

# Ethics & Malpractice

## Ethical Dilemmas Encountered by Members of the American Psychological Association: A National Survey

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**ABSTRACT:** A random sample of 1,319 members of the American Psychological Association (APA) were asked to describe incidents that they found ethically challenging or troubling. Responses from 679 psychologists described 703 incidents in 23 categories. This process of gathering critical incidents from the general membership, pioneered by those who developed APA's original code of ethics, may be useful in considering possible revisions of the code and preserving APA's unique approach to identifying ethical principles that address realistically the emerging dilemmas that the diverse membership confronts in the day-to-day work of psychology.

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Founded in 1892, the American Psychological Association (APA) faced ethical problems without a formal code of ethics for 60 years. As the chair of the Committee on Scientific and Professional Ethics and Conduct in the early 1950s observed,

In the early years of the American Psychological Association, the problems of ethics were relatively simple. We were essentially an organization of college teachers. The only ethical problems which seemed to present themselves were those of plagiarism and of academic freedom. (Rich, 1952, p. 440)

The Committee on Scientific and Professional Ethics was created in 1938 and began handling complaints on an informal basis ("A Little Recent History," 1952). By 1947, the committee recommended that APA develop a formal code. "The present unwritten code...is tenuous, elusive, and unsatisfactory" ("A Little Recent History," 1952, p. 427).

The method used to create the formal code was innovative and unique, an extraordinary break from the traditional methods used previously by more than 500 professional and business associations (Hobbs, 1948 ). Setting aside what Hobbs termed the "armchair approach" (p. 82) in which a committee of those "who are most mature, in wisdom, experience, and knowledge of their fellow psychologists" (p. 81) would study the various available codes, issues, and literature and then submit a draft to the membership for approval, APA decided to create "an empirically developed code" based on an investigation of the ethical dilemmas encountered by a "representative sample of members": "The research itself would involve the collection, from

psychologists involved in all of the various professional activities, of descriptions of actual situations which required ethical decisions" (p. 83). A survey collecting examples of the ethical dilemmas encountered by APA members led to a draft code (APA Committee on Ethical Standards for Psychology, 1951a, 1951b, 1951c) that was refined and approved in 1952 (APA, 1953). APA had created a process through which it could produce "a code of ethics truly indigenous to psychology, a code that could be lived" (Hobbs, 1948, p. 84).

The 1959 revision, the result of nine drafts over a three-year period, was adopted for use on a trial basis (APA, 1959). The committee anticipated that future revisions would be necessary to address changing conditions of practice:

The Committee on Ethical Standards hopes that these major principles stated in general form will weather considerable growth of psychology without drastic alteration. Unlike the general principles, the explanatory paragraphs which accompany them are quite specific and, therefore, subject to change or extension as the need arises. They may serve the purpose fairly well for the present, but it would be a sad mistake indeed to assume that there is little left to say about the ethical behavior of psychologists! (Holzman, 1960, p. 247).

To maintain the unique nature and effectiveness of the code, future revisions were to be based not only on discussion among members but also on "additional critical incidents of controversial behavior" (Holzman, 1960, p. 247). To base revisions on recommendations by ethics committees seemed inadequate because "the energies of ethics committees are so totally devoted to fire fighting that fire proofing or concern with problems that have not yet emerged in the form of complaints must take a lower priority" (Golann, 1969, p. 454). Moreover, if the existing code neglected certain issues or dilemmas, individuals would obviously have no basis on which to file complaints relevant to those issues or dilemmas; thus there could be extreme discrepancies between the issues brought to the attention of an ethics committee and the issues encountered by the diverse membership. Even if a committee of experts were to develop ethical standards for diverse areas, they would, according to the rationale of the original code, likely overlook problems in implementing those standards that would be obvious to someone whose day-to-day work was in one of those areas.

The conviction that revisions should be based on subsequent critical incident studies was also based on beliefs about empowerment, management style, group process, and allegiance (e.g., Golann, 1969; Hobbs, 1948; Holzman, 1960). This conviction reflected the assumption that two ways of developing a revision would produce very different results. In the first approach, unique to psychology, the revision process would begin by actively soliciting through a formal mail survey the observations, ideas, and questions from those working "on the front lines" in diverse specialties, settings, and circumstances. A revision committee would then base its work on the

primary data of this survey. In the alternate approach, used by virtually all other professional and business associations, a committee would decide how the code should be revised. The draft would then be circulated or published along with an announcement inviting comments. The first approach, as a style for managing the revision process, was considered to empower individual members by involving them meaningfully at the beginning of the project. The process seemed likely not only to lead to a better revision but also to create and benefit from better group dynamics. The membership would be involved at ground level in the revision process, an involvement more likely to foster a psychological sense of community and a personal as well as professional allegiance to the revised code.

The unique nature of the code was that it was "based upon the day-to-day decisions made by psychologists in the practice of their profession, rather than prescribed by a committee" (Golann, 1969, p. 454). Basing revisions on recent critical incidents provided by the membership was believed necessary to maintain an ethical code "close enough to the contemporary scene to win the genuine acceptance of the majority who are most directly affected by its principles" (Holzman, 1960, p. 250).

Although studies in which investigators usually specified the dilemmas to be addressed have examined various ethical issues in specific topic areas by surveying speciality groups, APA never again conducted a mail survey of a representative sample of the membership as the basis for revising the general code. However, the Ad Hoc Committee on Ethical Standards in Psychological Research, appointed by the Board of Directors in 1966, patterned its work in accordance with APA's heritage as "the first society to develop a code of ethics by means of empirical and participatory principles" (Committee for the Protection of Human Participants in Research, 1982, p. 10). They conducted an impressive pilot survey and two major mail surveys of APA membership as a foundation for the *Ethical Principles in the Conduct of Research with Human Participants* (Committee for the Protection of Human Participants in Research, 1982).

The purpose of the study reported in this article was to collect, from a representative sample of APA members, contemporary data of the type that provided the unique foundation for APA's ethics code and was intended as a basis for revisions.

## **METHOD**

A cover letter and survey form were developed to invite APA members to provide examples of the ethical dilemmas they faced in their work. A major objective of refining the survey form was to identify factors that would encourage participation in light of the original APA study's return rate of "approximately 15%," which has tended to be the range of "all surveys that request actual incidents regarding problems of ethics" (Golann, 1969, p. 456). Brevity and simplicity emerged as salient factors. Consequently, all questions regarding the participant's age, sex, and other related

information were eliminated. Participants were asked only to "describe, in a few words or more detail, an incident that you or a colleague have faced in the past year or two that was ethically challenging or troubling to you." They were asked to reply even if they had not encountered a troubling incident.

A table of random numbers was used to select 1,319 individuals listed as members or fellows in the APA membership directory. Each member was sent a cover letter, survey form, and stamped return envelope. When packages were returned as undeliverable, a replacement name was randomly selected from the directory.

## **RESULTS**

Replies were received from 679 psychologists, for a return rate of 51%. Fourteen respondents reported that they were retired and 3 reported that they were not working as psychologists. There were 134 respondents who indicated that they had not encountered ethically troubling incidents in the past year or two, as the following examples illustrate.

Happily, I am able to report no ethical problems in the past several years. Which is not to suggest that military research psychology is without its frustrations. The challenge is to convince leadership of the value of advice and analysis provided. This has become easier, albeit not easy. My work has been in both social and instructional settings.

As an Industrial/Organizational psychologist I have not encountered *any* issues that I believed were related to ethical challenges. Specifically when the context of our work has been explained to executives/managers relating to confidentiality/conflict of interest etc no one has *ever* challenged me or asked me to do something that would compromise the ethical standards of the APA. Essentially I have been surprised that more incidents have not occurred! I also believe that the ethics issues are much more clear cut than colleagues would like to believe. Either you are conforming or you're compromising. I believe the APA has set down very clear guidelines. If psychologists struggle with the guidelines then possibly their ability to form concise judgments in these areas are problems that should be examined.

Respondents provided 703 ethically troubling incidents in 23 general categories, as presented in **Table 1 (#table1)** . Examples of the ethical dilemmas are presented in the Discussion section.

Table 1 - Categories of 703 Ethically Troubling Incidents

<b>Category</b>	<b><i>n</i></b>	<b>%</b>
Confidentiality	128	18
Blurred, dual, or conflictual relationships	116	17

Payment sources, plans, settings, and methods	97	14
Academic settings, teaching dilemmas, and concerns about training	57	8
Forensic psychology	35	5
Research	29	4
Conduct of colleagues	29	4
Sexual issues	28	4
Assessment	25	4
Questionable or harmful interventions	20	3
Competence	20	3
Ethics (and related) codes and committees	17	2
School psychology	15	2
Publishing	14	2
Helping the financially stricken	13	2
Supervision	13	2
Advertising and (mis)representation	13	2
Industrial-organizational psychology	9	1
Medical issues	5	1
Termination	5	1
Ethnicity	4	1
Treatment records	4	1
Miscellaneous	7	1

## ***DISCUSSION***

The primary purpose of this discussion is to present examples of the critical incidents, highlighting areas and instances in which psychologists find themselves confronting ethical challenges in their day-to-day work. These incidents may be useful as a basis for discussion in graduate courses, workshops, and other settings in which ethics are a focus of formal or informal learning and exploration. Discussion of the issues was limited in order to present as many incidents as possible; however, in some sections, the issues are discussed in light of not only emerging theory and research but also the current ethical code and the most recent draft revision.

In the following sections, percentages are used only when based on the total number (703) of incidents; simple frequencies are used to refer to subsets and trends within each of the 23 general categories.

## *Confidentiality*

The most frequently described dilemmas involved confidentiality. Of these troubling or challenging incidents, 38 involved actual or potential risks to third parties, 23 involved child abuse reporting, 8 involved individuals infected with human immunodeficiency virus (HIV) or suffering from acquired immunodeficiency syndrome (AIDS), 6 involved patients who threatened or had committed violence, and 1 involved elder abuse.

An additional 79 dilemmas reveal that respondents are wrestling with agonizing questions about whether confidential information should be disclosed and, if so, to whom. The following were typical:

One girl underwent an abortion without the knowledge of her foster parents... I fully evaluated her view of the adults' inability to be supportive and agreed but worried about our relationship being damaged if I was discovered to know about the pregnancy and her action.

A colleague withheld information about a client from the therapist to whom she transferred the case (within the same agency). She did so on the grounds of maintaining client confidentiality. This case raises questions not only about client confidentiality and professional relationships, but about the limits of confidentiality within an agency setting.

The executive director of the Mental Health Clinic with which I'm employed used his position to obtain and review clinical patient files of clients who were members of his church. He was [clerical title] in an --- church and indicated his knowledge of this clinical (confidential) information would be of help to him in his role as [clerical title].

Having a psychologist as a client who tells me she has committed an ethical violation and because of confidentiality I can't report it.

One of my clients claimed she was raped; the police did not believe her and refused to follow up (because of her mental history). Another of my clients described how he raped a woman (the same woman).

The remaining 11 incidents involved respondents' concerns about the careless or unintentional disclosure of confidential information: for example, "A psychiatrist who leases me space and does some of my billing is careless about discussing patient names in front of other patients. What

should I do about this?"

In 1990, confidentiality accounted for only 2% of the primary category of active cases before the APA ethics committee ("Report of the Ethics Committee," 1991), yet participants in this research reported more struggles with confidentiality than any other category. This illustrates what the creators of the initial APA ethics code emphasized—that there may be a significant discrepancy between the ethical dilemmas encountered by the membership and the complaints received by the ethics committee, and therefore revisions to the code should be informed by the former as well as the latter.

Perhaps it is not surprising that confidentiality is the most frequently reported ethical dilemma reported by the membership. Although confidentiality is considered one of the most fundamental principles (Knapp & VandeCreek, 1987), and in some research has been endorsed by psychologists as the most important ethical duty (Crowe, Grogan, Jacobs, Lindsay, & Mark, 1985), national studies of psychologists have found that the most frequent *intentional* violations of formal standards involved confidentiality (**Pope & Bajt, 1988** (<http://www.kspope.com/ethics/research8.php>) ) and that more than half of the respondents reported *unintentionally* violating confidentiality (**Pope, Tabachnick, & Keith-Spiegel, 1987** (<http://www.kspope.com/ethics/research4.php>) ). So difficult is the task of formulating clear, useful, practical, and generally acceptable ethical principles in this area that in the late 1970s, at the end of nine years of work revising the code, APA was unable to agree on a revision of the confidentiality section.

Because the Council could not agree on several sections of Principle 5 (Confidentiality), the final action was to approve the final revised draft with the exception of this principle. The old principle (formerly Principle 6 in the Ethical Standards as printed in the 1975 *Biographical Directory* ) will hold until a revision has been adopted by Council. (APA, 1979, p. 1)

Although the incidents raise a variety of concerns, they highlight two critical areas that the most recent draft revision does not address adequately. First, the boundaries of confidentiality when multiple caregivers (including administrators and supervisors) or clients are involved (e.g., clinics, therapy groups, and participants in couple or family therapy) need to be explicitly discussed.

Second, some of the incidents, especially about mandatory child abuse reporting laws, illustrate situations in which some psychologists believe it is better to break the law and act on that belief (Kalichman, Craig, & Follingstad, 1989; Koocher & Keith-Spiegel, 1990; Pope & Bajt, **1988** (<http://www.kspope.com/ethics/research8.php>) ; Pope et al., **1987** (<http://www.kspope.com/ethics/research4.php>) ). Most psychologists are likely to have encountered dilemmas in which following legal requirements seemed clinically and ethically wrong, perhaps

placing the client or third parties at needless risk for harm and injustice (Pope & Bajt, 1988 (<http://www.kspope.com/ethics/research8.php>)). The current ethics code states that psychologists must adhere to the law "in the ordinary course of events" (APA, 1990, p. 391), implying that in extraordinary circumstances some form of resistance to a particular law might be an ethically acceptable course. The most recent draft revision, however, specifies a solution to conflicts between the law and ethics that "complies with the law and yet most nearly conforms to the ethics code" ("Draft," 1991, p. 35), implying that civil disobedience (Gandhi, 1948; King, 1958, 1964; Plato, 1956a, 1956b; Thoreau, 1849/1960) and related approaches are unethical. This issue is in need of careful exploration and vigorous, informed debate. For a presentation of philosophical approaches, research data, and case law on this topic as they are relevant to psychology, see Pope and Bajt (1988) and Pope and Vasquez (1998 (<http://www.kspope.com/ethics/ethics.php>)).

### *Blurred, Dual, or Conflictual Relationships*

The second most frequently described incidents involved maintaining clear, reasonable, and therapeutic boundaries around the professional relationship with a client. In some cases, respondents were troubled by such instances as serving as both "therapist and supervisor for hours for [patient/supervisee's] MFCC [marriage, family, and child counselor] license" or when "an agency hires one of its own clients." In other cases, respondents found dual relationships to be useful "to provide role modeling, nurturing and a giving quality to therapy"; one respondent, for example, believed that providing therapy to couples with whom he has social relationships and who are members of his small church makes sense because he is "able to see how these people interact in group context." In still other cases, respondents reported that it was sometimes difficult to know what constitutes a dual relationship or conflict of interest; for example, "I have employees/supervisees who were former clients and wonder if this is a dual relationship." Similarly, another respondent felt a conflict between his own romantic attraction to a patient's mother and responsibilities to the child who had developed a positive relationship with him:

I was conducting therapy with a child and soon became aware that there was a mutual attraction between myself and the child's mother. The strategies I had used and my rapport with the child had been positive. Nonetheless, I felt it necessary to refer to avoid a dual relationship (at the cost of the gains that had been made).

Taken as a whole, the incidents suggest, first, that the ethical principles need to define dual relationships more carefully and to note with clarity if and when they are therapeutically indicated or acceptable. For example, a statement such as "Minimal or remote relationships are unlikely to violate this standard" ("Draft," 1991, p. 32) may be too vague and ambiguous. A psychologist's relationship to a very casual acquaintance whom she or he meets for lunch a few times a year, to an accountant who only does very routine work in filling out her or his tax forms once a year (all



such business being conducted by mail), to her or his employer's husband (who has no involvement in the business and with whom the psychologist never socializes), and to a travel agent (who books perhaps one or two flights a year for the psychologist) may constitute relatively minimal or remote relationships. However, will a formal code's assurance that minimal or remote relationships are unlikely to violate the standard provide a clear, practical, valid, and useful basis for ethical deliberation to the psychologist who is serves as therapist to all four individuals? Research and the professional literature focusing on nonsexual dual relationships underscores the importance and implications of decisions to enter into or refrain from such activities (e.g., **Borys & Pope, 1988** (<http://www.kspope.com/dual/research2.php>) ; Ethics Committee, 1988; Keith-Spiegel & Koocher, 1985; **Pope & Vasquez, 1998** (<http://www.kspope.com/ethics/ethics.php>) ; Stromberg et al., 1988).

Second, the principles must address clearly and realistically the situations of those who practice in small towns, rural communities, and other remote locales. Neither the current code nor the current draft revision explicitly acknowledges and adequately addresses such geographic contexts. Forty-one of the dual relationship incidents involved such locales. Many respondents implicitly or explicitly complained that the principles seem to ignore the special conditions in small, self-contained communities. For example,

I live and maintain a...private practice in a rural area. I am also a member of a spiritual community based here. There are very few other therapists in the immediate vicinity who work with transformational, holistic, and feminist principles in the context of good clinical training that "conventional" people can also feel confidence in. Clients often come to me *because* they know me already, because they are not satisfied with the other services available, or because they want to work with someone who understands their spiritual practice and can incorporate its principles and practices into the process of transformation, healing, and change. The stricture against dual relationships helps me to maintain a high degree of sensitivity to the ethics (and potentials for abuse or confusion) of such situations, but doesn't give me any help in working with the actual circumstances of my practice. I hope revised principles will address these concerns!

Third, the principles need to distinguish between dual relationships and accidental or incidental extratherapeutic contacts (e.g., running into a patient at the grocery market or unexpectedly seeing a client at a party) and to address realistically the awkward entanglements into which even the most careful therapist can fall. For example, a therapist sought to file a formal complaint against some very noisy tenants of a neighboring house. When he did so, he was surprised to discover "that his patient was the owner-landlord." As another example, a respondent reported,

Six months ago a patient I had been working with for 3 years became romantically involved with my best and longest friend. I could write no less than a book on the complications of this fact! I have been getting legal and therapeutic consultations all along, and continue to do so. Currently they are living together and I referred the patient (who was furious that I did this and felt abandoned). I worked with the other psychologist for several months to provide a bridge for the patient. I told my friend soon after I found out that I would have to suspend our contact. I'm currently trying to figure out if we can ever resume our friendship and under what conditions.

The latter example is one of many that demonstrate the extreme lengths to which most psychologists are willing to go to ensure the welfare of their patients. Although it is impossible to anticipate every pattern of multiple relationship or to account for all the vicissitudes and complexities of life, psychologists need and deserve formal principles that provide lucid, useful, and practical guidance as an aid to professional judgment.

[NOTE: For those interested, please follow this link to **additional material on dual relationships, multiple relationships, etc** (<http://www.kspope.com/dual/index.php>) .]

### *Payment Sources, Plans, Settings, and Methods*

The third most frequently described incidents involved payment providers, plans, settings, or methods. Fifty-six focused on insurance coverage. Inadequate coverage for clients with urgent needs created a cruel ethical dilemma in which therapists felt forced either to breach their responsibilities to clients ("Insurance companies force me to provide inadequate care for patients because of policy limitations and patients' limited financial resources") or to be less than honest with what sometimes seems an adversarial provider of reimbursement ("I'm forced to lie about clients' mental condition to obtain insurance coverage that is due them, while insurance company psychologists are struggling to deny their customers their rightfully due coverage"). As one respondent put it: "I feel caught between providing the best service and being truly ethical." A vast range of troubling issues were described, including billing for no-shows, billing family therapy as if it were individual, distorting a patient's condition so that it qualifies for coverage, signing forms for unlicensed staff, and not collecting copayments.

Fifteen focused on what are typically called managed health plans, such as health maintenance organizations (HMOs) and employee assistance plans (EAPs). Most of the dilemmas, such as those focusing on more general insurance, highlighted (a) the discrepancy between the needs of the client and the services covered, and (b) the tensions between the interests of clients and the interests of those providing, administering, or investing in the managed health plan. The following examples were typical:

A 7 year old boy was severely sexually abused and severely depressed. I evaluated the case and recommended 6 months treatment. My recommendation was evaluated by a managed health care agency and approved for 10 sessions by a nonprofessional in spite of the fact that there is no known treatment program that can be performed in 10 sessions on a 7 year old that has demonstrated efficacy.

[I am] a part-time psychologist in an HMO. Am I an insurance agent or a clinician?... The primary obligation of the HMO is towards stockholders, not clients.

A managed care company discontinued a benefit and told my patient to stop seeing me, then referred her to a therapist they had a lower fee contract with.

Twelve dilemmas focused on payment-related issues in hospital settings; again, the emphasis tended to be on the conflict between the needs of the patient and the financial needs of the hospital.

Need to meet admission quotas...for private hospital. Pressure to develop diagnosis for inpatients in private hospital that would support hospitalization.

Much of my practice is in a private hospital which is in general very good clinically. However its profit motivation is so very intense that decisions are often made for \$ reasons that actively hurt the patients. When patients complain, this is often interpreted as being part of their psychopathology, thus reenacting the dysfunctional families they came from. I don't do this myself and don't permit others to do so in my presence--I try to mitigate the problem--but I can't speak perfectly frankly to my patients and I'm constantly colluding with something that feels marginally unethical.

I have been concerned about the unnecessary hospitalization of teenagers, extensive and expensive testing (often farmed out to MFCCs or interns on commission), 10 minute visits in hospital at \$80 to \$100 a visit (also often farmed out on a fee splitting basis) with the teenager leaving hospital when medical insurance runs out and receiving no further treatment.

As a clinical psychologist in a large metropolitan area, I have been frustrated on a few occasions recently by the apparent profit motive of the private psychiatric facilities. It appears that decisions to release patients are almost routinely delayed beyond that which I think is in the best interest of the patient. Psychologists appear to be pressured to "go along" with the system, or risk no referrals.

Similarly, in six dilemmas that focused on mental health clinics or centers and two that focused on individuals who paid for someone else's therapy, there was an actual or potential conflict between the interests of the patient and the (generally but not always financial) interests of the party paying for or providing the therapy, as these examples illustrate.

As a psychologist working in a private clinic, I feel that the use of biofeedback to support individual therapy is inappropriately done as an extra billing device.

A woman who is married, but unemployed comes to a psychologist for therapy or counseling. The husband of the woman is paying the bills. After a few sessions, it becomes evident that the patient is planning on leaving or divorcing the husband, who is unaware of this. The psychologist is put in a position of helping the patient to carry through an adverse (to the husband) action, which the husband is unknowingly paying for.

Four dilemmas addressed billing issues with clients who were paying for their own therapy; they tended to involve questions about adjusting fees (e.g., "I worry about the ethics of varying fee scale but feel less concerned than I would if I denied services to those unable to pay the higher rate"). Finally, two focused on gifts or financial advantages offered by clients; for example, a consulting psychologist described how "I have had to deal with a number of offers to get expensive items for me 'wholesale.' (I've resisted because it would compromise the relationship but it *is* tempting)."

The *Ethical Principles of Psychologists* (APA, 1990) and the current draft revision ("Draft," 1991) address many of these issues, such as organizational demands that are in conflict with the principles, the relationship of financial arrangements to a client's best interests, and prolonging a professional relationship beyond the point that it benefits the consumer. However, the growing influence and prevalence of third-party payment sources, from traditional insurance to HMOs and EAPs, seem to have intensified the need for explicit ethical standards that address more directly, realistically, and helpfully the dilemmas created by these payment sources (see, e.g., Cummings & Duhl, 1987; DeLeon, VandenBos, & Kraut, 1986; Dorken & DeLeon, 1986; Kiesler & Morton, 1988a, 1988b; Pope, 1990a; Zimet, 1989). Psychologists who find themselves working for organizations such as HMOs *and* for patients served by those organizations may be facing conflicts parallel to those faced by industrial-organizational psychologists. An author of the 1959 standards noted the unavoidable question that the revision committee confronted: "Can one really serve the needs of management in developing a more effective company while also doing what is always best from the point of view of the man down the line who may be adversely affected by the outcome?" (Holzman, 1960).

## *Academic Settings, Teaching Dilemmas, and Concerns About Training*

Twenty-five dilemmas focusing on teaching, training, and academia involved concern about lax or unenforced standards. Thirteen mentioned "grade inflation" and the pressures of to give "A"s, whether or not deserved. An additional 8 worried about the selection and graduation of unqualified students. Although some were worried about "diploma mills" (termed "a crisis" by one respondent), a majority were concerned about more mainstream programs, as the following examples illustrate.

My colleagues and I are concerned about the emotional instability and intellectual deficits of several students who have been accepted by APA-approved educational institutions.

I employ over 600 psychologists. I am disturbed by the fact that those psychologists with marginal ethics and competence were so identified in graduate school and no one did anything about it.

Asked to comment to a search committee about a graduate student whom I feel is "ethically dubious" but has a good publication record and is a top candidate for a job.

I have had students who were clearly emotionally disturbed, yet were completing programs in counseling psychology to become "therapists."

One barrier to addressing the dilemmas associated with unsuitable students seemed to be the threat of lawsuits, mentioned by an additional four respondents.

Three dilemmas mentioned academic discrimination on the basis of race, sex, or physical disability. Another three mentioned psychology graduate programs' failure to offer adequate coursework in the areas of ethics and values, the treatment of minorities, and psychopharmacology. The remaining dilemmas were extremely diverse, including such topics as exploitation of students, teaching group therapy using experiential participation by students, teachers using questions taken from licensing exams and distributing them to students, and misuse of power by professors or administrators.

### *Forensic Psychology*

Some of the respondents' most bitter language (e.g., "whores") was used to describe psychologists who seem willing to present false testimony in court.

There are psychologists who are "hired" guns who testify for whoever pays them.

A psychologist in my area is widely known, to clients, psychologists, and the legal community to give whatever testimony is requested in court. He has a very commanding "presence" and it works. He will say anything, adamantly, for pay. Clients/lawyers continue to use him because if the other side uses him, that side will probably win the case (because he's so persuasive, though lying).

Four dilemmas stressed the psychologist's willingness to provide such testimony, and an additional three stressed the attorney's pressures or inducements for this kind of testimony. Yet another four, although making no inferences concerning the psychologist's motivation, expressed concern about testimony that is not founded on the data or established scientific principles (e.g., Huber, 1991).

Another psychologist's report or testimony in a court case goes way beyond what psychology knows or his own data supports. How or whether I should respond.

Overstepping of professional knowledge; e.g., testifying in child abuse cases that the perpetrator is "cured" and that there is *no* chance of reabuse (crystal ball predictions).

An additional eight forensic dilemmas reflected these tendencies to go beyond the data or to respond to lawyers' pressure specifically in child custody disputes (especially to provide custody recommendations based on interviews with only one parent).

Colleagues feel uncomfortable in courtroom settings, making recommendations of one parent over another in a custody dispute when the child clearly has a strong relationship with both. Subjective impressions of patients are used as fact.

An attorney wants me to see one patient and the children in a custody case, but won't refer the case to me if I insist on seeing both parents.

Participating in a system in which false or misleading testimony is rendered confronts psychologists with troubling ethical challenges. However, five dilemmas revealed that, bogus testimony aside, psychologists are concerned that presenting *accurate* data in a forensic setting may have harmful consequences.

I find it difficult to have to testify in court or by way of deposition and to provide sensitive information about a client. Although the client has given permission to provide this information, there are times when there is much discomfort in so doing.

I felt compelled to go against a subpoena from a former client's attorney in her divorce proceedings because I strongly believed my written case notes would be

severely detrimental to her case. I explained that to her, and barely avoided contempt charges.

Unlike the current code (APA, 1990), which does not explicitly address forensic settings, procedures, and standards, the draft revision ("Draft," 1991) provides a separate section (with seven subsections) on "Forensic Activities." Readers may wish to compare this section with the "Specialty Guidelines for Forensic Psychologists" (Committee on Ethical Guidelines for Forensic Psychologists, 1991).

## *Research*

Twelve dilemmas focusing on research mentioned pressures or tendencies to misstate research procedures or findings.

I design, analyze and write up research reports that identify the advantages for one medium over the other media. Yet with large expenditures for the research, I feel constrained to report *something* .... But there is a limit to how many unpleasant findings I come up with-Finally, I have to find some truthful positives or I start looking for another job.

A particular company...has been citing my research conclusions...without considering my stated cautions, qualifications, and so forth. That is, my work is cited out of the context of conflicting research and the conclusions are uncritically overgeneralized or overstated. I am concerned that my name or my research may be associated with a kind of deceit.

I am co-investigator on a grant. While walking past the secretary's desk I saw an interim report completed by the PI [principal investigator] to the funding source. The interim report claimed double the number of subjects who had actually entered the protocol.

I have consulted to research projects at a major university medical school where "random selection" of subjects for drug studies was flagrantly disregarded. I resigned after the first phase.

A colleague frequently distorts the results of poorly conducted collaborative research with students in order to gain recognition and material to present at conferences. He typically works in applied areas with considerable public interest.

Eight dilemmas reflected concern about the rights of research participants.

With some field experiments, it is unclear whether informed consent is needed and, if so, from whom it should be sought.

As a consultant at a speech clinic, the director wishes to use clinical data for research without informing or getting informed consent.

Deception that was not disclosed, use of a data videotape in a public presentation without the subject's consent (the subject was in the audience), using a class homework assignment as an experimental manipulation without informing students.

The remainder of the dilemmas involved such diverse topics as mistreatment of animals, established researchers squelching new research, inadequate resources, and the difficulties of conducting research for large organizations in which many employees exert influence over how the research should be conducted.

The current draft revision addresses research issues in much more detail than the current code. Its combined section on "Teaching, Research, and Publishing" contains 15 subsections focusing primarily on research. This expansion probably reflects increasing awareness of the ways in which research can, both intentionally and unintentionally, result in harm, violation of human rights, the dissemination of results in a misleading manner, and an erosion of professional integrity (Ceci, Peters, & Plotkin, 1985; Denmark, Russo, Frieze, & Sechzer, 1988; Helms, 1989; Johnson, 1990; Keith-Spiegel & Koocher, 1985; Koocher & Keith-Spiegel, 1990; Levine, 1988; Mulvey & Phelps, 1988; Scarr, 1988; Sieber, in press; Stanley & Sieber, 1991).

### *Conduct of Colleagues*

Four percent of the responses described dilemmas created by disruptive (e.g., competitive) relationships with colleagues or difficulties confronting colleagues engaging in unethical or harmful behavior.

As a faculty member, it was difficult dealing with a colleague about whom I received numerous complaints from students.

At what point does "direct knowledge" of purportedly unethical practices become direct knowledge which I must report-is reporting through a client "direct" knowledge?

I referred a child to be hospitalized at a nearby facility. The mother wanted to use a particular psychiatrist.... When I called the psychiatrist to discuss the case, he advised me that, since he was the admitting professional, he'd assume full responsibility for



the case.... He advised how he had a psychologist affiliated with his office whom he preferred to use.

I see foster children who have little control over their lives and case workers who have little time/interest in case management. How can I maintain good professional relationships with those who don't function up to their duties?

A director of the mental health center where I worked was obviously emotionally disturbed and it impacted on the whole center-quality of service to clients, staff morale, etc. He would not get professional help or staff development assistance.

The toughest situations I and my colleague seem to keep running into (in our small town) are ones involving obvious (to us) ethical infractions by other psychologists or professionals in the area. On 3 or more occasions he and I have personally confronted and taken to local Boards... issues which others would rather avoid, deal with lightly, ignore, deny, etc., because of peer pressure in a small community. This has had the combined effect of making me doubt my reality (or experience), making me wonder *why* I have such moral compunctions, making me feel isolated and untrusting of professional peers, etc.

During the last 15-20 years, it has been upsetting to me to see my colleagues' primary focus to be image building, income building, status seeking and "equality" with psychiatric brothers and sisters, rather than public service. Not that those things are not important but the priorities are wrong.

Although the draft revision devotes two subsections to the ethics of addressing a colleague's unethical behavior, the profession may need to address more realistically the beliefs and external pressures that lead psychologists to remain complicitly silent and passive when confronted with a colleague who cannot or will not fulfill ethical and professional responsibilities. Research evidence suggests that only about 58% of psychologists believe that to file an ethics complaint against a colleague is itself an unquestionably ethical act (**Pope et al., 1987** (<http://www.kspope.com/ethics/research4.php>)), that about 5% believe that it is never ethical to help a student to file an ethics complaint against another teacher (Tabachnick, Keith-Spiegel, & Pope, 1991), and that only 21% report that they have never simply ignored unethical behavior by colleagues (**Tabachnick et al., 1991** (<http://www.kspope.com/ethics/research6.php>)). In some instances, the "whistleblower" may risk punishing consequences for not remaining silent (Simon, 1978), even when his or her critique is offered in the context of formal peer review, a process supposedly created to bring inappropriate, unethical, or harmful practices to light (Kleinfield,

1991).

## *Sexual Issues*

Four percent of the dilemmas reflected concerns about sexual issues, particularly the conditions under which sexual involvements are unethical.

Not often, but I have had female clients indicate their interest in romantic involvement with me.

Therapists asking patients to masturbate in front of them.

A student after seeing a client for therapy for a semester terminated the therapy as was planned at the end of the semester, then began a sexual relationship with the client.... I think APA should take a stronger stance on this issue.

I currently have in treatment a psychiatrist who is still in the midst of a six year affair with a patient. He wishes to end the affair but is afraid to face the consequences.

A colleague and friend engaged in sexual activity with an employee of our organization. He was "caught," caused to resign (and did) and is seeking personal help. That seems "punishment" enough without adding reporting the activity to APA ethics.

My psychological assistant was sexually exploited by her former supervisor and threatened her with not validating her hours for licensure if she didn't service his needs.

Sexual involvement with therapy clients (e.g., Bates & Brodsky, 1989; Committee on Women in Psychology, 1989; Ethics Committee, 1988; Feldman-Summers, 1989; Feldman-Summers & Jones, 1984; Gabbard, 1989; Hare-Mustin, in press; Holroyd & Brodsky, 1977; Pope **1990c** (<http://www.kspope.com/sexiss/sex1.php>), **1994** (<http://www.kspope.com/sexiss/involv.php>); Pope & Vasquez, **1998** (<http://www.kspope.com/ethics/ethics.php>); Sonne, 1987, 1989; Sonne, Meyer, Borys, & Marshall, 1985; Sonne & Pope, 1991; Stromberg et al., 1988) and with students (e.g., Glaser & Thorpe, 1986; Robinson & Reid, 1985; Pope, Levenson, & Schover, **1979** (<http://www.kspope.com/sexiss/research1.php>); Pope, Schover, & Levenson, **1980** (<http://www.kspope.com/sexiss/supervision.php>); Tabachnick et al., **1991** (<http://www.kspope.com/ethics/research6.php>)) has been a difficult issue for the profession to address effectively, as the cited references emphasize and illustrate. Part of the difficulty may be due to

surprising historical and related factors (see Brodsky, 1989; Pope. **1990b** (<http://www.kspope.com/sexiss/therapy1.php>) ). Part may be due to challenging methodological issues that have been repeatedly emphasized and examined since the earliest research reports; among these enduring methodological issues are "selective memory in retrospective studies, reporting biases, unrepresentative samples, and distortions in data obtained from secondary sources" (Pope, **1990c** (<http://www.kspope.com/sexiss/sex1.php>) , p. 477). Part may be due to the incongruity of therapists placing those who come to them for help at risk for significant harm; the harm can be deep and pervasive, meeting the 10 diagnostic criteria of Therapist-Patient Sex Syndrome (Pope, 1986, 1989, **1994** (<http://www.kspope.com/sexiss/involv.php>) ). This incongruity highlights the problems of responding effectively to those therapists who sexually abuse their clients. The profession has a significant responsibility to address in good faith the ethical, methodological, legal, and policy questions about rehabilitation approaches that have shown no evidence of validity through independently conducted, carefully controlled research published in peer-reviewed scientific journals and may place future clients at increased risk for severe harm without their knowledge or consent (**Pope, 1991, 1994** (<http://www.kspope.com/sexiss/involv.php>) ; **Pope & Vetter, 1991** (<http://www.kspope.com/sexiss/sex2.php>) ; Sonne & Pope, 1991). Yet another part of the difficulty may be due to the accelerating evolution of our research-based understanding. Inferences based on research have been modified, as subsequent research findings provide more detailed understanding. For example, numerous variables such as therapist gender, region of residence, and practice setting have emerged as significant in this type of research (e.g., **Borys & Pope, 1989** (<http://www.kspope.com/dual/research2.php>) ); attempts to compare and contrast research findings from different studies without taking into account (e.g., computing statistical adjustments for) the between-studies differences in such variables may lead to confusion when attempting to understand differing findings.

The long-standing attention to the methodological challenges has prompted researchers to develop creative, diverse research strategies. For example, reviews of research concerning possible harmful effects of Therapist-Patient sex have noted diverse research studies examining

the effects of abuse on patients who did not return to a subsequent therapy as well as those who did, have compared patients who were subjected to abuse by a prior therapist with matched groups of patients who were not victimized, and have explored the sequelae as evaluated variously by the patients themselves, by subsequent therapists, and by independent clinicians through methods including observation, clinical interviews, and standardized psychological testing. (**Pope, 1990b** (<http://www.kspope.com/sexiss/therapy1.php>) , p. 232)

Other research has collected data in such a way that "the effects of sexual involvement with a therapist could be compared to consensual sexual involvement with a spouse, long- and short-term extramarital liaisons, and sexual involvements traditionally considered traumatic (e.g., rape,

incest)" (Pope, 1990c (<http://www.kspope.com/sexiss/sex1.php>) , p. 478). Although studies of harm were first conducted in the United States, studies in other countries have significantly enriched our understanding of the phenomenon (e.g., Lapierre & Valiquette, 1989). Similarly, attempts to understand how frequently Therapist-Patient sexual involvement occurs now draw on national, anonymous, direct-survey data provided by populations of therapists and patients, as well as indirect-survey data provided by therapists about their patients' reports of sexual involvement with prior therapists (consequently, this latter group of patients, unlike patients participating the direct-survey research, consists only of patients who have initiated a subsequent therapy).

In light of a national study (Pope & Vetter, 1991 (<http://www.kspope.com/sexiss/sex2.php>) ) in which half of the clinical and counseling psychologists reported encountering at least one patient who had been sexually involved with a prior therapist (with 5% reporting patients making false claims against prior therapists), and in light of the severe harm that can occur from such involvements, attempts to highlight evidence that the rate may be relatively small (i.e., that there are many therapists who do not sexually exploit their patients and that even those who do may often refrain from sex with almost all of their patients) seem similar to then White House Chief of Staff John Sununu's defensive reaction to the oil spill by the Exxon Valdez: "Three quarters of [the oil] was contained within the ship. There's been very little reporting on that" ("Dubious Achievement Awards," 1990 , p. 82).

In the mid-1980s, the scientific and professional literature began to examine in more detail the clinical, ethical, and policy implications of posttermination relationships (Brodsky, 1988; Brown, 1988; Gabbard & Pope, 1989; Keith-Spiegel & Koocher, 1985; Shopland & VandeCreek, 1991; Vasquez, 1991), and to provide research data regarding the harm to the patient (Pope & Vetter, 1991 (<http://www.kspope.com/sexiss/sex2.php>) ) and consequences for the therapist (Sell, Gotlieb, & Schonfeld, 1986) that occurs in cases in which sexual intimacies are initiated only after the termination of therapy. These works, like those examining pretermination relationships, tended to focus less on transference than on a variety of nontransferential factors. That the current *Ethical Principles of Psychologists* (APA, 1990) do not explicitly address the issue of posttermination sexual involvements has left many psychologists uncertain about APA policy in regard to such relationships. The revision process has not yet produced a clear approach to this issue. As recently as the 13th draft, the revision stated "Psychologists do not engage in sexual intimacies with current or former psychotherapy clients" ( Task Force for Revision of the Ethical Principles, 1990, p. 15), whereas the current (15th) draft ("Draft," 1991, p. 33) seeks comments on two proposed options (involving "the most unusual circumstances" and a one year waiting period).

## **Assessment**

As the following examples illustrate, the most typical dilemmas focusing on assessment tended to

involve one of two themes: (a) the availability of tests (or computerized interpretations) to those who may not be adequately trained in testing, and (b) basing conclusions on inadequate data or ignoring important sources of data (e.g., observation, interview, or other contact with the client) or expertise.

11 of us cover a 22,000 student population (K-12). When the Binet IV came out, only one person was sent for training.... We are often asked to add new tests without appropriate supervision. Test publishers aren't motivated to slow down sales by requiring training to purchase tests. Someone like me needs APA protection via strict access to tests only upon proof of training. It sounds self-serving according to our employer to request appropriate training.

I am often asked by social workers to "interpret" psychological tests which they administer without allowing me to see the client. I refuse to render an opinion without client contact.

Colleagues in the medical profession have the right to order psychological tests from computer companies that give computer generated interpretations.

As director of testing in a hospital setting, I routinely encounter problematic testing issues such as full and part-time psychologists...making neuropsychological diagnoses without expertise at the same time they ignore our resident neuropsychologist.

Other practitioners, especially internists, wanting to base important decisions on just an MMPI [Minnesota Multiphasic Personality Inventory] result.

Some psychologists will omit subtests from the Wechsler and report verbal and performance IQ scores without indicating that they have omitted subtests. This practice was so common we had to require a copy of the summary sheet to ensure that all tests were administered. ABPP [American Board of Professional Psychology] members were just as guilty as the rest.

Psychologists use computer-generated test reports as the only report of an evaluation, without integrating the test results with other data.

### *Questionable or Harmful Interventions*

In a concise article, Singer (1980) illuminated the implications of psychology's scientific tradition for providing effective interventions in a safe manner. The importance of attending to this aspect

of our work is highlighted by dilemmas reflecting respondents' concern about the efficacy, legitimacy, and safety of treatment approaches, modalities, and conditions.

A patient of mine...left town to attend college. Very shortly before departure, she revealed an early history of sexual abuse. The recurrent thoughts and memories were extremely disturbing to her. She refused to seek a new therapist at school.... She asked me to talk with her by phone. I am not licensed in that state. Would I be practicing in that state? Is "phone therapy" a reasonable choice?... If...not, is it abandonment?

Am most troubled by the thesis "If it works, go for it" rather than "Is it scientifically sound?" The practitioner vs. the researcher.

The issue of using therapeutic touch... with traditional psychotherapy.

Seeing clients in an unprofessional atmosphere-e.g., in the home with pets present in the consultation room.

Colleagues... making/receiving 4-5 phone calls during a session.

As a state psychologist working with retarded clients...we may not use response cost or any negative reinforcers with our clients.... To me failure to enforce real controls is unethical, yet it is a very strong national movement to use only positive reinforcement.

Institutions for the developmentally disabled/M/R., especially care from institution, not be supervised properly as to care they get in group homes; foster type care, etc-I've seen some deplorable living conditions and clients almost starved to death.

## *Competence*

About 3% of the dilemmas involved moving into areas without adequate competence or the erosion of competence through time and stress.

Clients approach me to do therapy on them but have problems I'm not really trained to do.

Sometimes a clinical client will raise questions about his/her management needs from a company that he may own, and I'm inclined to provide information or services, based on what I know, but I always wonder if I'm crossing over into the I/O areas of responsibility.

In our small town, political community, colleagues are less well trained and often practice beyond their training and competency level.

Some current staff psychologists, trained many years ago, who have not kept their skills and/or knowledge base current and, thus, we have a problem with competence.

I often feel exhausted and burned out, but lack supervisory/therapy resources for myself. How do I know my own limits?

### *Ethics (and Related) Codes and Committees*

Eleven dilemmas in this area reflected concern about ethics, licensing, and related committees. Three described how committees were too slow to take action or were inactive because of such factors as the threat of litigation. The other diverse concerns about committees included their "presumption of guilt" and "police method," the problem of an ethical violator sitting on the committee, the redundancy of different level (i.e., local, state, and national) committees, and the potential conflict of interest when members are competitive with those they investigate.

The remaining dilemmas reflected concerns that the current ethics code is trivial, that it does not sufficiently address minority values and concerns, that the guidelines are extremely vague, and that it does not reflect adequate concern for clients. One respondent was particularly troubled by APA's view of homosexuality: "My professional association, the APA, has said that my religious beliefs (e.g., that homosexual acts are wrong) are unethical. Therefore, should I quit the APA or my religion?"

### *School Psychology*

These dilemmas tended to reflect psychologists' struggles to act in the best interests of students despite pressure from administrators.

A retarded boy in a school district is kept isolated from the rest of his class because of his disruptive behavior. The school district hires me to decrease disruptive behaviors while still keeping him isolated. I feel that he should be integrated. Whose agent am I?

My school district administrator would like me to distort test data to show improvement.

I am employed as a school psychologist in a large school district.... I am asked to provide a diagnosis which will qualify the examinee for certain services, even if the

test results do not justify that diagnosis. I have not done so, but the frequency with which the request is made is troubling.

As a school psychologist there is often pressure from administrators to place children in programs based on the availability of services rather than the needs of the individual student. School psychology: "Do no harm to the client" -EHA [Education for Handicapped Children Act] regulations, state regulations, etc. Identifications and placement are not always in best interest, however, if eligible there is no escape. As a school psychologist... I frequently am called to task when my input as to the most appropriate manner of service is one which adds cost.

### *Publishing*

Dilemmas in the area of publishing tended to focus on giving publication credit to those who do not deserve it, denying publication credit to those who deserve it, and teachers plagiarizing students' papers for their own articles. As one respondent wrote,

I am asked to give P.I. status to M.D. colleagues on training grants that I write and manage within a Dept. of Family Medicine at a large medical school.

### *Helping the Financially Stricken*

Respondents expressed concerns about addressing the needs of those who are poor, unemployed, or homeless.

My concern: not enough educational programs and financial support for those who could help the homeless.

A dilemma has been the short sighted and oft brutal fashion in which business and industry has "downsized" American work forces. Much "muscle" has been dumped on the streets with little aid in finding new jobs or rigorously attempting to place laid off workers in internal jobs at lower levels. Its concurrent issues of psychological and financial damage have made waves in family and other societal institutions.

Pro bono work often leaves one wide open to litigation, and a leading national authority has said to psychologists "Write letters to your congressmen and senators for your pro bono work."

How to be able to serve people of low income.



How to meet the needs of a broadbased socioeconomic clientele in the same offices without alienating them from the pursuit of psychological services.

My fee for psychotherapy makes me unavailable to needy clients, but I cannot afford to do pro bono work...I feel wrong (unethical), even though I refer clients to lower-fee therapists.

Although both the current code and the most recent draft revision address the issue of providing services for little or no financial or other personal gain, no sections explicitly address the ethics of interventions, such as those used by community psychologists or primary preventionists, created specifically to serve the needs of those who are poor, unemployed, or homeless, or who are members of other vulnerable populations (e.g., Pope & Garcia-Peltoniemi, 1991; **Pope & Morin, 1991** (<http://www.kspope.com/ethics/aids-hiv.php>) ). Extensive examinations of the ethics of community psychology and related endeavors have begun to appear somewhat more frequently in the professional literature (e.g., Levin, Trickett, & Hess, 1991; O'Neill, 1989; O'Neill & Hern, 1991), as have discussions of training in the ethics of such activities (Bond & Albee, 1991).

### *Supervision*

Dilemmas in this area reflected concerns about supervisors who were negligent or disrespectful.

Individuals hired and supervised by prominent licensed psychologist, who actually receive little or no supervision.

Clinical supervisors who work with students and impose their own orientation onto the students without regard or respect for different orientations and personality styles.

A colleague was harassed by his supervisor, publicly criticized, as well as being disparagingly talked about to third parties, despite any real problem other than the supervisor's dislike of that colleague's therapeutic technique.

A psychology intern has a primary supervisor who is psychoanalytically oriented. The intern's final evaluation by the supervisor states that...the intern "needs two years of intensive, personal psychotherapy." While there was no doubt the intern "passed" the internship satisfactorily, this final evaluation was made part of his record.... It became evident to the intern years later that this was being sent out in the way of references to potential employers.... The intern is barred from all or most jobs which require a recommendation from the internship site.... The supervisor left the internship site... so that the internship site is not in a position of being able to negotiate a settlement.

## *Advertising and (Mis) Representations*

Dilemmas in this area reflected concerns about how professionals present themselves and their work to the public in a false, misleading, or questionable manner.

My clinic wishes to advertise my services in ways which I find offensive and unprofessional.

Advertising in Yellow Pages stating "Psychological Referral Service" which was nothing more than a number generating referrals for several private practice psychologists.

The Yellow Pages includes "bogus" listings under "Psychologists."

A psychological assistant allows herself to be misrepresented as a psychologist. The hospital for whom she works supports her misrepresentation.

Several psychologists, especially in these days of increased competition,...exaggerate or stretch their credentials for marketing purposes.

In some instances individual board members put considerable pressure on me as agency director to allow...testimonials from clients for use in "development" (fund-raising) efforts.... Medical agencies in the community...make a regular practice of soliciting testimonials from patients via their newsletters. Example: In the [newsletter title] this piece has appeared: "Once again, [name of organization] will advertise using Member testimonials. Why not take advantage of this opportunity to let your friends and neighbors know about the quality of care and service you receive from [name of organization]? We invite you to submit your testimonial to..."

Psychology as a profession has enjoyed and suffered a fascinating relationship to the factors affecting its attempts to create and enforce ethical standards for advertising and related activities. Space permits mention of only one ironic aspect, and interested readers are referred to Keith-Spiegel and Koocher (1985, Chapter 7) for a more detailed discussion of much of this history. During the Reagan administration, organized psychology vigorously opposed all legislative attempts that would exempt APA from the jurisdiction of the Federal Trade Commission (FTC; Association for the Advancement of Psychology, 1982; see also Keith-Spiegel & Koocher, 1985). The commission then issued an order to restrain APA from disseminating and enforcing a number of sections of its ethics code. Rather than contest the FTC's efforts in court, APA entered into what was described as an agreement to make "emergency" changes in its code ("Report of the Ethics Committee," 1991, p. 751). Publication of the revised code included a card indicating that the

Board of Directors, on June 2, 1989, had rescinded and would stop enforcing certain formal ethical standards. The association had agreed to drop its ethical standards in regard to the following portions of the 1981 code: 4.b.iii, 4.b.v, 4.b.vi, 4.b.vii, 4.b.viii, and sections of 6.d and 7.b. The latter two sections had previously prohibited psychologists from paying colleagues to refer patients to them (and accepting such payments, sometimes known as "kickbacks," from colleagues in exchange for steering people who are seeking help to those colleagues) and from offering their own services directly to a person who is already receiving similar services from a colleague (APA, 1990).

### *Industrial-Organizational*

Dilemmas in this area tended to describe ways in which management interfered with the psychologist's duties, especially instances in which psychologists were expected or pressured to break pledges of confidentiality to employees or survey respondents or in which a company breaks a pledge (which the psychologist had conveyed in good faith) to remedy problems identified in an employee survey. One respondent, however, noted what he or she felt to be an interesting conflict of interest: As an organizational psychologist in charge, he or she was responsible for setting his or her own pay.

### *Medical Issues*

About 1% of the dilemmas focused on several medical issues, as the following examples illustrate.

A parent of a 10 year old resists taking the child for appropriate medical evaluation.  
Should I stop working with the child and family?

I evaluated a nursing home resident whose medical doctor had missed an obvious neurological disease and had misdiagnosed her. Despite my report and telephone conversation with him about considering revising her diagnosis, he did not do so and continued to prescribe medication which worsened her symptoms.

One of my jobs is to help parents and children adjust to disabling and disfiguring traumatic injuries. I sometimes know that the medical treatment the child has received has increased the disability/disfigurement unnecessarily or that another approach to treatment exists which gets better results. Yet, unless the child/parent can choose some corrective action, no goal would be accomplished in telling them and it seems better to support their belief that they are receiving the most excellent care. By remaining silent, am I in fact supporting poor treatment?

### *Termination*

About 1% of the dilemmas focused on difficulties terminating and rendering appropriate follow-up. Examples include,

My greatest "ethical crisis" comes from conceptualizing terminations with clients (who have been victims as children of ritual sexual abuse) in whose lives I have been "involved" for 5-7 years.

Has client for 2 years dealing with sexual abuse as a child. She went to college, was into drugs and ended up in the hospital where they focused on post-traumatic stress as the cause of her problems, ignored the drug problem. She got out and they sent her home and recommended a therapist who dealt with post-traumatic stress. She desired to keep contact with me. I felt I couldn't see her as a client, but would talk to her occasionally on the phone. This contact was perhaps once or twice per month-but I always had some concerns about the degree of contact. She wanted to call more often, but I discouraged that-rather encouraged her to work hard with her new therapist.

A colleague took a 4 month leave of absence and referred a patient to me (as a "babysitter therapist") for the duration. The patient preferred me and did not wish to return to my colleague, who insisted I should force the patient to do so. I am having ambivalent feelings and wondering what is best for the patient-but also, whether to risk losing the friendship of my colleague.

## *Ethnicity*

Dilemmas that focused on ethnicity included the following:

Many clients when referred to my office show initial shock that I am ethnically different from the mainstream. As a result, more time is needed to establish rapport.

In my academic institution, there are verbal statements and policies around affirmative action for courses and academic development of ethnic minority students and faculty. However, efforts directed toward those goals are constantly sabotaged and dismantled by the administration of the campus, who are psychologists.

Although both the current code and the most recent draft revision prohibit discrimination on the basis of ethnicity, race, or culture and the professional literature addresses relevant training and related issues in this area (e.g., Gibbs & Huang, 1989; Mays & Comas-Diaz, 1988; Pedersen, Draguns, Lonner, & Trimble, 1989; **Pope & Vasquez, 1998** (<http://www.kspope.com/ethics/ethics.php>) ; Stricker et al., 1990), the profession may benefit from a discussion of whether confronting racism and similar forms of discrimination is an ethical

responsibility that should be explicitly addressed by the formal code (Brown, 1991).

### *Treatment Records*

About 1% of the dilemmas expressed concerns about what information should go into the record, agency policies of charging for records, providing copies of records to patients who have not paid their bills, and what to do when records are unintentionally destroyed.

### *Miscellaneous*

Finally, a diversity of dilemmas did not fall into any of the previous categories. They reflected such concerns as patients troubled by the high public profile of their therapist, radio psychologists giving bad advice to callers, and the "relative normality of suicide as a problem solving option."

### **CONCLUSION**

APA's rich tradition includes the remarkable decision to use its indigenous methods to construct a formal code of ethics. While acknowledging that the "research approach would consume considerably more time than the committee recommendation approach" (Hobbs, 1948 , p. 82), the chair of the committee charged with development of our first ethics code emphasized that

we may well want to devote more attention to the *process* of developing a code.... Our ends may best be served if there is widespread participation among psychologists in the process of working out the principles that we adopt. Certainly one of the most significant recent developments in psychology is the growing sensitivity to group processes in human behavior. If we conceive the problem of developing ethical standards as one of group dynamics, an approach more original than the committee-recommendation technique is indicated. (p. 82)

This approach helped to ensure that the original code was informed by the day-to-day experiences of the membership (increasing the likelihood that members' activities would be informed and guided by the code), and it can play a vital role in revising the code. Unless guided by contemporary empirical data about the incidents faced by the full range of APA's current membership, the code risks losing relevance and applicability. No code can address every situation, but careful attention to the incidents, concerns, and quandaries provided by the respondents in this study can help minimize those occasions on which a psychologist looks to the code for help in confronting a dilemma and finds it to be unduly silent, dated, or unrealistic. The distinctive process through which the code and the experiences of our membership are so closely linked is an aspect of our heritage worth maintaining.

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