses of doing therapy. *Psychotherapy*, 35, 137-146.
- Nagy, T. F. (2000). *Ethics in plain English: An illustrative casebook for psychologists*. Washington, DC: American Psychological Association.
- Nagy, T. F. (2005). *Ethics in plain English: An illustrative casebook for psychologists* (2nd ed.). Washington, DC: American Psychological Association.
- Natanson v. Kline*, 186 Kans. 393, 406, 350, 350 P.2d 1093 (1960).
- Nathan, P. E. (1986). Unanswered questions about distressed professionals. In R. R. Kilburg, P. E. Nathan, & R. W. Thoreson (Eds.), *Professionals in distress: Issues, syndromes, and solutions in psychology* (pp. 27-36). Washington DC: American Psychological Association.
- National Association of Social Workers. (1999). *Code of ethics*. Washington, DC: Author.
- Neukrug, E., Milliken, T., & Walden, S. (2001). Ethical complaints made against credentialed counselors: An updated survey of state licensing boards. *Counselor Education and Supervision*, 41, 57-70.
- O'Connor v. Donaldson*, 575 (422 U.S. 1975).
- Packard, T., Simon, N. P., & Vaughn, T. J. (2006). Board certification by the American Board of Professional Psychology. In T. J. Vaughn (Ed.), *Psychology licensure and certification: What students need to know* (pp. 117-126). Washington, DC: American Psychological Association.
- Parham v. J. R.*, 442 U.S. 584 (S. Ct. 1979).
- Peterson, D. R., & Bry, B. H. (1980). Dimensions of perceived competence in professional psychology. *Professional Psychology*, 11, 965-971.
- Pope, K. S., & Brown, L. S. (1996). *Recovered memories of abuse: Assessment, therapy, forensics*. Washington, DC: American Psychological Association.
- Pope, K. S., & Morin, S. F. (1990). AIDS and HIV infection update: New research, ethical responsibilities, evolving legal frameworks, and published resources. *Independent Practitioner*, 10, pp. 43-53.
- Pope, K. S., & Vasquez, M. J. T. (1991). *Ethics in psychotherapy and counseling*. San Francisco: Jossey-Bass.
- Pope, K. S., & Vasquez, M. J. T. (1998). *Ethics in psychotherapy and counseling: A practical guide for psychologists* (2nd ed.), San Francisco: Jossey-Bass.
- Pope, K. S., & Vasquez, M. J. T. (2005). *How to survive and thrive as a therapist: Information, ideas, and resources for psychologists*. Washington, DC: American Psychological Association, 2005.
- Pope, K. S., Sonne, J. L., & Greene, B. (2006). *What therapists don't talk about and why: Understanding taboos that hurt us and our clients*. Washington, DC: American Psychological Association.
- Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, P. (1987). Good news and poor practices in psychotherapy: National survey on beliefs of psychologists. *Professional Psychology: Research and Practice*, 19, 547-552.
- Pryzwansky, W. B., & Wendt, R. N. (1999). *Professional and ethical issues in psychology: Foundations of practice*. New York: W. W. Norton & Co.
- Remley, T. & Herlihy, B. (2007). *Ethical, legal, and professional issues in counseling* (2nd Ed.). New Jersey: Pearson Education, Inc.
- Rivers, E., Schuman, S., Simpson, L., & Olansky, S. (1953). Twenty years of follow-up experience in long-range medical study. *Public Health Reports*, 68, 391-395.
- Robinson, G., & Merav, A. (1976). Informed consent: Recall by patients tested postoperatively. *Annals of Thoracic Surgery*, 22, 209-212.
- Rupert, P. A., & Morgan, D. J. (2005). Work setting and burnout among professional psychologists. *Professional Psychology*, 36, 544-550.

ETHICS: CASE STUDIES I

- Salgo v. Leland Stanford Jr. Univ. Bd. Of Trustees*, 317 P.2d 170 (Cal. Ct. App. 1957).
- Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92 (1914).
- Schwebel, M., Skorina, J. K., & Schoener, O. (1994). *Assisting impaired psychologists: Program development for state psychological associations* (Rev. ed.), Washington, DC: American Psychological Association.
- Sell v. United States*, 539 (U.S. 166 2003).
- Shiron, A. (2006). Job-related burnout: A review. In J. C. Quick & L. E. Tetrick (Eds.), *Handbook of occupational health psychology* (pp. 245-264). Washington, DC: American Psychological Association.
- Skorupa, J., & Agresti, A. A. (1993). Ethical beliefs about burnout and continued professional practice. *Professional Psychology: Research and Practice*, 24, 281-285.
- Slater v. Baker & Stapleton*, 95 Eng. Rep. 860 (K.B. 1767).
- Stevens, N. (1990, August 25). Did I say average? I meant superior. *New York Times*, p. 15.
- Stromberg, C., & Dellinger, A. (1993). A legal update on malpractice and other professional liability. *The Psychologist's Legal Update*, 3, 3-15.
- Sullivan, T., Martin, W., & Handelsman, M. (1993). Practical benefits of an informed consent procedure: An empirical investigation. *Professional Psychology: Research and Practice*, 24, 160-163.
- Tabachnick, B., Keith-Spiegel, P. & Pope, K. S. (1991). Ethics of teaching: Beliefs and behaviors of psychologists as educators. *American Psychologists*, 46, 506-515.
- Thoreson, R. W., Miller, M., & Krauskopf, C. J. (1989). The distressed psychologist: Prevalence and treatment considerations. *Professional Psychology: Research and Practice*, 20, 153-158.
- Truman v. Thomas*, California, 611 P.2d 902.27 Cal. 3d 285 (1980).
- Tryon, G., & Winograd, G. (2001). Goal consensus and collaboration. *Psychotherapy: Theory, Research, Practice, Training*, 38, 385-389.
- U. S. Public Health Service. (1973). *Final report of the Tuskegee syphilis study ad hoc advisory panel*. Washington, DC: Author.
- Vogel, D. L., & Wester, S. R. (2003). To seek help or not to seek help: The risks of self-disclosure. *Journal of Counseling Psychology*, 50, 351-361.
- Vredenburgh, L. D., Carlozzi, A. F., & Stein, L. B. (1999). Burnout in counseling psychologists: Type of practice setting and pertinent demographics. *Counseling Psychology Quarterly*, 12, 293-302.
- Weinrach, S. G. (1989). Guidelines for clients of private practitioners: Committing the structure to print. *Journal of Counseling and Development*, 67, 299-300.
- Weithorn, L. A. (Ed.). (1987). *Psychology and child custody determination: Knowledge, roles, and expertise*. Lincoln, NE: University of Nebraska Press.
- Weithorn, L. A. (2006). The legal contexts of forensic assessment of children and families. In S. N. Sparta & G. P. Koocher (Eds.), *Forensic mental health assessment of children and adolescents* (pp. 11-29). New York: Oxford University Press.
- Welfel, E. R. (2006). *Ethics in counseling and psychotherapy: Standards, research, and emerging issues* (3rd ed.). Pacific Grove, CA: Brooks/Cole.

TEST - ETHICS: CASE STUDIES I

6 Continuing Education Contact Hours

Record your answers on the Answer Sheet (click the "Michigan Answer Sheet" link on Home Page and click your answers).

Passing is 70% or better.

For True/False questions: A = True and B = False.

TRUE/FALSE

1. **Uniform agreement within the mental health field on the definition of competence is lacking.**
A) True B) False
2. **Therapists have an ethical responsibility to practice in specialty areas that are new to them only after obtaining suitable education, training, and supervised experience.**
A) True B) False
3. **Psychotherapists are competent to treat all people for all issues.**
A) True B) False
4. **In cases 1-4 and 1-5, both therapists are offering below-standard treatment resulting from failure to keep abreast with advancements in the field.**
A) True B) False
5. **The decision to terminate therapy is based on the best interest of the client.**
A) True B) False
6. **A therapist ethical responsibility exists to explain the informed consent information to client.**
A) True B) False
7. **Ethically, informed consent is a recurring process rather than a single event.**
A) True B) False
8. **A mechanical and obligatory response from clients that they understand the informed consent form is always reliable.**
A) True B) False
9. **Studies show that clients perceive therapists who offer informed consent information to be more professional and trustworthy.**
A) True B) False
10. **Informing clients how therapy works demystifies the relationship and empowers their active involvement.**
A) True B) False
11. **The Codes of Ethics of the professional mental health organizations serve to educate members about ____.**
A) sound ethical conduct
B) professional accountability
C) improved practice through mandatory and aspirational ethics
D) all of the above
12. **Therapist impairment _____.**
A) is a deterioration of professional abilities from a previous competent level
B) occurs when therapists' personal problems overflow into their professional activity
C) decreases therapeutic effectiveness
D) all of the above
13. **Competent professionals uphold two essential ethical principles: beneficence and _____.**
A) nonmaleficence
B) benevolence
C) being helpful to client
D) honesty
14. **In case 1-10, Therapist D learned of the _____.**
A) need to mirror client
B) importance to seek education, supervision, and consultation when entering into new specialty areas
C) value of comprehensive session notes
D) benefits of active listening
15. **_____ is defined as a type of emotional exhaustion due to extreme demands on energy, strength, and personal resources in the workplace.**
A) Depression
B) Melancholia
C) Burnout
D) Dysthymic Disorder

This course, Ethics: Case Studies I, is accepted for 6 continuing education contact hours by the Michigan Board of Social Work for Michigan social workers via approval by the National Association of Social Workers (NASW Provider ID # 886398989), and the California (PCE 2156), Texas (Provider # 3329), New Jersey, Illinois (Provider # 159-000806), and Florida (Provider # 50-446) State Social Work Boards.

16. **Studies demonstrate that informed consent procedures increase likelihood that clients will _____.**
- A) become less anxious
 - B) follow the treatment plan
 - C) recover more quickly
 - D) all of the above
17. **Glosoff recommends therapists to expand informed consent information to clients in managed care systems, including _____.**
- A) how clients' specific plan will affect length of treatment
 - B) confidentiality limits
 - C) how diagnoses are made and used
 - D) all of the above
18. _____ **provides relevant information to clients regarding expectations of therapy before onset of assessment or treatment.**
- A) Informed consent
 - B) Empiricism
 - C) Naturalistic observation
 - D) Deductive reasoning
19. **The requirement for health professionals to secure informed consent from their clientele prior to rendering services started in the field of _____.**
- A) dentistry
 - B) medicine
 - C) communication
 - D) linguistics
20. **Failure to provide informed consent is illustrated in the _____.**
- A) Coalition of Coal Miners study
 - B) Federation of Teachers project
 - C) Tuskegee syphilis study
 - D) Tennessee Heart Research Project

Please transfer your answers to the Answer Sheet (click the "Michigan Answer Sheet" link on Home Page and click your answers).

Press "Back" to return to "Michigan Courses" page.