Doing Good Well: The Ethical Conduct of Clinical Psychology

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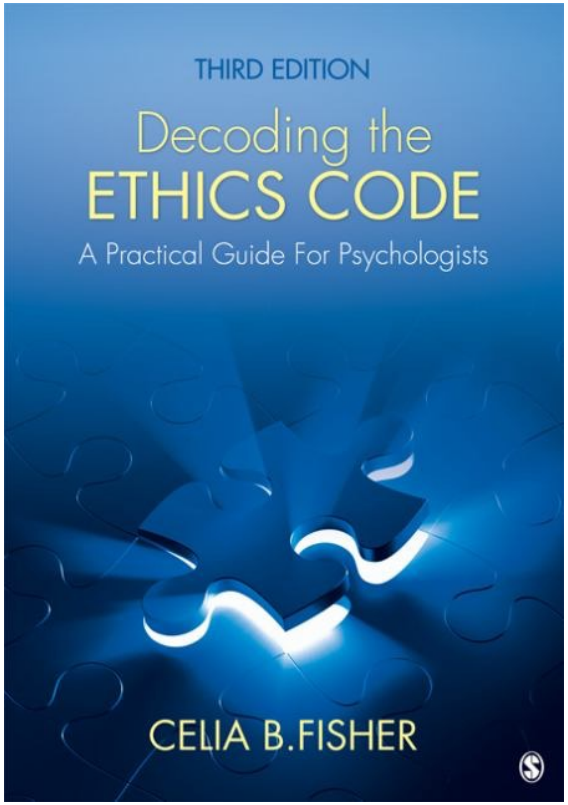
All information and opinions shared are those of the presenter only.

Major Topics

- Applying the APA Ethics Code to everyday clinical practice
- Informed consent for diverse treatment modalities and populations
- Client sensitive confidentiality and disclosure policies
- Avoiding harm and maintaining boundaries
- Respecting Client Diversity



Applying the APA Ethics Code

APA 2010

Aspirational Principles

- Beneficence/Nonmaleficence
- Fidelity/Responsibility
- Integrity
- Justice
- Respect

Applying the APA Ethics Code

Enforceable Standards

- 6 General/4 Area Specific
- Behavioral Rules provided Due Notice
- Use of modifiers: *"Feasible" "Reasonable"*
- APA specialty guidelines

INFORMED CONSENT

- Informed consent basics
- Health literacy and medical mistrust
- Suicidal patients
- Children/adolescents
- Family/couples therapy
- Group therapy
- Internet policies

Informed Consent: Building the Therapeutic Alliance

Standards 3.05, 10.01

- Client-centered language
- Opportunity to ask questions and receive answers
- Limits of confidentiality: What will be shared with insurers
- Risks and alternatives for new or emerging treatments
- *As early as feasible*

Need to Know

HIPAA Notice of Privacy Practices must be a separate document

Institutional consent by intake staff does not substitute for therapist informed consent

Nature and Anticipated Course of Therapy

- Duration of sessions
- Treatment modality
- Number of sessions given current knowledge of presenting problem
- Re-consent when initial goals are met or modified based on revised diagnosis
- Do not assume client is familiar with psychotherapy!

Fees

Standard 6.04; 4:04

- Session costs and annual fee increases
- Payment schedule and type of payment accepted
- Health care plan: Limitations on sessions
- Missed appointments
- Late payment, collection agencies

  "minimum necessary" Standard 4.04

  Inclusion in Notice of Privacy Practices

Need to Know: When Insurers Refuse Extended Coverage

Did you take reasonable steps to:

- Learn about and communicate to client about anticipated number of covered sessions at outset?
- Communicate with insurer when need for continuing treatment became apparent?
- Be prepared to handle client's response to termination of coverage?

Health Literacy & Medical Mistrust

WHO

- Recently immigrated
- Non-English language communities
- Lack of health literacy opportunities
- Those experiencing health care disparities

CONSENT CHALLENGE

- Medical Mistrust
- Lack of familiarity with treatment goals, procedures and terminology
- Lack of familiarity with terms and concepts of voluntary choice and other client rights

Health Literacy & Medical Mistrust

INFORMED CONSENT ETHICAL PRACTICE

- Include educational components during informed consent
- Be aware that language preferences do not always indicate language proficiency

Use of Interpreters

Standard 2.05

Select trained interpreters and Initiate pre-and post session training to ensure that the interpreter has competencies to:

- Interpret consent relevant concepts
- Cultural meanings not just word for word translations
- Identify when clients are confused or concerned about consent relevant information
- Facilitate client-psychologist discussion of questions
- Refrain from reframing information in a misguided but well-intentioned desire to avoid culture embarrassment

Informed Consent with Suicidal Clients

Rudd, Joiner et al (2009)

Frank discussion about suicide risk during informed consent:

- Assists clients (& families) in understanding suicide risk during treatment
- Establishes practitioner/client/family shared responsibility to reduce its likelihood
- Helps clarify importance of treatment compliance & crises management
- Provides opportunity to emphasize need for effective self-management during out-patient care
- Helps psychologist identify & target skill deficits that limit client willingness/ability to access emergency services

Child/Adolescent Therapy

- State laws regarding guardian permission/waiver
- HIPAA rules on "personal representative"
- Developmental data on children's understanding of therapy, mental health disorders, and treatment rights (Standard 2.04)
- Scientific and clinical knowledge on relationship between diagnoses and cognitive and emotional capacity to consent (Standard 2.04)
- Individual evaluation of client's appreciation of mental health needs and history of health care decision-making
- **NEVER ASK A CHILD TO CONSENT IF THEIR REFUSAL WILL NOT BE RESPECTED**

Family and Couples Therapy

Standard 10.02

- Which individuals are clients
- Individual/conjoint sessions
- Correct misimpressions in expectations on treatment goals
- Secret sharing policies
- State laws governing privilege in case of child custody, divorce or other legal proceedings
- Mandated reporting requirements
- **Be aware of signs of child abuse, elder abuse, and IPV (see relevant APA Guidelines in references)**

Group Therapy

Standard 10.03

- Group member responsibility: Turn taking, prohibitions against socializing outside sessions
- Confidentiality: Therapist and member obligations
- Clients responsibilities in acceptance of diverse opinions, abusive language, coercive or aggressive behaviors, member scapegoating
- Termination policies and voluntary withdrawal

Concurrent Single/Group Therapy

Brabender & Fallon, 2009

- Why clinically indicated (Standard 3.05, 3.06, 3.08)
- Voluntary or required at outset of treatment
- Concerns about cost and time
- Differences in exclusivity of therapist's attention vs attention to group dynamics
- Confidentiality across modalities

Informed Consent: Electronic Communication Policy

- INTERNET SEARCH POLICY: For emergency contact, corroborate client clinically relevant statements
- SOCIAL MEDIA POLICY: Friending, fanning; following twitter or blog posts; cancelling unintentional online relationship
- EMAIL/TEXTING POLICIES: Billing, appointments, administrative—policy on responding to clinical questions
- PROFESSIONAL WEBSITE POLICY: be mindful of client access to personal information on Internet

E-Therapy

- Cyber security a 2-way street
- Limits of insurance coverage--Submitted claims must clearly identify services as electronic with specific IDs
- Initial and continuing verification of identity, age, state, contact information, support contacts
- Know state laws on e-therapy involving minors

CONFIDENTIALITY

- General requirements
- Responding to client request for disclosure
- Implications of HIPAA
- Disclosure policies: Harm to self or others
- Involvement of parents in child/adolescent treatment

Confidentiality: General Requirements

Standards 4.01, 4.02

- Password protect all records
- Institutional Cyber security
- Keep progress notes separate from Protected Health Information (PHI: HIPAA)
- When electronically transmitting PHI encrypt when appropriate and ensure receiver is HIPAA compliant
- Avoid when possible and develop confidentiality protection procedures for telephone or other electronic messages

Need to Know: Under HIPAA

Insurers do not have access to psychotherapy notes

Insurers should not be given access to names of clients not covered by insurer

Client Request for Disclosure of Confidential Information

Standard 4.05 & HIPAA

Obtain signed HIPAA authorization specifying:

- Recipient
- Time limitations
- Nature of information disclosed

Psychologists may decline request if:

- They believe it will cause harm client, but…
- HIPAA defines harm as physical endangerment or life-threatening AND permits appeal by licensed health professional

Need to Know

- Clients do not have access to psychotherapy/process notes as long as they are filed separately from PHI
- When working for or receiving information from an institution or attorney confirm appropriate consent/authorization

Disclosures w/out Client Consent: Duty to Protect

Standard 4.05b

- Special Relationship
- Established scientific or clinical basis for predicting violence and immediacy of threat;
- Identifiable victim*
- *Some courts have broadened requirement to identifiable population of victims

Disclosures: Suicidal Intent

Jobes, Rudd, Overholser & Joiner, 2008

COMPETENCIES

- Training to recognize, manage and treat suicidality
- Prior identification of social support and community resources
- Knowledge of legal principles and institutional policies regarding voluntary or involuntary commitment

Disclosures: Suicidal Intent

PROCEDURES

- Evaluate level of risk
- Draw on consultative relationships with other professionals
- Evaluate client's support systems and ability to access emergency services
- Involve client to the extent possible in disclosure procedure

Disclosure: Nonsuicidal Self-Injury

Andover et al., 2010; Lieberman et al., 2008; Nock e al., 2006; Walsh, 2008

- Distinguish NSSI from suicidal behavior (e.g. cutting on extremities)
- Recognize NSSI and suicidality can co-occur
- Be familiar with gender differences in age of onset, degree of medical injury and NSSI methods
- Be able to distinguish peer (body piercing) vs. pathology related self-injury (face, eyes, genitals)
- Recognize when NSSI requires medical attention and know in advance local emergency services
- When disclosing self-injury to parents, help distinguish NSSI from suicidality as well as possibility of future suicidal behaviors

Confidentiality & Disclosure in Child/Adolescent Treatment

1. The Consent Conference

- Establish a trusting relationship with child and parent(s)
- Describe ethical and legal responsibilities
- Discuss developmentally appropriate confidentiality and information sharing
- Obtain feedback
- Establish confidentiality policy consistent with professional standards, child's clinical needs *and* cultural and familial context

2. Parental Requests for Information

- Empathic and respectful listening—assume genuine parental concern
- Avoid turning request into power struggle
- Guard against taking on parental counseling role
- Help parents reframe confidentiality: Child's developing autonomy; Maintaining therapeutic trust
- Consider clinically appropriate child/parent sharing processes

3. Determine if Disclosure May be Warranted

- Confirm child is actually engaging in risk behavior
- Is incident isolated? A continuing pattern? Escalating?
- Assess child's ability to terminate risk behaviors
- Conduct appropriate risk reduction interventions; monitor behavior
- Weigh therapeutic, social, health, and legal consequences
- Anticipate parents' response to disclosure

4. Work with Client to Disclose

- Evaluate willingness of child to disclose to parents
- Avoid entering into a clinically contraindicated "secrecy pact"
- Be wary of assumptions regarding client's desire for confidentiality
- Prepare client for disclosure—respond to feelings, but do not avoid focus on disclosure process
- Go over steps to be taken

5. Disclosing to Parent

- Involve child as much as possible
- Frame within the context of ongoing treatment
- Focus on positive actions child and parent can take
- Provide appropriate referrals
- Schedule follow-up meetings with parents and client to monitor reactions and provide additional guidance

HUMAN RELATIONS

- Setting boundaries
- Nonsexual physical contact with clients
- Referrals from clients
- Avoiding Harm: Exposure & Aversion therapies
- Avoiding Harm: Psychotherapy
- Terminating Therapy

Setting Appropriate Boundaries

Standards 3.05, 3.06, 3.08

Boundaries protect against a blurring of personal and professional domains that could:

- Impair the psychologist's objectivity, competence, or effectiveness to deliver services
- Jeopardize clients' confidence that psychologists will act in their best interests.
- Risks client exploitation or harm

Nonsexual Physical Contact

- Is physical contact consistent with treatment goals?
- Will contact strengthen or jeopardize future treatment
- How will client perceive contact?
- Does contact serve needs of psychologist?
- Is contact a substitute for more professionally appropriate behavior?
- Is contact part of a continuing pattern of behavior that may reflect psychologist's personal problems or conflicts?

Referrals from Clients

Standard 3.05; Shapiro & Ginsberg, 2003

EVALUATE

- Does client's mental health or motive to refer suggest acceptance would be clinically contraindicated?
- Is a former referring client likely to need the psychologist's services in the future?
- Can referral impair the psychologist's objectivity? Treatment effectiveness?
- Does the psychologist's current financial situation risk client exploitation?
- Has psychologist explicitly or implicitly encouraged referrals?

Referrals from Clients

Standards 3.05

PRECAUTIONS

- Consider including a non-referral policy during informed consent
- Provide professional referral in case of emergency

UNAVOIDABLE MULTIPLE RELATIONSHIPS: REFERRALS IN UNDER-SERVED POPULATIONS

- Consult with colleagues to ensure objectivity
- Take extra steps to protect confidentiality
- Engage clients in discussion of ethical challenges and steps psychologist will take to mitigate risk
- Encourage clients to alert psychologist to instances that might jeopardize his/her effectiveness

Avoiding Harm: Exposure & Aversion Therapies

- Is there evidence of treatment effectiveness for individuals similar to client in diagnosis, age, physical health, gender, culture?
- Have empirically/clinically validated alternative treatments been considered?
- Has the nature of the treatment and anticipated emotional/physical responses been adequately explained during initial informed consent and at the beginning of each subsequent treatment?
- Is there a well-developed monitoring plan to: Minimize anxiety, avoid precipitous termination or ineffective continuation of treatment?

Can Behavioral and Cognitive Therapy Cause Harm?

- Treatments powerful enough to change cognition and behavior have the potential for iatrogenic effects
- Fluctuation of negative symptoms and mental health needs are a natural course of evidence-based therapy
- Harmful psychotherapies produce outcomes worse than what would have occurred without treatment (Dimidjian & Hollon, 2010)

Avoiding Psychotherapy Harms

Barlow, 2010; Beutler et al, 2006; Castonguay et al, 2010; Lilienfeld, 2007

- Obtain training in flexible use of interventions
- Avoid premature clinical interpretations and over/under diagnosis
- Determine whether client characteristics and treatment setting match those reported for specific EBP
- Monitor change suggesting deterioration or lack of improvement
- Continuously evaluate what works or interferes with positive change
- Attend to and use client disclosures of frustration with treatment to evaluate and modify diagnosis, adjust treatment, and strengthen therapeutic alliance

Terminating Therapy

Standard 10.10

WHEN

- Client patient no longer needs service, not likely to benefit, or is being harmed
- Psychologist is threatened or endangered by client or person w/ whom the client has a relationship

HOW

- Conduct pre-termination counseling and suggest alternative services
- Avoid persistence in contacting client who abruptly drops out of treatment

What is Abandonment?

When client in imminent need of treatment is harmed by termination of services in the absence of a clinically and ethically appropriate process (Younggren et al, 2011).

Avoiding Abandonment

- Develop termination plan at outset of treatment and discuss during IC along with nature and anticipated course of therapy
- Develop well conceptualized rationale for termination based on clinical, relational, and situational factors
- Consult with client as early as feasible
- Construct termination timeline and be responsive to client reaction
- Provide appropriate referrals if appropriate

NEED TO KNOW: AVOIDING ABANDONMENT

- Avoid unnecessary follow-up
- Create record document key components of termination rationale and process

Ethical Competence with Diverse Populations

- Ethical pluralism
- Goodness-of-Fit Ethics
- Diagnostic pluralism
- Religion & spirituality in therapy

Competence

Competence is the lynchpin of the discipline enabling psychologists to fulfill all other ethical obligations.

Competence & Ethical Pluralism

Standard 2.01b

- Psychologists draw on established scientific and professional knowledge
- To appropriately identify factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status
- Essential for effective services

Goodness-of-Fit Ethics

Fisher, 2003; 2013; 2014; Fisher & Ragsdale, 2006; Masty & Fisher, 2008

- What life circumstances render client more susceptible to the benefits or risks of the intended psychological assessment or treatment?
- Are there aspects of the treatment or setting that are "misfitted" to client competencies, values, fears and hopes?
- Does client have different conceptions of treatment goals?
- How can psychologist engage client in mutually respectful dialogue to illuminate the lens through which each view the psychologist's work?
- How can psychologists draw on such dialogue to best harmonize their procedures to reflect the values and merit the trust of those they serve?

Diagnostic Pluralism

Korchin (1980, p. 264)

"Pathology can be said to exist if a person:

- Lacks voluntary control, ego strength, flexibility, and adaptability
- Has only a weak sense of personal identity
- Feels driven by powerful and painful impulses and negative affects
- At the extreme, reveals disturbances of basic psychological functions (perception, learning, memory)…"

Avoiding Misdiagnosis

Standard 2.04, 9.02

- Have EBP or DSM criteria has been validated on client population?
- Have comparative or deficit approaches led to inappropriate or overuse of certain diagnoses?
- Are positive mental health criteria based on majority group attitudes or behaviors?
- Can I recognize the meaning function of particular behaviors/symptoms within the client's particular cultural context?
- How does the meaning of mental illness in the client's life affect his/her motivation and perseverance to sustain treatment?

Population Sensitivity vs. Stereotype

- Grouping clients into social categories that may not reflect how they see themselves
- Over- or under-estimating the role of cultural, gender, and other characteristics on the presenting problem?
- Failing to recognize the fluid, evolving and multifaceted nature of identity
- Precipitously separating medical conditions from psychosocial and physiological and cumulative effects of discrimination

Religion and Spirituality in Therapy

Bartoli, 2007; Fisher, 2013; Plante, 2007

- Understand how religion presents itself in mental health and psychopathology
- Be able to identify when a mental health problem is related to religious beliefs
- Do not confuse religious values with mental health problems
- Become familiar with techniques to assess and treat clinically relevant religious/spiritual beliefs and emotional reactions
- Obtain knowledge of EBP on the use of religious imagery, prayer, or other religious techniques
- Be familiar with appropriate role of traditional medicines, clergy and cultural healers as conjunctive services

Need to Know

- Shared faith beliefs do not equal competence to provide religion sensitive psychotherapy
- When appropriate discuss your approach to the role of religion in treatment during informed consent
- Be aware of personal religious bias that may interfere with your objectivity
- Know boundaries between discussing treatment relevant responses to religious doctrine vs. religious counseling or imposing religious values

Religion and Therapy with LGBTQ Clients

Magaldi-Dopman & Park-Taylor, 2010; Matthews et al., 2012; Sherry, 2010

Obtain training in therapeutic techniques to effectively address:

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

NEED TO KNOW:
RELIGION AND THERAPY WITH LGBTQ CLIENTS

- Rejection by one's religious institution does not mean LGBTQ clients are not deeply religious, spiritual or seeking to be!

Doing Good Well

- Psychologists are not technocrats working their way through a maze of ethical rules
- The APA Code provides aspirations and general rules of conduct that must be interpreted and applied to the unique roles and relationships of clinical practice
- Good and justly implemented professional practice relies on a conception of psychologists as active moral agents committed to doing what is right because it is right.

Questions/further discussion

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