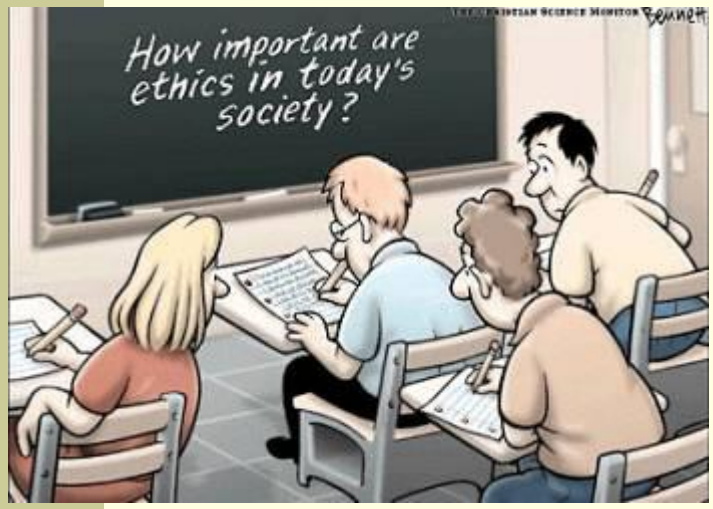
Ethics in Psychotherapy

Obligatory directives and idealistic virtues

Why do we need ethical principles?



- Therapeutic relationships are unbalanced (Who has more power?)
- Therapeutic relationships are complicated
  - Client's issues/problems are complicated
  - The nature of the relationship itself is complicated
- Therapists are human, and humans are fallible. Ethical guidelines provide guidance and accountability.

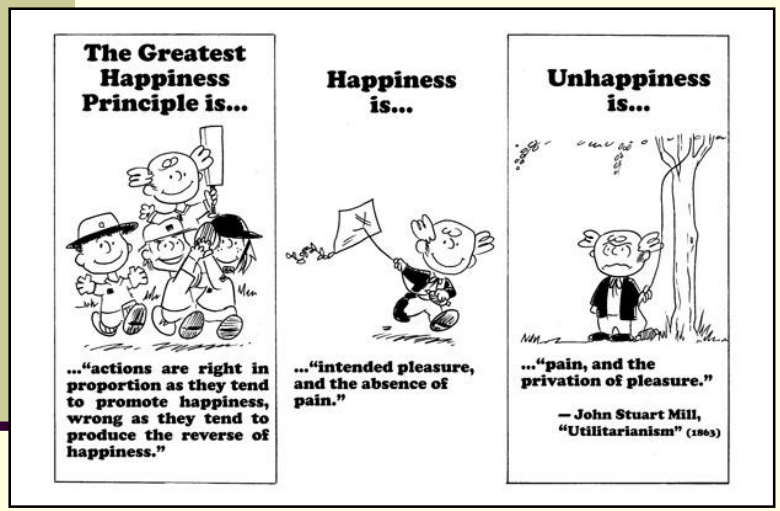
What are ethical codes?

- **Ethical codes are guidelines for what therapists can and cannot do** that have been developed by each therapeutic discipline's organizational body, including the ACA & APA
- There are two dimensions to ethical decision making:
  - Principle ethics: Overt ethical obligations that must be addressed
  - Virtue ethics: Above and beyond the obligatory ethics and are idealistic

- **Ethical codes are often ambiguous by design.** Each therapeutic situation is unique and sometimes the code requires interpretation

Philosophical Guidelines

- Consequentialist Theories
  - Act utilitarianism
  - Rule-utilitarianism

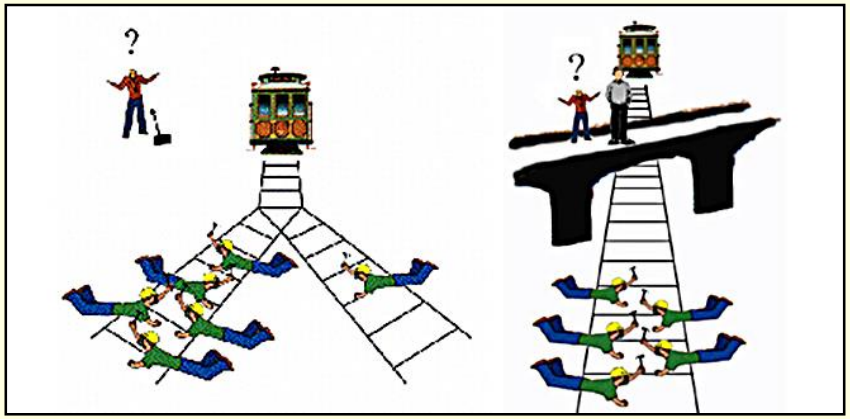


What can go wrong?

If a judge can prevent riots that will cause many deaths only by convicting an innocent person of a crime and imposing a severe punishment on that person, act utilitarianism implies that the judge should convict and punish the innocent person

If a doctor can save five people from death by killing one healthy person and using that person’s organs for life-saving transplants, then act utilitarianism implies that the doctor should kill the one person to save five.

If a person makes a promise but breaking the promise will allow that person to perform an action that creates just slightly more well-being than keeping the promise will, then act utilitarianism implies that the promise should be broken.



The Trolley dilemma video

Philosophical Guidelines

- Deontological Theories
  - Act is right or wrong, and we have **duty** to do what is right
  - Duties can be obligatory, permissible, and forbidden
  - Three best examples of where duties come from
    - God (religion)
    - Intuition
    - Kantian “categorical Imperative” –> Universal Law

      "Act only according to that maxim whereby you can at the same time will that it should become a universal law."

Ethical issues affecting clinical practice

- Therapist Competence: Therapists need to only provide services for which they are qualified
- Client Welfare: Client needs come before counselor needs and counselor must act in client's best interest
- Informed Consent: Counselors must inform clients regarding nature of counseling and answer questions so that clients can make an informed decision
- Confidentiality: Clients must be able to feel safe within the therapeutic relationship for counseling to be most effective
- Dual Relationships: More than one relationship with a client (e.g. the counselor is a friend and the counselor) should be avoided when possible
- Sexual Relationships: Sexual relationships with clients are strongly prohibited and in some states constitute a criminal offense

Competence and malpractice

- To provide competent treatment, therapists need to:
  - only provide services for which they are qualified
  - accurately represent their credentials and qualifications
  - keep up on current information of the field, especially in specialty areas
  - seek counseling when they have personal issues
- Malpractice
  - Occurs when a counselor fails to provide reasonable care that is generally provided by other professionals and it results in injury to the client.
  - Four conditions must exist:
    - The counselor had a duty to the client
    - The duty of care was not met
    - The client was injured in the process
    - There was a close causal relationship between the counselor's failure to provide reasonable care and the client's injury

Informed consent

- All of the following should be covered in order for the client to be able to make an informed choice
  - The financial costs of counseling
  - Any special arrangements
  - The competencies of the counselor
  - Nature of treatment (experimental Tx should be indicated)
  - Confidentiality (and its limits)

Privileged Communication (confidentiality)

- Legal protection of the client which prevents a counselor from disclosing what was said within the counseling session(s)
- This right belongs to the client, not the counselor
- Laws concerning privileged communication vary from state to state, but Federal laws also exist

Privileged Communication (confidentiality)

"Effective psychotherapy. . . depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment."

U.S. Supreme Court (*Jaffee v. Redmond,* 1996).

Other relevant privacy legislation

- Health Insurance Portability and Accountability Act of 1996 (HIPPA)

- Family Educational Rights and Privacy Act of 1974 (FERPA)

When privileged communication doesn't apply

- *Tarasoff v. Board of Regents of the University of California (1976)*: A landmark case with the end result being that counselors have a "duty to warn" if a client threatens another person's life or with significant bodily harm.

  Justice Mathew O. Tobriner majority opinion. "The public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins."

- When the client is suicidal
- When a client needs hospitalization.
- When a counselor is performing a court ordered evaluation
- When the client sues the counselor
- When the client uses a mental disorder as a legal defense
- When an underage child (under 16) is being abused

Ethical issues affecting clinical practice

- Therapist Competence:
- Client Welfare:
- Informed Consent:
- Confidentiality:
- Dual Relationships:
- Sexual Relationships:

The ethics of dual relationships

- Guiding questions
  - Is the dual relationship necessary?
  - Is the dual relationship exploitative?
  - Who does the dual relationship benefit?
  - Is there a risk that the dual relationship could damage the client?
  - Is there a risk that the dual relationship could disrupt the therapeutic relationship?
- Other recommendations:
  - Consult with colleagues
  - Document decision-making process in the treatment records (the spirit of the law is "If it is not written down, it did not happen.“)
  - Obtain informed consent regarding the risks/benefits of engaging in the dual relationship

Decision-making model for negotiating dual relationships

Table 1 - Dimensions for Ethical Decision-Making

Low Power	Mid-Range Power	High Power
Little or no personal relationship **or** Persons consider each other peers (may include elements of influence).	Clear power differential present but relationship is circumscribed.	Clear power differential with profound personal influence.
Brief Duration	**Intermediate Duration**	**Long Duration**
Single or few contacts over short period of time.	Regular contact over a limited period of time.	Continuous or episodic contact over a long period of time.
Specific Termination	**Uncertain Termination**	**Indefinite Termination**
Relationahip is limited by time externally imposed or by prior agreement of parties who are unlikely to see each other again.	Professional function is completed but further contact is not ruled out.	No agreement regarding when or if termination is to take place.

(Gottlieb, 1993)

Physical touch in psychotherapy

- Touch in therapy is not inherently unethical
  - None of the professional organizations code of ethics (i.e., APA, ApA, ACA, NASW, CAMFT) view touch as unethical.
  - Touch increases therapeutic alliance, has many healing qualities
  - Meaning of touch varies across both culture and individual

Read more

- National survey of 285 male and female therapists (141 men and 141 women)
  - Over half respondents reported hugging clients
  - Over one fourth reported holding hands with clients
  - More than 1 in 10 reported flirting with regard to both female and male clients.

Pope and Tabachnick, 1993

Therapist attraction to clients (N=585)

Table 1 - Therapists' Attraction to Male and Female Clients

Therapists	none N	none %	male only N	male only %	female only N	female only %	both male & female N	both male & female %
All men	17	5.0	2	0.6	275	81.1	45	13.3
Younger men	7	4.1	1	0.6	140	81.4	24	13.9
Older men	10	6.0	1	0.6	135	80.8	21	12.6
All women	60	24.4	123	50.0	6	2.4	57	23.2
Younger women	14	12.3	61	53.5	1	0.9	38	33.3
Older women	46	34.8	62	47.0	5	3.8	19	14.4

Table 2 describes in detail the frequencies and percentages of attraction to male and female clients by male and female therapists.

Table 2 - Therapists' Frequency of Attraction to Clients

	Never		Rarely		Occasionally		Frequently	
Therapists → Clients	N	%	N	%	N	%	N	%
	Female clients							
All men	19	5.6	94	27.8	172	50.9	53	15.7
Younger men	8	4.7	44	25-7	92	53.8	27	15.8
Older men	11	6.6	50	29-9	80	47.9	26	15.6
All women	181	74.2	51	20.9	11	4.5	1	0.4
Younger women	73	65.2	29	25.9	9	8.0	1	0.9
Older women	108	81.8	22	167	2	1.5	0	0,0
	Male clients							
All men	288	86.0	35	10.4	9	2.7	3	0.9
Younger men	146	85.4	19	11.1	4	2.3	2	1.2
Older men	142	86.6	16	9.8	5	3.0	1	0.6
All women	66	26.8	101	41.1	76	30.9	3	1.2
Younger women	15	13.2	51	44.7	46	40.3	2	1.8
Older women	.51	38.6	50	37.9	30	22.7	1	0.8

Dated data?

22% of therapists reported never being attracted to client (2001)

Pope, Keith-Spiegel, & Tabachnick, 1986

Frequency of sexual intimacy in therapy

(Pope, Keith-Spiegel, & Tabachnick, 1986)

- 50% of therapists consulted with supervisor, 10% discussed in therapy, 1% discussed w/ own partner, 27% did not discuss (2001)
- Vast majority of respondents (82%) reported that they never seriously considered actual sexual involvement with client (1986)
- Of the 104 therapists who had considered sexual involvement, 91 (88%) had considered it only once or twice. (1986)
  - More male therapists (27%) had considered sexual involvement with clients than had female therapists (5%)
  - Therapists did not differ significantly according to age
- 9.4% of male and 2.5 % of female therapists reported having intercourse or erotic contact with clients (1986)

Sexual Relationships

Results of 8 Studies of Sex with Clients Using National Samples of Therapists[1]

Study	Publication date	Discipline	Sample size	Return rate	% Male Therapists Reporting Sex With Clients	% Female Therapists Reporting Sex with Clients
Holroyd & Brodsky[2]	1977	psychologists	1,000	70%	12.1%	2.6%
Pope, Levenson & Schover	1979	psychologists	1,000	48%	12.0%	3.0%
Pope, Keith-Spiegel & Tabachnick	1986	psychologists	1,000	58.5%	9.4%	2.5%
Gartrell, Herman, Olarte, Feldstein & Localio[3]	1986	psychiatrists	5,574	26%	7.1%	3.1%
Pope, Tabachnick & Keith-Spiegel.[4]	1987	psychologists	1,000	46%	3.6%	0.4%
Akamatsu.[5]	1988	psychologists	1,000	39.5%	3.5%	2.3%
Borys & Pope.[6]	1989	psychiatrists, psychologists & social workers	4,800	56.5%	0.9%	0.2%
Bernsen, Tabachnick & Pope	1994	social workers	1,000	45.3%	3.6%	0.5%

Characteristics of patients who engaged in sexual intimacies with a therapist

Table 1 - Characteristics of 958 patients who had engaged in sexual intimacies with a th

%	Characteristics
5%	Patient was a minor at the time of the intimacies[1]
3%	Patient married the therapist
32%	Patient had experienced incest or other child sex abuse
10%	Patient had experienced rape prior to intimacies with therapist
11%	Patient required hospitalization considered to be at least partially a result of the intimacies
14%	Patient attempted suicide
1%	Patient committed suicide
17%	Patient achieved complete recovery from any harmful effects of intimacies[2]
20%	Patient seen pro bono or for reduced fee
12%	Patient filed formal (e.g., licensing, malpractice) complaint

Pope & Vetter, 1991

Reasons for refraining from sexual intimacy

Table 3 - Reasons Offered for Refraining from Sexual Intimacies with Clients

Content category	Frequency
Unethical	289
Countertherapeutic/exploitative	251
Unprofessional practice	134
Against therapists' personal values	133
Therapist already in a committed relationship	67
Fear of censure/loss of reputation	48
Damaging to therapist	43
Disrupts handling of transference/countertransference	28
Fear of retaliation by client	19
Attraction too weak/short-lived	18
Illegal	13
Self-control	8
Common sense	8
Miscellaneous	32

Pope, Keith-Spiegel, & Tabachnick, 1986

“Ethicality” of specific therapy behaviors

Table 1

Ratings codes: 1 = never ethical; 2 = ethical under rare conditions; 3 = ethical under some conditions; 4 = ethical under most conditions; 5 = always ethical; NS = not sure; NR = no response (i.e., missing data).

Percentage of Clinicians (N=1,108) Responding in Each Ethicality Category

Item	1	2	3	4	5	NS	NR
Accepting a gift worth under $10	3.0	13.0	38.4	40.1	5.0	0.4	0.2
Accepting a client's invitation to a special occasion	6.3	26.3	41.0	20.8	4.6	0.8	0.1
Accepting a service or product as payment for therapy	21.4	30.0	28.2	12.7	2.7	4.2	0.7
Becoming friends with a client after termination	14.8	38.4	32.0	10.2	2.1	1.9	0.6
Selling a product to a client	70.8	18.0	7.5	0.9	0.3	2.1	0.5
Accepting a gift worth over $50	44.9	37.0	13.1	1.4	0.8	2.3	0.5
Providing therapy to an employee	57.9	26.2	10.9	2.1	0.2	2.4	0.4
Engaging in sexual activity with a client after termination	68.4	23.2	4.2	0.6	0.3	2.6	0.7
Disclosing details of current personal stresses to a client	26.0	39.3	29.5	2.9	1.3	0.5	0.5
Inviting clients to an office/clinic open house	26.6	24.7	21.5	15.4	5.8	5.0	0.9
Employing a client	49.9	29.5	14.5	2.8	1.2	1.5	0.5
Going out to eat with a client after a session	43.2	37.9	13.6	2.4	0.8	1.4	0.5
Buying goods or services from a client	36.7	35.4	20.6	4.7	0.7	1.5	0.3
Engaging in sexual activity with a client	98.3	0.5	0.0	0.1	0.6	0.4	0.0
Inviting clients to a personal party or social event	63.5	29.2	4.6	0.7	0.5	1.2	0.2
Providing individual therapy to a relative, friend, or lover of an ongoing client	12.6	21.4	38.8	21.4	4.2	1.0	0.5
Providing therapy to a current student or supervisee	44.4	31.0	16.0	5.4	1.0	2.0	0.4
Allowing a client to enroll in one's class for a grade	39.0	28.0	18.0	7.6	1.9	5.2	0.4

Note: Rows may not sum to 100% due to rounding.

Borys & Pope, 1989

Legal Issues and Managed Care

- Counselors have duty to appeal adverse decisions regarding their client(s).
- Counselors have duty to disclose to clients the limitations of managed care and the limits of confidentiality under managed care.
- Counselors have a duty to continue treatment and are not supposed to “abandon” a client if the client does not have the financial means to pay for services.

Ethical Quandaries: What to do?

- Should I rent an apartment to a current client?
- A couple to which I provided marital counseling has asked me to serve as the mediator in their divorce. Should I agree to the request?
- Should I accept a gift from a client at the end of therapy?
  - The gift is a piece of art (value unknown)
  - The gift is a CD made by the client, containing songs that reminded her about our therapy sessions
- Should I buy a car from a dealership owned by a client?

  It is the only dealership in town and the client knows I need a new car
- A work colleague asks me to see her kids (who I don't know) because they are having social problems at school
  - The kids were recently adopted from the former Soviet Union
  - My wife (who is also employed by the Psych dept.) and I are the only Russian-speaking therapists in the community

Complex ethical quandaries: What to do?

(Adapted from Gottlieb, 1993)

- Dr. X was a clinical psychologist in private practice. A single woman in her early twenties consulted him for career and adjustment issues. After working together for six months, the patient felt that the issues were resolved, the psychologist agreed, and treatment was terminated. Two years later, the psychologist attended a social gathering and coincidentally met his former patient. They had a lengthy conversation. Toward the end of the evening she asked the psychologist if he would be interested in establishing a friendship. He told her he would enjoy such a relationship, but noted that he was not free to do so because of their pre-existing professional one. In explaining the dilemma, he specifically mentioned the possibility that a social relationship would preclude any future professional consultation with him. She appeared to understand the issue, waived her right to consult him in the future, and agreed to accept a referral from him if she desired service in the future.

- Dr. Y, a tenured professor in a large psychology department, was having an informal conversation with a current graduate student, a female of similar age, who was leaving for her internship within the year. In the course of the conversation, Dr. Y mentioned missing having a man in her life; she had been widowed some years previously. Some weeks later the graduate student called Dr. Y at home, reminded her of their conversation, and offered to introduce her to a man whom she believed Dr. Y would find interesting.

Ethical issues during termination

- Evaluation
  - Can client maintain gains made in therapy?
  - What resources does client have to manage threats to these gains?
  - How has the change impacted family members or others?
  - What are the client’s feelings regarding termination?
  - Initiate termination when the client is not benefiting from services
  - Address the client's post-terminations concerns
  - Evaluate the efficacy of the counseling services
- Referral needs

Ethical challenges to the discipline

- What (if any) should be psychologists' role in
  - the military
  - government intelligence gathering
  - incarceration

Read more here:

http://ethicalpsychology.org/