CHAPTER 3

The APA Ethics Code and Ethical Decision Making

The APA’s Ethics Code provides a set of aspirational principles and behavioral rules written broadly to apply to psychologists’ varied roles and the diverse contexts in which the science and practice of psychology are conducted. The five aspirational principles described in [Chapter 2](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/ch02.html) represent the core values of the discipline of psychology that guide members in recognizing in broad terms the moral rightness or wrongness of an act. As an articulation of the universal moral values intrinsic to the discipline, the aspirational principles are intended to inspire right action but do not specify what those actions might be. The ethical standards that will be discussed in later chapters of this book are concerned with specific behaviors that reflect the application of these moral principles to the work of psychologists in specific settings and with specific populations. In their everyday activities, psychologists will find many instances in which familiarity with and adherence to specific Ethical Standards provide adequate foundation for ethical actions. There will also be many instances in which (a) the means by which to comply with a standard are not readily apparent, (b) two seemingly competing standards appear equally appropriate, (c) application of a single standard or set of standards appears consistent with one aspirational principle but inconsistent with another, or (d) a judgment is required to determine if exemption criteria for a particular standard are met.

The Ethics Code is not a formula for solving these ethical challenges. The Ethics Code provides psychologists with a set of aspirations and broad general rules of conduct that must be interpreted and applied as a function of the unique scientific and professional roles and relationships in which they are embedded. Psychologists are not moral technocrats simply working their way through a maze of ethical rules. Successful application of the principles and standards of the Ethics Code involves a conception of psychologists as active moral agents committed to the good and just practice and science of psychology. Ethical decision making thus involves a commitment to applying the Ethics Code to construct rather than simply discover solutions to ethical quandaries.

This chapter discusses the ethical attitudes and decision-making strategies that can help psychologists prepare for, identify, and resolve ethical challenges as they continuously emerge and evolve in the dynamic discipline of psychology. An opportunity to apply these strategies is provided in the 10 case studies presented in [Appendix B](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/appendixb.html).

**Ethical Commitment and Virtues**

*The development of a dynamic set of ethical standards for psychologists’ work-related conduct requires a personal commitment and lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees, and colleagues; and to consult with others concerning ethical problems.*

—APA (2010c, Preamble)

Ethical commitment refers to a strong desire to do what is right because it is right (Josephson Institute of Ethics, 1999). In psychology, this commitment reflects a moral disposition and emotional responsiveness that move psychologists to creatively apply the APA’s Ethics Code principles and standards to the unique ethical demands of the scientific or professional context.

The desire to do the right thing has often been associated with moral virtues or moral character, defined as a disposition to act and feel in accordance with moral principles, obligations, and ideals—a disposition that is neither principle bound nor situation specific (Beauchamp & Childress, 2001; MacIntyre, 1984). Virtues are dispositional habits acquired through social nurturance and professional education that provide psychologists with the motivation and skills necessary to apply the ideals and standards of the profession (see, e.g., Hauerwas, 1981; Jordan & Meara, 1990; May, 1984; National Academy of Sciences, 1995; Pellegrino, 1995). Fowers (2012) describes virtues as the cognitive, emotional, dispositional, behavioral, and wisdom aspects of character strength that motivates and enables us to act ethically out of an attachment to what is good.

**Focal Virtues for Psychology**

Many moral dispositions have been proposed for the virtuous professional (Beauchamp & Childress, 2001; Keenan, 1995; MacIntyre, 1984; May, 1984). For disciplines such as psychology, in which codes of conduct dictate the general parameters but not the context-specific nature of ethical conduct, conscientiousness, discernment, and prudence are requisite virtues.

* A *conscientious* psychologist is motivated to do what is right because it is right, diligently tries to determine what is right, and makes reasonable attempts to do the right thing.
* A *discerning* psychologist brings contextually and relationally sensitive insight, good judgment, and appropriately detached understanding to determine what is right.
* A *prudent* psychologist applies practical wisdom to ethical challenges leading to right solutions that can be realized given the nature of the problem and the individuals involved.

Some moral dispositions can be understood as derivative of their corresponding principles (Beauchamp & Childress, 2001). Drawing on the five APA General Principles, [Table 3.1](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/ch03.html#table3-1) lists corresponding virtues.

The virtues considered most salient by members of a profession will vary with differences in role responsibilities. Benevolence, care, and compassion are often associated with the provision of mental health services. Prudence, discretion, and trustworthiness have been considered salient in scientific decision making. Scientists who willingly and consistently report procedures and findings accurately are enacting the virtue of honesty (Fowers, 2012). Fidelity, integrity, and wisdom are moral characteristics frequently associated with teaching and consultation. Across all work activities the virtue of “self-care” enables psychologists to maintain appropriate competencies under stressful work conditions (see the Hot Topic “The Ethical Component of Self-Care” at the end of this chapter.

“Openness to the other” has been identified as a core virtue for the practice of multiculturalism (Fowers&Davidov, 2006). Openness is characterized by a personal and professional commitment to applying a multicultural lens to our work motivated by a genuine interest in understanding others rather than reacting to a new wave of multicultural “shoulds” (Gallardo, Johnson, Parham, & Carter, 2009). It reflects a strong desire to understand how culture is relevant to the identification and resolution of ethical challenges in research and practice, to explore cultural differences, to respond to fluid definitions of group characteristics, to recognize the realities of institutional racism and other forms of discrimination on personal identity and life opportunities, and to creatively apply the profession’s ethical principles and standards to each cultural context (Aronson, 2006; Fisher, in press; Fowers&Davidov, 2006; Hamilton &Mahalik, 2009; Neumark, 2009; Riggle, Rostosky, & Horne, 2010; D. W. Sue & Sue, 2003; Trimble, 2009; Trimble & Fisher, 2006).

**Table 3.1** APA Ethics Code General Principles and Corresponding Virtues

|  |  |
| --- | --- |
| *APA General Principles* | *Corresponding Virtues* |
| Principle A: Beneficence and Nonmaleficence | Compassionate, humane, nonmalevolent, and prudent |
| Principle B: Fidelity and Responsibility | Faithful, dependable, and conscientious |
| Principle C: Integrity | Honest, reliable, and genuine |
| Principle D: Justice | Judicious and fair |
| Principle E: Respect for People’s Rights and Dignity | Respectful and considerate |

**Can Virtues Be Taught?**

*No course could automatically close the gap between knowing what is right and doing it.*

—Pellegrino (1989, p. 492)

Some have argued that psychology professors cannot change graduate students’ moral character through classroom teaching, and therefore ethics education should focus on understanding the Ethics Code rather than instilling moral dispositions to right action. Without question, however, senior members of the discipline, through teaching and through their own examples, can enhance the ability of students and young professionals to understand the centrality of ethical commitment to ethical practice. At the same time, the development of professional moral character is not to simply know about virtue but to become good (P. A. Scott, 2003). Beyond the intellectual virtues transmitted in the classroom and modeled through mentoring and supervision, excellence of character can be acquired through habitual practice (Begley, 2006). One such habit is that the virtuous graduate student and seasoned psychologist are committed to lifelong learning and practice in the continued development of moral excellence.

**Ethical Awareness and Moral Principles**

*In the process of making decisions regarding their professional behavior, psychologists must consider this Ethics Code, in addition to applicable laws and psychology board regulations.*

—APA (2010c, Introduction)

*Lack of awareness or misunderstanding of an ethical standard is not itself a defense to a charge of unethical conduct.*

—APA (2010c, Introduction)

Ethical commitment is just the first step in effective ethical decision making. Good intentions are insufficient if psychologists fail to identify the ethical situations to which they should be applied. Psychologists found to have violated Ethical Standards or licensure regulations have too often harmed others or damaged their own careers or the careers of others because of ethical ignorance. Conscientious psychologists understand that identification of situations requiring ethical attention depends on familiarity and understanding of the APA Ethics Code, relevant scientific and professional guidelines, laws and regulations applicable to their specific work-related activities, and an awareness of relational obligations embedded within each context.

**Moral Principles and Ethical Awareness**

To identify a situation as warranting ethical consideration, psychologists must be aware of the moral values of the discipline. Although the Ethics Code’s General Principles are not exhaustive, they do identify the major moral ideals of psychology as a field. Familiarity with the General Principles, however, is not sufficient for good ethical decision making. Psychologists also need the knowledge, motivation, and coping skills to detect when situations call for consideration of these principles and attempt to address these issues when and if possible before they arise (Crowley & Gottlieb, 2012; Tjeltveit& Gottlieb, 2010; see also the Hot Topic “The Ethical Component of Self Care” at the end of this chapter). [Table 3.2](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/ch03.html#table3-2) identifies types of ethical awareness corresponding to each General Principle.

**Table 3.2** APA Ethics Code General Principles and the Ethical Awareness Necessary to Apply the Principles

|  |  |
| --- | --- |
| *APA General Principles* | *Corresponding Ethical Awareness* |
| Principle A: Beneficence and Nonmaleficence | Psychologists should be able to identify what is in the best interests of those with whom they work, when a situation threatens the welfare of individuals, and the competencies required to achieve the greatest good and avoid or minimize harm. |
| Principle B: Fidelity and Responsibility | Psychologists should be aware of their obligations to the individuals and communities affected by their work, including their responsibilities to the profession and obligations under the law. |
| Principle C: Integrity | Psychologists should know what is possible before making professional commitments and be able to identify when it is necessary to correct misconceptions or mistrust. |
| Principle D: Justice | Psychologists should be able to identify individual or group vulnerabilities that can lead to exploitation and recognize when a course of action would result in or has resulted in unfair or unjust practices. |
| Principle E: Respect for People’s Rights and Dignity | Psychologists must be aware of special safeguards necessary to protect the autonomy, privacy, and dignity of members from the diverse populations with whom psychologists work. |

**Ethical Awareness and Ethical Theories**

Ethical theories provide a moral framework to reflect on conflicting obligations. Unfortunately, ethical theories tend to emphasize one idea as the foundation for moral decision making, and illustrative problems are often reduced to that one idea. Given the complexity of moral reality, these frameworks are probably not mutually exclusive in their claims to moral truth (Steinbock, Arras, & London, 2003). However, awareness of the moral frameworks that might help address an ethical concern can also help clarify the values and available ethical choices (Beauchamp & Childress, 2001; Fisher, 1999; Kitchener, 1984).

**Deception Research: A Case Example for the Application of Different Ethical Theories**

Since Stanley Milgram (1963) published his well-known obedience experiments, the use of deception has become normative practice in some fields of psychological research and a frequent source of ethical debate (Baumrind, 1964, 1985; Fisher &Fyrberg, 1994). Deceptive techniques in research intentionally withhold information or misinform participants about the purpose of the study, the methodology, or roles of research confederates (Sieber, 1982). The methodological rationale for the use of deception is that some psychological phenomena cannot be adequately understood if research participants are aware of the purpose of the study. For example, deception has been used to study the phenomenon of “bystander apathy effect,” the tendency for people in the presence of others to observe but not help a person who is a victim of an attack, medical emergency, or other dangerous condition (Latane& Darley, 1970). In such experiments, false emergency situations are staged without the knowledge of the research participants, whose reactions to the “emergency” are recorded and analyzed.

By its very nature, the use of deception in research creates what Fisher (2005a) has termed the *consent paradox*. On the one hand intentionally deceiving participants about the nature and purpose of a study conflicts with Principle C: Integrity and with enforceable standards requiring psychologists to obtain fully informed consent of research participants prior to study initiation. On the other hand by approximating naturalistic contexts in which everyday behaviors take place, the use of deception research can reflect Principle A: Beneficence and Nonmaleficence by enhancing the ability of psychologists to generate scientifically and socially useful knowledge that might not otherwise be obtained.

Below are examples of how different ethical theories might lead to different conclusions about the moral acceptability of deception research. Readers should refer to [Chapter 11](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/ch11.html) for a more in-depth discussion of [Standard 8.07](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/appendixa.html#st8-7), Deception in Research.

*Deontology*

Deontology has been described as “absolutist,” “universal,” and “impersonal” (Kant, 1785/1959). It prioritizes absolute obligations over consequences. In this moral framework, ethical decision making is the rational act of applying universal principles to all situations irrespective of specific relationships, contexts, or consequences. This reflects Immanuel Kant’s conviction that ethical decisions cannot vary or be influenced by special circumstances or relationships. Rather, a decision is “moral” only if a rational person believes the act resulting from the decision should be universally followed in all situations. For Kant, respect for the worth of all persons was one such universal principle. A course of action that results in a person being used simply as a means for others’ gains would be ethically unacceptable.

With respect to deception in research, from a deontological perspective, since we would not believe it moral to intentionally deceive individuals in some other context, neither potential benefits to society nor the effectiveness of participant debriefing for a particular deception study can morally justify intentionally deceiving persons about the purpose or nature of a research study. Further, deception in research would not be ethically permissible since intentionally disguising the nature of the study for the goals of research violates the moral obligation to respect each participant’s intrinsic worth by undermining individuals’ right to make rational and autonomous decisions regarding participation (Fisher &Fyrberg, 1994).

*Utilitarianism*

Utilitarian theory prioritizes the consequences (or utility) of an act over the application of universal principles (Mill, 1861/1957). From this perspective, an ethical decision is situation specific and must be governed by a risk–benefit calculus that determines which act will produce the greatest possible balance of good over bad consequences. An “act utilitarian” makes an ethical decision by evaluating the consequences of an act for a given situation. A “rule utilitarian” makes an ethical decision by evaluating whether following a general rule in all similar situations would create the greater good. Like deontology, utilitarianism is impersonal: It does not take into account interpersonal and relational features of ethical responsibility. From this perspective, psychologists’ obligations to those with whom they work can be superseded by an action that would produce a greater good for others (Fisher, 1999).

A psychologist adhering to act utilitarianism might decide that the potential knowledge about social behavior generated by a specific deception study could produce benefits for many members of society, thereby justifying the minimal risk of harm and violation of autonomy rights for a few research participants. A rule utilitarian might decide against the use of deception in all research studies because the unknown benefits to society did not outweigh the potential harm to the discipline of psychology if society began to see it as an untrustworthy science.

*Communitarianism*

Communitarian theory assumes that right actions derive from community values, goals, traditions, and cooperative virtues. Accordingly, different populations with whom a psychologist works may require different conceptualizations of what is ethically appropriate (MacIntyre, 1989; Walzer, 1983). Unlike deontology, communitarianism rejects the elevation of individual over group rights. Whereas utilitarianism asks whether a policy will produce the greatest good for all individuals in society, communitarianism asks whether a policy will promote the kind of community we want to live in (Steinbock et al., 2003).

Scientists as members of a community of shared values have traditionally assumed that (a) the pursuit of knowledge is a universal good and that (b) consideration for the practical consequences of research will inhibit scientific progress (Fisher, 1999; Sarason, 1984; Scarr, 1988). From this “community of scientists” perspective, the results of deception research are intrinsically valuable, and standards or regulations prohibiting deceptive research would deprive society of this knowledge. Thus, communitarian theory may be implicitly reflected, at least in part, in the acceptance of deception research in the APA Ethics Code ([Standard 8.07](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/appendixa.html#st8-7), Deception in Research) and in current federal regulations (Department of Health and Human Services [DHHS], 2009) as representing the values of the scientific community. At the same time little is known about the extent to which the “community of research participants” shares the scientific community’s valuing of deception methods (Fisher &Fyrberg, 1994).

*Feminist Ethics*

Feminist ethics, or an ethics of care, sees emotional commitment to act on behalf of persons with whom one has a significant relationship as central to ethical decision making. This moral theory rejects the primacy of universal and individual rights in favor of relationally specific obligations (Baier, 1985; Brabeck, 2000; Fisher, 2000; Gilligan, 1982). Feminist ethics also focuses our attention on power imbalances and supports efforts to promote equality of power and opportunity. In evaluating the ethics of deception research, feminist psychologists might view intentional deception as a violation of interpersonal obligations of trust by investigators to participants and as reinforcing power inequities by permitting psychologists to deprive persons of information that might affect their decision to participate.

**Ethical Absolutism, Ethical Relativism, and Ethical Multiculturalism**

The movement known as multiculturalism is reshaping moral dialogue in psychology through its emphasis on inclusion, social justice, and mutual respect (Fowers&Davidov, 2006).

Psychologists with high levels of ethical commitment and awareness are often stymied by moral complexities that surface when psychological activities are conducted in diverse contexts, cultures, or communities. For example, when applied to ethical decision making across different contexts, the universal perspective of the deontic position is indifferent to particular persons and situations. It therefore rejects the influence of culture on the identification and resolution of ethical problems in a manner that can lead to a one-size-fits-all form of ethical problem solving (Fisher, 1999). In sharp contrast, ethical relativism, often associated with some forms of utilitarianism and communitarianism, denies the existence of universal or common moral values characterizing the whole of human relationships, proposing instead that the identification and resolution of ethical problems are unique to each particular culture or community.

Ethical contextualism (Fisher, 1999, 2000, in press; Macklin, 1999) blends the two approaches assuming that moral principles such as beneficence and respect for autonomy are universally valued across diverse contexts and cultures, but the expression of an ethical problem and the right actions to resolve it can be unique to the cultural context. From this perspective, universal moral principles can mediate our understanding of ethical meaning across diverse contexts without placing a priority on the principles themselves over the moral frameworks of others (Walker, 1992).

*Culture and Informed Consent: A Case Example*

Take the example of the ethical challenge of obtaining informed consent for mental health treatment for women suffering from posttraumatic stress disorder (PTSD) in war-torn countries where cultural mores require that permission is obtained from fathers, husbands, or brothers before a practitioner can offer services to women.

A psychologist who is an ethical absolutist might refuse to obtain permission from a male relative prior to obtaining consent from a female living in this culture on the grounds that any action that privileges the opinion of a third party in a treatment or research decision is a violation of a universal principle of respect for individual autonomy. The cultural relativist, on the other hand, might interpret the cultural mores dictating male privilege as evidence that respect for individual autonomy is not a moral value in this particular culture; consequently, any action consistent with the cultural norm (e.g., obtaining the male relative’s permission) is ethical.

The ethical contextualist would see the problem as one that requires consideration of both a universal valuing of individual autonomy and its traditional expression within this particular culture. A psychologist adopting this position would seek to resolve the ethical problem in a manner consistent with both. For example, examining the cultural meaning of this tradition, a psychologist might find that women in this culture value the male gatekeeper role and see it as beneficial to themselves and/or the stability of their families and communities. In this scenario, principles of justice and respect for personhood might result in an ethical resolution in which psychologists seek permission from a male relative before they obtain informed consent from potential female clients/patients—at the same time making it clear to both parties that the psychologist would respect the woman’s right to refuse treatment irrespective of male permission.

Alternatively, the ethical contextualist might find that women living in this particular cultural community view this tradition as repressive and fear harsh retaliation if they disagree with the decision of their husbands or other male relatives. In this scenario, drawing on the principles of beneficence and nonmaleficence and respect for personhood, the psychologist might create a safe and confidential opportunity for women to learn about and then consent or refuse the treatment on their own without male involvement. For further discussion of these and related issues, readers are referred to the Hot Topics in [Chapter 5](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/ch05.html), on multicultural ethical competence, and in [Chapter 13](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/ch13.html), on the integration of religion and spirituality in therapy.

**Ethical Competence and Ethical Decision Making**

Too often, psychologists approach ethics as an afterthought to assessment or treatment plans, research designs, course preparation, or groundwork for forensic or consulting activities. Ethical planning based on familiarity with ethical standards, professional guidelines, state and federal laws, and organizational and institutional policies should be seen as integral rather than tangential to psychologists’ work.

**Ethical Knowledge and Planning**

*Ethical Standards*

Familiarity with the rules of conduct set forth in the Ethical Standards enables psychologists to take preventive measures to avoid the harms, injustices, and violations of individual rights that often lead to ethical complaints. For example, psychologists familiar with the standards on confidentiality and disclosure discussed in [Chapter 7](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/ch07.html) will take steps in advance to (a) develop appropriate procedures to protect the confidentiality of information obtained during their work-related activities; (b) appropriately inform research participants, clients/patients, organizational clients, and others in advance about the extent and limitations of confidentiality; and (c) develop specific plans and lists of appropriate professionals, agencies, and institutions to be used if disclosure of confidential information becomes necessary.

*Guidelines*

Good ethical planning also involves familiarity with guidelines for responsible practice and science. The APA and other professional and scientific organizations publish guidelines for responsible practice appropriate to particular psychological activities. Guidelines, unlike ethical standards, are essentially aspirational and unenforceable. As a result, compared with the enforceable Ethics Code standards, guidelines can include recommendations for and examples of responsible conduct with greater specificity to role, activity, and context. For example, [Standard 2.01](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/appendixa.html#st2-1), Boundaries of Competence, requires psychologists to limit their services to populations and areas within their boundaries of competence, but as a general standard it does not specify what such competencies are in different work contents. By contrast, guidelines such as those for multicultural education, training, research, practice, and organizational change for psychologists (APA, 2003) describe the specific areas of training, education, or supervision that psychologists must have to perform their jobs competently. The Guidelines for Assessment of Dementia and Evaluation of Age-Related Cognitive Change (APA, 2012a) provides a list of necessary competencies, including memory changes associated with normative aging and the broad range of medical, pharmacological, and mental health disorders (e.g., depression) that can influence cognition in older adults. The crafters of guidelines developed by APA constituencies usually attempt to ensure that their recommendations are consistent with the most current APA Ethics Code—readers should be alert to instances in which the 2010 Ethics Code renders some guideline recommendations adopted prior to 2010 obsolete. Specific Guidelines are discussed throughout this book where their relevance to ethical standards can be applied.

*Laws, Regulations, and Policies*

Another important element of information gathering is identifying and understanding applicable laws, government regulations, and institutional and organizational policies that may dictate or limit specific courses of action necessary to resolve an ethical problem. There are state and federal laws and organizational policies governing patient privacy, mandated reporting, research with humans and animals, conduct among military enlistees and officers, employment discrimination, conflicts of interest, billing, and treatment. Psychologists involved in forensically relevant activities must also be familiar with rules of evidence governing expert testimony. Readers may wish to refer to the Hot Topic in [Chapter 12](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/ch12.html) on the implications of case and federal law on the use of assessments in expert testimony.

As discussed in [Chapter 2](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/ch02.html), only a handful of Ethical Standards require psychologists to adhere to laws or institutional rules. However, choosing an ethical path that violates law, institutional rules, or company policy can have serious consequences for psychologists and others. Laws and policies should not dictate ethics, but familiarity with legal and organizational rules is essential for informed ethical decision making. When conflicts between ethics and law arise, psychologists consider the consequences of the decision for stakeholders, use practical wisdom to anticipate and take preventive actions for complications that can arise, and draw on professional virtues to help identify the moral principles most salient for meeting professional role obligations (Knapp, Gottlieb, Berman, &Handelsman, 2007).

*Stakeholders*

Ethical decision making requires sensitivity to and compassion for the views of individuals affected by actions taken. Discussions with stakeholders can clarify the multifaceted nature of an ethical problem, illuminate ethical principles that are in jeopardy of being violated or ignored, and alert psychologists to potential unintended consequences of specific action choices. By taking steps to understand the concerns, values, and perceptions of clients/patients, research participants, family members, organizational clients, students, IRBs or corporate compliance officers, and others with whom they work, psychologists can avoid ethical decisions that would be ineffective or harmful (Fisher, 1999, 2000).

**Steps in Ethical Decision Making**

Ethical commitment and well-informed ethical planning will reduce but not eliminate ethical challenges that emerge during the course of psychologists’ work. Ethical problems often arise when two or more principles or standards appear to be in conflict, in unexpected events, or in response to unforeseen reactions of those with whom a psychologist works. There is no ethical menu from which the right ethical actions simply can be selected. Many ethical challenges are unique in time, place, and persons involved. The very process of generating and evaluating alternative courses of action helps place in vivid relief the moral principles underlying such conflicts and stimulates creative strategies that may resolve or eliminate them.

Ethical decisions are neither singular nor static. They involve a series of steps, each of which will be determined by the consequences of previous steps. Evaluation of alternative ethical solutions should take a narrative approach that sequentially considers the potential risks and benefits of each action. Understanding of relevant laws and regulations as well as the nature of institutions, companies, or organizations in which the activities will take place is similarly essential for adequate evaluation of the reactions and restraints imposed by the specific ethical context.

A number of psychologists have proposed excellent ethical decision-making models to guide the responsible conduct of psychological science and practice (e.g., Barnett & Johnson, 2008; Canter et al., 1994; Kitchener, 1984; Koocher& Keith-Spiegel, 2008; Newman, Gray, & Fuqua, 1996; Rest, 1983; Staal& King, 2000). Drawing on these models and the importance of ethical commitment, awareness, and competence, an eight-step model is proposed:

*Step 1:* Develop and sustain a professional commitment to doing what is right.

*Step 2:* Acquire sufficient familiarity with the APA Ethics Code General Principles and Ethical Standards to be able to anticipate situations that require ethical planning and to identify unanticipated situations that require ethical decision making.

*Step 3:* Gather additional facts relevant to the specific ethical situation from professional guidelines, state and federal laws, and organizational policies.

*Step 4:* Make efforts to understand the perspective of different stakeholders who will be affected by the decision and consult with colleagues.

*Step 5:* Apply Steps 1 to 4 to generate ethical alternatives and evaluate each alternative in terms of moral theories, General Principles and Ethical Standards, relevant laws and policies, and consequences to stakeholders.

*Step 6:* Select and implement an ethical course of action.

*Step 7:* Monitor and evaluate the effectiveness of the course of action.

*Step 8:* Modify and continue to evaluate the ethical plan if feasible and necessary.

[Appendix B](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/appendixb.html) contains 10 case studies that provide readers with the opportunity to creatively apply to ethical challenges across a broad range of psychological work the ethical decision-making model described above and the knowledge they gain in reading chapters throughout this book. The next section provides an example of how the eight ethical decision-making steps can be applied to an ethical dilemma.

**An Example of Ethical Decision Making**

Dr. Ames conducts outpatient individual and group therapy for young adults with dual diagnosis (substance dependence and anxiety disorders). Although Dr. Ames was careful not to enter into the group those of her patients who were friends, partners, or relatives, she has recently learned that two group members (James and Angela) have started to date one another. In her next individual therapy session, Angela excitedly tells Dr. Ames that she is pregnant and is planning to move in with James, the father of her baby. When asked if she has seen a doctor, Angela replies that she does not have health insurance and has nothing to worry about since neither she nor James have any diseases. Dr. Ames knows from previous individual sessions with James that he is HIV positive. She asks Angela’s permission to speak with James about their new situation and Angela agrees. During his next session James tells Dr. Ames that he does not plan to tell Angela that he is HIV positive because she would leave him. He also angrily reminds Dr. Ames that she is “sworn to secrecy” because she promised that everything he told her, except child abuse or hurting someone, would be confidential.

*Step 1.* Dr. Ames is committed to doing the right thing. She thinks of herself as honest, judicious, respectful, and compassionate. She struggles with her desire to maintain James’s confidentiality about his HIV status and her concern about the health risks to Angela and her pregnancy ([Standards 2.01](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/appendixa.html#st2-1), Maintaining Confidentiality; 3.05, Avoiding Harm).

*Step 2.* Dr. Ames reviews the Ethics Code standards. She realizes that because two of her group therapy patients have unexpectedly entered into a romantic relationship discussed only in their individual sessions that she is confronting an unforeseen potentially harmful multiple relationship ([Standard 3.05b](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/appendixa.html#st3-5), Multiple Relationships). She realizes that her concerns regarding the health risks to Angela and her baby and her conflict over maintaining James’s confidentiality can potentially compromise her objectivity and effectiveness in performing her job. According to [Standard 3.05b](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/appendixa.html#st3-5), she must take reasonable steps to resolve the problem with due regard for the best interests of all the affected persons.

Dr. Ames also recognizes that while it is important to protect James’s confidentiality ([Standard 4.01](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/appendixa.html#st4-1), Maintaining Confidentiality), the Ethics Code permits her to disclose confidential information to protect others from harm ([Standard 4.05](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/appendixa.html#st4-5), Disclosures). She had thought that her informed consent procedure was consistent with ethical standards since she did inform James and all her individual and group clients/patients of her legal obligation to report child abuse and the possibility that disclosure could also occur to protect others from harm ([Standard 4.02](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/appendixa.html#st4-2), Discussing the Limits of Confidentiality). However, although she was prepared to address issues of group members fraternizing outside of group, she had not anticipated that this type of situation would arise and she was unsure about the answers to the following questions. Should James’s decision to intentionally keep his HIV status secret and to continue to have unprotected sex with Angela be considered “harm” to another person? Did the consent language adequately inform Dr. Ames’s clients/patients that the risk of transmitting HIV would meet criteria for disclosure? Are there prohibitions in state law against revealing a non-medical client’s/patient’s HIV status? Is exposing a fetus to HIV infection included in the legal definition of child abuse in Dr. Ames’s state?

Dr. Ames also reviews the Ethics Code’s aspirational principles. She recognizes that she has a fiduciary responsibility to both James and Angela that rests on establishing relationships of trust (Principle B: Fidelity and Responsibility) and worries that the therapeutic alliance with James may be jeopardized if she discloses his HIV status to Angela and that her therapeutic alliance with Angela may be compromised if she is perceived to be colluding with James in a secret that could be harmful to the health of Angela and her baby (Principle A: Beneficence and Nonmaleficence, Principle C: Integrity, and Principle E: Respect for People’s Rights and Dignity).

*Step 3.* Dr. Ames consults with legal counsel at her state psychological association and discovers that her state does not have a “duty to protect” law requiring clinicians to take steps to protect identified others from harm (see [Chapter 7](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/ch07.html)) and that mandatory child abuse–reporting laws are not extended to pregnancies. There are also no laws requiring or preventing mental health providers from disclosing information on HIV obtained in a nonmedical context. She reviews relevant publications and discovers that conditions requiring disclosure remain under debate within the discipline (Donner, VandeCreek, Gonsiorek, & Fisher, 2008).

*Step 4.* She consults with medical colleagues regarding the probability that James will transmit the virus to Angela and the risks to her fetus and learns that infectivity rates are highly variable ranging from 1 per 1,000 to 1 per 3 contacts (Powers, Poole, Pettifor, & Cohen, 2008) and mother to child transmission is 15% to 30% occurring mostly in the last trimester (Orendi et al., 1999). She also speaks to the prenatal department of the community clinic and finds out that they routinely provide pregnant women with information regarding HIV risk protection. To ensure that she is sensitive to the cultural context from which James and Angela’s reactions to her decision may be embedded, she consults with her community advisory board (CAB) composed of former drug users and social service workers with experience serving this community. Some board members express the belief that the risk of HIV is well-known in the community and that Angela is responsible for protecting herself. Others believe that James is violating community standards and that he has therefore given away his right to confidentiality (see Fisher et al., 2009). Still, others point out that Dr. Ames may lose the trust of the rest of her group therapy members if she violates James’s confidentiality ([Standard 10.03](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/appendixa.html#st10-3), Group Therapy). Through all of these discussions, Dr. Ames is careful not to reveal the identities of James and Angela ([Standard 4.06](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/appendixa.html#st4-6), Consultations).

*Step 5.* Dr. Ames begins to contemplate alternative actions. From a Kantian/deontic perspective, by not disclosing the HIV risk information to Angela, she would fulfill her confidentiality commitment to James, on which his autonomous consent to participate was based. At the same time, Kant’s idea of humanity as an end in itself might support taking steps to protect Angela and her fetus from harm. From a utilitarian perspective, the importance of protecting Angela and her fetus from a potentially life-threatening health risk must be weighed against the unknown probability of HIV infection to Angela and her fetus as well as Angela’s reaction to the disclosure. Dr. Ames also considers what type of decision would preserve the trust she has developed with her other group therapy clients/patients. The advisory board consultation suggested that there was not a broadly shared common moral perspective that would suggest a specific communitarian or multicultural approach to the problem. From a feminist ethics perspective, failing to disclose the information to Angela might perpetuate the powerlessness and victimization of women in this disenfranchised community. At the same time, disclosure might undermine Angela’s autonomy if in fact she is aware of HIV risk factors in general and knows or suspects James’s HIV positive status.

*Step 6.* On the basis of the previous steps, Dr. Ames decides that she will not at this point disclose James’s HIV status to Angela. She concludes that her promise of confidentiality to James was explicitly related to his agreement to participate in treatment, while her sense of obligation to protect Angela from James’s behavior was not a requisite or an expectation of Angela’s participation. The community board’s comments suggest that Angela is most likely aware of the general risks of HIV transmission among drug users, as do some of Angela’s comments in Dr. Ames’s notes from previous sessions. In addition, Dr. Ames’s visit to the clinic indicated that there are community health services that routinely advise pregnant women about these risks and provide HIV testing. Dr. Ames decides that at her next individual session with Angela, and during subsequent sessions, she will encourage her to visit the free prenatal clinic, as well as discuss prenatal risks and the value of prenatal care. She will also tell James of her decision not to disclose his HIV status to Angela, continue to encourage him to do so, and provide him with written information regarding prenatal risk and safer sexual practices.

*Step 7.* Dr. Ames will monitor and evaluate the effectiveness of her course of action. She will keep apprised of whether Angela visits the prenatal clinic, including whether Angela is tested for HIV. She will also monitor whether James begins to act in ways that will be protective of Angela, especially as Angela enters her third trimester. Dr. Ames will also continue to evaluate whether the unexpected multiple relationship with James and Angela compromises her ability to maintain objectivity in her individual and group sessions and seek consultation if necessary.

*Step 8.* Whether or not monitoring over the next few months leads Dr. Ames to modify her decision to maintain James’s confidentiality, her evaluation of the effect of her course of action will influence her confidentiality and disclosure policies in the future. She plans to convene a meeting of community drug users and community practitioners to develop procedures that can anticipate and best address this type of issue in the future.

Ethical decision making in psychology requires flexibility and sensitivity to the context, role responsibilities, and stakeholder expectations unique to each work endeavor. At their best, ethical choices reflect the reciprocal interplay between psychological activities and ethical standards in which each is continuously informed and transformed by the other. The specific manner in which the APA Ethics Code General Principles and Ethical Standards are applied should reflect a “goodness of fit” between ethical alternatives and the psychologist’s professional role, work setting, and stakeholder needs (Fisher, 2002b, 2003b; Fisher & Goodman, 2009; Fisher & Ragsdale, 2006; Masty& Fisher, 2008). Envisioning the responsible conduct of psychology as a process that draws on psychologists’ human responsiveness to those with whom they work and their awareness of their own boundaries, competencies, and obligations will sustain a profession that is both effective and ethical.

**Doing Good Well**

Ethics requires self-reflection and the courage to analyze and challenge one’s values and actions. Ethical practice is ensured only to the extent that there is a personal commitment accompanied by ethical awareness and active engagement in the ongoing construction, evaluation, and modification of ethical actions. In their commitment to the ongoing identification of key ethical crossroads and the construction of contextually sensitive ethical courses of action, psychologists reflect the highest ideals of the profession and merit the trust of those with whom they work.

**HOT TOPIC**

The Ethical Component of Self-Care

The professional practice of psychology can be rewarding as well as stressful. Psychological treatment often involves working with clients/patients who express acute or chronic suicidality, engage in self-harm, are victims of abuse or assault, or are coping with the death of loved ones or with their own chronic or fatal disease. Clinicians treating veterans or others with posttraumatic stress disorder (PTSD) are regularly assessing and treating patients struggling with repetitive aggressive or homicidal episodes that may place the client/patient, their families, and the treating psychologist in physical danger (Voss Horrell, Holohan, Didion, & Vance, 2011).

**The Emotional Toll of Professional Practice**

The emotional toll and precarious nature of this work makes psychologists vulnerable to occupational stress, including emotional exhaustion, depersonalization and lack of personal accomplishment that lead to burnout, overcompensating efforts to “save” clients/patients or participants, boundary violations, and other behaviors that impair job performance (APA Committee on Colleague Assistance, 2006; Lee, Lim, Yang, & Lee, 2011; Webb, 2011). For example, military psychologists with extended deployments to war zones who are practicing in life-threatening contexts risk direct trauma-related distress and vicarious distress working with traumatized military personnel (W. B. Johnson et al., 2011). Psychologists working with patients or research participants graphically describing child or partner abuse, homelessness and hunger, drug abuse and violence, or death and dying may also experience vicarious or secondary trauma, guilt, or a sense of powerlessness for which there is little institutional support (McGourty, Farrants, Pratt, &Cankovic, 2010; Simmons & Koester, 2003). Psychologists who have a client/patient die from suicide, an accident, or fatal disease may not recognize or receive social support for their own grief reactions (Doka, 2008).

Psychologists working in schools, military hospitals, or correctional facilities may experience the painful feelings and psychological disequilibrium that characterizes moral distress—lack of professional control to do what they believe is right (Corely, 2002) in response to institutional constraints on caseload, resources, use of evidence-based practices (EBPs), up-to-date assessment instruments, or trained personnel (Maltzman, 2011; O’Brien, 2011; Voss Horrell et al., 2011). Or in response to work-related stressors, psychologists may develop compassion fatigue or begin to process client/patient experiences on a purely cognitive level, a syndrome W. B. Johnson et al. (2011) describe as empathy failure.

**“Wounded Healer”**

Competent treatment of fatally ill, violent, or suicidal clients/patients may require extensive patient contact, behavioral monitoring, interactions with family members, and significant flexibility in identifying appropriate treatment strategies. Not surprisingly, many ethical dilemmas for psychologists working with these patients revolve around decisions regarding maintaining an appropriate balance between personal and professional boundaries (e.g., [Standards 3.04](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/appendixa.html#st3-4), Avoiding Harm; 3.05, Multiple Relationships; 7.07, Sexual Relationships with Students and Supervisees; and 10.05, Sexual Intimacies with Current Therapy Clients/Patients).

Working in emotionally charged therapeutic contexts can lead to work-related exhaustion, sense of urgency, and worries that may compromise competent therapeutic decisions ([Standard 2.06](https://jigsaw.vitalsource.com/books/9781452285870/epub/OEBPS/appendixa.html#st2-6), Personal Problems and Conflicts). On the other hand, such experiences can lead to unique professional growth. Jackson (2001) introduced the term wounded healer to describe how the emotional experience of working with such clients/patients can later serve to enhance psychologists’ therapeutic endeavors. Voss Horrell et al. (2011) have described similar positive developments in compassion satisfaction and posttraumatic growth in response to the challenges of treating veterans with PTSD.

**Mindfulness-Based Stress Reduction**

Research and clinical scholarship on the potential for and diminished work competence associated with burnout, social isolation, compassion fatigue, depression, and vicarious traumatization among psychologists working with high-risk populations have led to a widening endorsement of self-care practices as an essential ethical tool in ensuring competence in psychological work. Discerning when stress becomes impairment is difficult in the present moment (Barnett, 2008) and thus requires a proactive approach to self-care that mitigates the effect of stressors on professional competence (Tamura, 2012).

One such approach is mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1993) adapted for the practice of psychology. MBSR is rapidly becoming a popular approach for maintaining appropriate competencies under stressful work conditions. MBSR is a technique for enhancing emotional competence through attention to present moment inner experience without judgment. It is seen as an effective means of reducing emotional reactions toward and identification with clients’/patients’ problems that can lead to therapeutic deficits (Christopher & Maris, 2010; D. M. Davis & Hayes, 2011; S. L. Shapiro, Brown, &Biegel, 2007). Several recent studies have demonstrated positive effects of MBSR training on counseling skills and therapeutic relationships (Christopher, Christopher, Dunnagan, &Schure, 2006; McCollum &Gehart, 2010), including self-care educational materials in graduate courses and modeling and mentoring self-care habits in supervisory relationships.

**Practical Guidelines for Self-Care**

While there are empirical studies on effective approaches such as MBSR for maintaining and developing the competencies required, several psychologists have generously shared their own experiences and hard-earned professional insights on personal and professional approaches to such challenging cases (Barnett, Cornish, Goodyear, & Lichtenberg, 2007; O’Brien, 2011; Tamura, 2012; Webb, 2011).

Specific self-care strategies for competent practice include the following:

* Minimize risks posed by the social isolation of working in individualized therapeutic settings through formal (peer consultation or supervision) and informal (professional conferences, lunch with peers) activities
* Schedule activities that are not work related and develop daily strategies for transitioning from work life to home life
* Develop healthy habits of eating, sleeping, and exercise
* Set appropriate boundaries for work-related activities such as beginning and ending sessions on time, limiting work-related phone calls or e-mails to specific times of the day or early evening
* Diversify work activities and/or caseload
* Utilize personal psychotherapy as a means of addressing psychological distress and enhancing professional competence through increased self-awareness, self-monitoring, and emotional competence

**Preparing Psychology Trainees for Work-Related Risks and Self-Care**

Self-care strategies should be included in graduate education and training and encouraged as lifelong learning techniques (Barnett & Cooper, 2009). Trainees and young professionals may be particularly susceptible to stressors associated with clinical work, especially when programs have not provided training in self-awareness and self-regulation techniques to balance self and other interests and to maintain emotional competence (Andersson, King, &Lalande, 2010; S. L. Shapiro et al., 2007; Tamura, 2012). W. B. Johnson et al. (2011) propose that psychologists must acknowledge the ethical obligation to routinely assess their colleagues’ performance. This is especially important in graduate and internships programs in which students may rely on peer and faculty reactions as measures of their own competence. Programs should thus strive to create a culture of community competence that encourages trainees to recognize themselves as vulnerable to work-related stress and reduced competence, to recognize personal and professional dysfunction, and to develop professional self-care habits that support emotional and professional competence.